

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056456	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/26/2024
NAME OF PROVIDER OR SUPPLIER Palazzo Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 5400 Fountain Ave Los Angeles, CA 90029	

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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44252</p> <p>Based on interview, and record review, facility failed to ensure dignity and respect for two of seven sampled residents (Residents 2 and 7).</p> <p>This failure resulted in Residents 2 and 7 not being treated with dignity and respect and had the potential to affect the resident ' s self-esteem and self-worth.</p> <p>Findings:</p> <p>A review of Resident 2 ' s Admission Record dated 6/24/24, indicated Resident 2 was admitted to the facility on [DATE], with diagnoses including, hypertension (high blood pressure), low back pain, anemia (a condition in which the body does not have enough healthy red blood cells, to transport oxygen around the body) and cellulitis (bacterial infection that enters your skin and tissue through a wound) of bilateral (both) lower extremities.</p> <p>A review of Resident 2 ' s Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 3/30/24 indicated Resident 2 had intact cognition (ability to think, understand and make daily decisions). The same MDS indicated Resident 2 required set up assistance from staff for eating, and supervision for bed mobility, toileting, dressing, and personal hygiene.</p> <p>A review of Resident 7 ' s Admission Record dated 6/26/24, indicated Resident 7 was admitted to the facility on [DATE], with diagnoses including, osteoarthritis (a type of arthritis that happens when the cartilage that lines your joints is worn down and your bones rub against each other) of right hip, anemia, reduced mobility (moving around), and lack of coordination.</p> <p>A review of Resident 7 ' s MDS dated [DATE] indicated Resident 7 had intact cognition. The same MDS indicated Resident 7 required set up assistance from staff for eating, and maximal to being totally dependent on staff for bed mobility, toileting, dressing, and personal hygiene.</p> <p>During an interview on 6/24/24 at 12:46 pm with, Resident 2, Resident 2 mentioned there was an incident early morning 6/18/24 when she was called into a resident ' s room to help because they were cold. The resident stated she found the resident uncovered and helped cover them. When a Certified Nursing Assistant (CNA) came into the room and yelled at them both as to why they were questioning his care. The resident further stated they (staff) all yell frequently on the night shift, and they should not be doing that.</p> <p>(continued on next page)</p>

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056456	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/26/2024
NAME OF PROVIDER OR SUPPLIER Palazzo Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 5400 Fountain Ave Los Angeles, CA 90029	
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)		
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/26/24 at 6:45 am with Resident 7, Resident 7 stated she had heard and argument between more than two people around the same time Resident 2 stated the yelling took place. Resident 7 stated she didn ' t know what they were saying but it was an argument.</p> <p>A review of the facility ' s policy and procedures (P&P) titled, Resident rights, revised on 12/2016, indicated Employees shall treat all residents with kindness, respect and dignity . Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident ' s rights to be treated with respect, kindness, and dignity.</p>		