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	12/16/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm 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. (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

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	12/16/2025

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 0656 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 create and implement a Care Plan (a plan of care that summarizes a resident's health conditions, specific care needs, and current treatments) to meet the individual needs for one of three sample residents (Resident 1) care plan, by failing to: 1. Create and implement a care plan on 11/29/2025 when the resident displayed aggressive behavior and was placed on 1:1supervision (one staff member always stays with one patient to keep them from harming others or themselves). 2. Create and implement a care plan on 12/8/2025 when the resident was readmitted to the facility from the GACH (General Acute Care Hospital) after being evaluated for increased agitation with aggression. These deficient practices had the potential to delay and affect the quality of care and services Resident 1 received.Findings: During a review of Resident 1's admission Record, the admission Record indicated the facility admitted Resident 1 on 3/10/2025 and readmitted on [DATE] with diagnoses that included bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), current episode depressed (a serious mood disorder causing persistent sadness), severe, with psychotic(severe mental illness where the individual's thoughts and perceptions are so out of sync with those around them that they have trouble functioning in daily life) features, paranoid schizophrenia (your brains wiring gets crossed, making you intensely suspicious [paranoid], hearing things that are not there [hallucinations, often voices], and strong beliefs [delusions, thinking you're being plotted against], leading to confused thinking and difficulty handling daily life), unspecified mood affective disorder (your emotions go swinging beyond the normal ups and downs affecting daily life), and other psychoactive substance abuse (a drug, herb, or chemical that changes how your brain works), uncomplicated. During a review of Resident 1's History and Physical (H&P) dated 12/9/2025, the H&P indicated Resident 1 did not have the capacity (ability) to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS - a standardized resident assessment tool) dated 11/11/2025, the MDS indicated Resident 1 had moderate cognitive (ability to think, understand, learn, and remember) impairment (reduced). During a review of Resident 1's behavior notes dated 11/29/205 at 4:12 PM, the note indicated Resident 1 was observed to be spitting to the nurse that is currently taking care of him. During a review of Resident 1's Situation Background Assessment and Recommendation (SBAR) Summary for Providers dated 11/29/2025 at 4:25 PM, the SBAR indicated Resident 1 was placed on 1:1 supervision per MD (Medical Doctor) orders. During a review of Resident 1's comprehensive (complete) care plans for 11/29/2025, the comprehensive care plans indicated a care plan for Resident 1's aggressive behavior and 1:1 supervision was not implemented. During a review of Resident 1's nursing progress notes dated 11/29/2025 at 11:15 PM, the notes indicated Resident 1 had a physician's order to transfer the resident to to the GACH. The notes indicated the resident was sent the GACH for further evaluation for increased agitation episode. During a review of Resident 1's progress notes dated 12/8/2025 at 5:24 PM, the notes indicated the resident was readmitted to the facility. During a review of Resident 1's comprehensive (complete) care for 12/8/2025, the comprehensive care plans indicated a care plan for Resident 1's aggressive behavior was not implemented. During a concurrent interview and record review on 12/16/2025 at 11:29 AM, with Licensed Vocational Nurse (LVN) 1, Resident 1's Behavior Note dated 11/29/2025 4:12PM, Resident 1's SBAR Summary for Providers dated 11/29/2025 4:25PM, and complete care plans were reviewed. LVN 1 stated a care plan should have been implemented when there was a significant changes or regression (a return to a former or less developed state) to achieve the most optimal plan of care for Resident 1 with the most recent baseline of behaviors. LVN 1 stated if a care plan was not updated it would not be 100 percent accurate on monitoring Resident 1's behavior and that it was not in the best interest of Resident 1 since it did not represent the resident's most current plan of care. During an interview on 12/16/2025 at 12:23 PM with Registered Nurse (RN)1, RN1 stated the importance of a care plan was to have a plan of care with interventions that outlined certain steps for resident care. RN 1 stated if there were changes in the resident's condition or if a resident returned from the GACH the care provided might not have appropriate interventions without an updated care plan. RN 1 stated care plans were created on a case-to-case basis and based on resident assessments (the process of evaluating someone to understand their condition). During a concurrent interview and record review on 12/16/2025 at 12:37 PM, with LVN 2, Resident 1's Behavior Note dated 11/29/2025, SBAR Summary dated 11/29/2025 and complete care plans