STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056456	A. Building B. Wing	09/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palazzo Post Acute	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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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

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

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(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 - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to protect one of three sampled residents (Resident 1) from physical abuse (any intentional act causing injury or trauma to another person by way of bodily contact) by failing to: -Ensure Certified Nursing Assistant 2 (CNA2) notified Registered Nurse 2 (RN2) that Resident 1 was agitated (to be visibly worried, upset, or restless, often showing this feeling through your movements or voice, like fidgeting or speaking in a tense way) when CNA1 did not allow Resident 1 to go smoke on 9/9/2025 at approximately 1AM. -Ensure Resident 2 did not hit Resident 1 who was blind on the left jaw (the lower part of the face below the mouth) on 9/9/2025 at 1AM. On 9/9/2025 at approximately 1AM, Resident 1 wanted to go smoke and CNA2 told Resident 1 to sit down. Resident 1 became agitated Resident 2 thought Resident 1would hit CNA2 and Resident 2 hit Resident 1 on Resident 1's left jaw. As a result, on 9/9/2025 at 1AM Resident 2 hit Resident 1 on the jaw causing Resident 1 to experience pain in the jaw and required an x-ray (medical imaging that uses radiation to take pictures of the inside of your body). Findings: 1. During a review of Resident 1's admission Record, the admission Record indicated the facility originally admitted Resident 1 on 7/26/2025 and readmitted Resident 1 on 8/26/2025 with diagnoses of lack of coordination, blindness of both eyes, 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). During a review of Resident 1's History and Physical (H&P), dated 7/26/2025, the H&P indicated Resident 1 had no capacity (ability) for decision-making. The H&P indicated Resident 1 had a history of nicotine dependence (your brain and body rely on nicotine from tobacco or vaping products to feel normal and avoid withdrawal). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 8/2/2025, the MDS indicated Resident 1 had the ability to make himself (Resident 1) understood, and had the ability to understand others. During a review of Resident 1's Care Plan Report dated 8/12/2025, the Care Plan Report indicated the CNAs (in general) would monitor Resident1 for unsafe smoking practices. The Care Plan Report indicated the CNAs (in general) would notify the charge nurse immediately if it was suspected Resident 1 violated the facility's smoking policy. During a review of Resident 1's Progress Note dated 9/9/2025 at 1 AM, the Progress Note indicated Resident 1 became agitated and Resident 2 hit Resident 1 because Resident 2 believed Resident 1 was going to hit the sitter (CNA2). The Progress Note indicated Resident 2's hand landed on Resident 1's jaw. The Progress Note indicated the facility staff (unidentified) separated Resident 1 and Resident 2. During a review of Resident 1's Progress Note, dated 9/9/2025 at 2:59 AM, the Progress Note indicated Resident 1 became agitated around 1 to 1:15 AM on 9/9/2025 and stood up from the bed. The Progress Note indicated the sitter (CNA2) approached Resident 1 and tried to calm Resident 1 down. The Progress Note indicated Resident 2 moved from his bed to his wheelchair and swung his hand and hit Resident 1 on the jaw. The Progress note indicated a Registered Nurse (RN2) and Charge Nurse (LVN2) separated Resident 1 and Resident 2 with the help of the sitter (CNA2). The Progress Note indicated Resident 2 was later moved (unknown time) to another room. The Progress Note indicated Resident 1 wanted to smoke and the RN (RN2) explained to Resident 1 the facility's designated smoking times. During a review of Resident 1's Radiology (the medical specialty that uses imaging techniques, such as X-rays) Results Report, dated 9/9/2025 at 2:15 PM, indicated the reason for the study was jaw pain and the results of the x-ray was no fracture (broken bone). During a review of Resident 1's Progress Note, dated 9/12/2025 at 3:57 PM, the Progress Note indicated the Interdisciplinary Team (IDT - group of people from different professions who work together by sharing knowledge and methods to solve a complex problem) met to discuss what happened on 9/9/2025 when Resident 2 hit Resident 1. The Progress Note indicated Resident 1 wanted to go to the smoking patio around 1 AM (date not indicated) and the sitter told Resident 1 it was not time for smoking. The Progress Note indicated Resident 2 shouted at Resident 1, kneeled on his (Resident 2) wheelchair, wheeled himself (Resident 2) toward Resident 1 and struck (hit) him (Resident 1) on the left jaw with his (Resident 2) right hand. The Progress Note indicated Resident 2 believed Resident 1 had struck the sitter and that Resident 2 felt he had a sense of duty to intervene (step in) in defense of the sitter because he (Resident 2) believed a man (in general) should hit a woman (in general). 2.During a review of Resident 2's admission Record, the admission Record indicated the facility originally admitted Resident 2 on 7/2/2025 and readmitted Resident 2 on 7/29/2025 with diagnoses of type 2 Diabetes Mellitus (DM-a disorder characterized

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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. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to supervise two of three residents (Resident 1 and Resident 2) by failing to: -Ensure Certified Nursing Assistant 2 (CNA2) notified Registered Nurse 2 (RN2) that Resident 1 was agitated (to be visibly worried, upset, or restless, often showing this feeling through your movements or voice, like fidgeting or speaking in a tense way) when CNA1 did not allow Resident 1 to go smoke on 9/9/2025 at approximately 1AM. -Ensure Resident 2 did not hit Resident 1 who was blind on the left jaw (the lower part of the face below the mouth) on 9/9/2025 at 1AM. -Ensure Resident 1 and Resident 2 had adequate supervision to prevent Resident 2 from hitting Resident 1 on his jaw. On 9/9/2025 at approximately 1AM, Resident 1 wanted to go smoke and CNA2 told Resident 1 to sit down. Resident 1 became agitated Resident 2 thought Resident 1would hit CNA2 and Resident 2 hit Resident 1 on Resident 1's left jaw. As a result, on 9/9/2025 at 1AM Resident 2 hit Resident 1 on the jaw causing Resident 1 to experience pain in the jaw and required an x-ray (medical imaging that uses radiation to take pictures of the inside of your body). Findings: 1.During a review of Resident 1's admission Record, the admission Record indicated the facility originally admitted Resident 1 on 7/26/2025 and readmitted Resident 1 on 8/26/2025 with diagnoses of lack of coordination, blindness of both eyes, 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). During a review of Resident 1's History and Physical (H&P), dated 7/26/2025, the H&P indicated Resident 1 had no capacity (ability) for decision-making. The H&P indicated Resident 1 had a history of nicotine dependence (your brain and body rely on nicotine from tobacco or vaping products to feel normal and avoid withdrawal). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 8/2/2025, the MDS indicated Resident 1 had the ability to make himself (Resident 1) understood, and had the ability to understand others. During a review of Resident 1's Care Plan Report dated 8/12/2025, the Care Plan Report indicated the CNAs (in general) would monitor Resident1 for unsafe smoking practices. The Care Plan Report indicated the CNAs (in general) would notify the charge nurse immediately if it was suspected Resident 1 violated the facility's smoking policy. During a review of Resident 1's Progress Note dated 9/9/2025 at 1 AM, the Progress Note indicated Resident 1 became agitated and Resident 2 hit Resident 1 because Resident 2 believed Resident 1 was going to hit the sitter (CNA2). The Progress Note indicated Resident 2's hand landed on Resident 1's jaw. The Progress Note indicated the facility staff (unidentified) separated Resident 1 and Resident 2. During a review of Resident 1's Progress Note, dated 9/9/2025 at 2:59 AM, the Progress Note indicated Resident 1 became agitated around 1 to 1:15 AM on 9/9/2025 and stood up from the bed. The Progress Note indicated the sitter (CNA2) approached Resident 1 and tried to calm Resident 1 down. The Progress Note indicated Resident 2 moved from his bed to his wheelchair and swung his hand and hit Resident 1 on the jaw. The Progress note indicated a Registered Nurse (RN2) and Charge Nurse (LVN2) separated Resident 1 and Resident 2 with the help of the sitter (CNA2). 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