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	06/25/2026

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure two of three sampled residents (Resident 8 and Resident 13) reviewed for dialysis (a medical treatment that acts as an artificial kidney, filtering waste products, toxins, and excess water from the blood when a person's kidneys can no longer perform these tasks properly) received dialysis services consistent with professional standards of practice by failing to:-Ensure Resident 8 did not miss dialysis appointments due to transportation on 5/16/2026.-Ensure the licensed nurses (in general) conducted the pre (before) and post (after) dialysis assessments for Resident 8 and Resident 13.-Ensure Resident 13 did not receive more than 1000 milliliters (ml, a unit of measurement) of fluid per day as ordered by Resident 13's physician.These failures had the potential to delay critical treatment, compromise the accuracy of dialysis orders, and place Resident 8 and Resident 13 at risk for injury, fluid overload (is a condition where the body accumulates too much fluid, leading to swelling, high blood pressure, and potential heart and lung complications), infection, or other complications. Findings: a. During a review of Resident 8's admission Record, the admission Record indicated the facility readmitted the resident on 5/19/2026, with diagnoses that included metabolic encephalopathy (brain dysfunction caused by an chemical imbalance in the blood), end stage renal failure (ESRD, irreversible kidney failure), and diabetes (a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 8's Care Plan Report dated 2/13/2026, the Care Plan Report indicated Resident 8 needed hemodialysis related to ESRD. The Care Plan Report indicated a nursing intervention to assist the resident with dialysis pick up every Tuesday, Thursday, and Saturday of every week. During a review of Resident 8's Order Summary Report dated 3/6/2026, the Order Summary Report indicated for Resident 8 to receive dialysis on Tuesday, Thursday, and Saturday. During a review of Resident 8's History and Physical (H&P) dated 3/8/2026, the H&P indicated the resident had the capacity to make and understand complex decisions. During a review of Resident 8's Order Summary Report dated 4/21/2026, the Order Summary Report indicated to assist Resident 8 with curbside pickup outside of the facility every Tuesday, Thursday, and Saturday for dialysis services. During a review of Resident 8's Minimum Data Set (MDS, a resident assessment tool) dated 5/12/2026, the MDS indicated the resident required supervision (helper provides verbal cues or (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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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	steadying assistance as resident completes activity) from staff to complete activities of daily living (ADLS, activities a person performs daily such as bathing, dressing, and toileting). The MDS indicated the resident received dialysis. During a review of Resident 8's Progress Note, dated 5/14/2026, the Progress Note indicated resident refused to attend a routinely scheduled dialysis appointment (5/14/2026). The Progress Note indicated that the Facility Medical Director (FMD) ordered a make-up dialysis and for the Social Services Department to arrange for transportation. During a review of Resident 8's Progress Note dated 5/15/2026, the Progress Note indicated resident left the facility for a make-up dialysis. The Progress Note indicated a Dialysis Communication Record was provided. During a review of Resident 8's Progress Note dated 5/15/26, the Progress Note indicated the resident left the facility for a make-up dialysis. During a review of Resident 8's Progress Note, dated 5/15/2026, the Progress Note indicated the resident returned from make-up dialysis the same day (5/15/2026). During a review of Resident 8's Progress Note, dated 5/16/2026, the Progress Note indicated Resident 8 missed a routinely scheduled dialysis appointment (5/16/2026) due to transportation not arriving. The Progress Note indicated the facility Medical Director was made aware that the staff (unidentified) would follow up the following Monday (5/18/26) to schedule a same-day make-up dialysis appointment. During a review of Resident 8's Progress Note, dated 5/18/2026, the Progress Note indicated a make-up dialysis was scheduled for 5/18/26 at 2 PM and for the Social Services Department to arrange for transportation. During a review of Resident 8's Order Details dated 5/18/2026, the Order Details indicated Received an order, may transfer out to hospital due to 2x [twice] missed dialysis treatment. During a review of Resident 8's Transfer Form dated 5/18/2026, the Transfer Form indicated an unplanned transfer to General Acute Care Hospital (GACH1) at 5:05 PM for missed dialysis. During an interview on 6/24/2026 at 10:55 AM with Licensed Vocational Nurse 6 (LVN6), LVN 6 stated it was important for residents (in general) to go to their dialysis appointments as scheduled. LVN 6 stated toxins (poisonous) build up in the body and fluid overload (a condition where the body accumulates too much fluid) can occur if residents missed their dialysis. During a concurrent interview and record review on 6/24/2026 at 10:55 AM with LVN6, Resident 8's Dialysis Communication Record was reviewed. LVN 6 reviewed the Dialysis Communication Record binder and was unable to find any pre/post dialysis assessments for the make-up dialysis on 5/15/2026. LVN 6 stated the record was used to track significant changes in residents' baseline (in general) after dialysis and would monitor compliance with the prescribed dialysis treatment. During an interview on 6/24/2026 at 11:14 AM with the Social Services Director (SSD), the SSD stated the facility arranged transportation based on the residents' (in general) dialysis schedule. The SSD stated residents (unidentified) had sometimes missed dialysis appointments due to (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	transportation issues. During an interview on 6/24/2026 at 11:34 AM with Registered Nurse 1 (RN 1), RN 1 stated missed dialysis could cause shortness of breath from fluid overload and abnormal labs, which could lead to hospitalization. RN 1 stated Resident 8 did not go to dialysis on 5/14/2026 but was able to go to a make-up dialysis on 5/15/2026. RN 1 stated Resident 8 was supposed to resume the regularly scheduled dialysis on 5/16/2026, but that appointment was missed. RN 1 stated the make-up dialysis was on 5/18/2026, but Resident 8 did not go to that make-up dialysis and was instead sent to GACH 1. During an interview and record review on 6/24/2026 at 11:34 AM with RN1 Resident 8's Dialysis Communication Record was reviewed. RN 1 reviewed the blank Dialysis Communication Record and stated that the form should have been filled out before the resident left for dialysis and when the resident came back from dialysis. RN 1 stated the Dialysis Communication Record was part of the dialysis assessment which included cognitive (mental) status, vital signs (clinical measurements, specifically pulse rate, temperature, respiration rate, and blood pressure, that indicate the state of a patient's essential body functions), breath sounds, and access site (a surgically created site used to remove and return blood during HD). During an interview on 6/24/2026 at 1:44 PM with the Social Services Specialist (SSS), the SSS stated transportation was not arranged for Resident 8's make-up dialysis appointment on 5/18/26. The SSS stated transportation should have been arranged. During a concurrent interview and record review on 6/24/2026 at 2:09 PM with the Director of Nursing (DON) the facility's policy and procedure (P&P) titled, Transportation, Appointment Arrangement and Scheduling Policy revised May 2026 was reviewed. The DON reviewed the P&P and stated Resident 8 did not go to the make-up dialysis appointments on 5/16/2026 and 5/18/2026 due to transportation issues. The DON stated missing scheduled dialysis sessions increased the risk of fluid overload, resulting in swelling and difficulty breathing. During a review of the facility's P&P titled, Transportation, Appointment Arrangement and Scheduling Policy, revised May 2026, the P&P indicated social services were responsible for coordinating appointments, transportations, and communication. During a concurrent interview and record review on 6/24/26 at 2:09 p.m., the facility's policy and procedure (P&P) titled, Hemodialysis Residents, revised May 2025, was reviewed with the Director of Nursing (DON. The DON reviewed the P&P and stated staff should have documented in the Dialysis Communication Record for the make-up dialysis on 5/15/26. During a review of the facility's P&P titled, Hemodialysis Residents, revised May 2025, the P&P indicated a Dialysis Communication Record is initiated and sent to the dialysis center each appointment. The P&P indicated to ensure the Dialysis Communication Record is received upon return to the facility. b. During a review of Resident 13's admission Record, the admission Record indicated the facility originally admitted Resident 13 on 3/18/2025 and was readmitted on [DATE] with diagnoses including end stage renal disease end stage renal disease (ESRD-a medical condition in which a person's kidney [organ in the body that filters waste and excess fluid from the blood] stop functioning on a permanent basis), and dependence on hemodialysis. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 13's H&P dated 3/19/2025, the H&P indicated Resident 13 had fluctuating capacity to understand and make decisions. During a review of Resident 13's MDS dated [DATE], the MDS indicated Resident 13 had intact cognition (mental action or process of acquiring knowledge and understanding) for daily decision-making and from setting up (helper sets up or cleans up, resident completes activity) to moderate assistance (helper does less than half the effort) from staff for activities of daily living (ADLs-bed mobility, surface transfer, eating, walk in room, dressing, toileting, and personal hygiene). The MDS indicated Resident 13 was on hemodialysis. During a review of Resident 13's Order Summary Report dated 3/2/2026, the Order Summary Report indicated Resident 13 had a physician order for the following: Dialysis Center at Hemodialysis Center 1 (HDC1) with chair time 12:15 PM to 3:45 PM every Monday, Wednesday, and Friday; notify Dialysis Center of any abnormalities noted before and after each dialysis treatment; notify doctor of any significant changes in residents condition before and after dialysis treatment; obtain post dialysis weights from the dialysis center; review post dialysis notes special instructions and new orders and fluid restrictions 1000 milliliter (ml) per day. During a concurrent interview and record review on 6/24/2026 at 3:15 PM with RN 1 and LVN 2, Resident 13's Dialysis Communication Record (form of communication between the facility and the hemodialysis center) dated 6/1/2026 to 6/23/2026 were reviewed. The Dialysis Communication Record indicated missing the Dialysis Communication Record dated 6/12/2026. RN 1 stated and validated Resident 13's hemodialysis was completed on 6/12/2026. Both RN 1 and LVN 2 stated that the facility was supposed to provide the Dialysis Communication Record with the resident when the resident went for dialysis appointment and the dialysis center was supposed to provide information regarding the resident's care and sent it back with the resident after dialysis. RN 1 stated it was important to get the Dialysis Communication Record back since the Dialysis Communication Record was a form of communication between the facility and the dialysis center in regards with Resident 13's dialysis care. During an interview on 6/25/2026 at 7:42 AM with the DON, the DON stated it was important to have the Dialysis Communication Record when the resident would come back from dialysis appointment since that form was the facility's and dialysis center's form of communication regarding resident's dialysis care. During a review of the facility's P&P, titled, Hemodialysis Residents, reviewed on 5/21/2026, P&P indicated that the facility would provide residents with safe, accurate and appropriate care, assessments and interventions to improve resident outcomes in coordination/collaboration with dialysis center. P&P also indicated that the DCR was initiated and sent to the dialysis center each appointment and facility staff would ensure that DCR was received upon return. During a concurrent interview and record review on 6/24/2026 at 3:15 PM with RN 1 and LVN 2, Resident 13's Progress Notes from 6/1/2026 to 6/23/2026 were reviewed. Resident 13's Progress Notes indicated missing documentation when Resident 13 left the facility for the dialysis appointment on the following dates: 6/3/2026, 6/8/2026, 6/10/2026, 6/12/2026, 6/15/2026, 6/19/2026 and 6/22/2026. Both RN 1 and LVN 2 stated the need of documenting when a resident (in general) would go out for an appointment and validated all seven missing documentations. During an interview on 6/25/2026 at 7:42 AM with the DON, the DON stated that nursing staff (in (continued on next page)

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