

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/22/2026
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)		
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, facility failed to ensure one of three sample resident (Resident 1)'s privacy was respected when Respiratory therapy (RT) 1 did not introduce himself and asked for permission before entering Resident 1's room. In addition, Certified Nursing Assistant (CNA) 1 did not knock on the door, introduced himself and asked for permission before entering room [ROOM NUMBER] and room [ROOM NUMBER]. These deficient practices resulted in residents' privacy being not respected and negatively affecting their care. 1. During a review of Resident 1's admission record dated 7/24/2026, the admission record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included but not limited to chronic pain, anxiety disorder (a condition that a person feels very worried, scared, or nervous much more often and much more strongly than most people, these feelings are hard to control and can make everyday life difficult), opioid dependence (a condition when a person's body gets used to taking opioid drugs [pain medicines], and can't feel normal without them) and hypertension (high blood pressure). During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool) dated 7/13/2026, the MDS indicated Resident 1's cognition (ability to think, remember and reason for daily decision making) was intact. During an observation on 7/22/2026 at 12:05 pm in Resident 1's room, RT 1 entered the room, after he saw me and Resident 1, RT 1 stated, he is here to do breathing treatment for Resident 1's roommate. During an interview on 7/22/2026 at 12:40 pm in Resident 1's room with Resident 1, Resident 1 stated she does not feel she has privacy, staff entered her room without asking. During an interview on 7/22/2026 at 1:20 pm with RT 1, RT 1 stated he said knock knock but forget to introduce himself and asked for permission before entering Resident 1's room. Sometimes, he moves too fast. RT 1 further stated he should knock on the door, introduce himself and ask for permission before entering residents' room. 2. During an observation on 7/22/2026 at 1:05 pm on the hallway, CNA 1 entered room [ROOM NUMBER] and room [ROOM NUMBER] without knocking, introduce himself and ask for permission. During an interview on 7/22/2026 at 1:10 pm with CNA 1, CNA 1 stated before entering a resident's room, staff should knock on the door, introduce themselves, and ask for permission, but he didn't do that, his action affects residents' privacy. During an interview on 7/22/2026 at 1:26 pm with CNA 2, CNA 2 stated before entering resident's room, staff should knock on the door, introduce themselves, and ask for permission to enter. Failing to do it affects residents' privacy. During an interview on 7/22/2026 at 1:35 pm with LVN 1, Licensed Vocational Nurse (LVN) 1 stated, when staff enter a resident's room, they should knock on door, introduce themselves, tell the residents why they are here and ask for permission to enter the room to respect all residents' privacy. During an interview on 7/22/2025 at 1:45 pm with Director of Nursing (DON), DON stated, staff, both nurses and RTs, should respect residents' privacy, when entering any residents' room, staff should knock on the door, introduce themselves, and ask for permission. Failing to do so affects resident's right of privacy (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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and negatively affects resident's care. During a review of facility's policy and procedures (P&P) titled dignity, dated 10/2025, the P&P indicated staff must announce their presence before entering a resident's room.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record, facility failed to ensure proper hand hygiene, when Certified Nursing Assistant (CNA) 1 observed entered and exited room [ROOM NUMBER] without performing hand hygiene and then immediately entered room [ROOM NUMBER] without performing hand hygiene again. This deficient practice increases the risk of transmitting infections among residents in room [ROOM NUMBER] and room [ROOM NUMBER]. During an observation on 7/22/2026 at 1:05 pm at the hallway, CNA 1 entered and exited room [ROOM NUMBER] without performing hand hygiene, then immediately entered room [ROOM NUMBER] without sanitizing hands. During an interview on 7/22/2026 at 1:10 pm with CNA 1, CNA 1 stated, he did not wash his hand inside room [ROOM NUMBER] or room [ROOM NUMBER], he forgot to use hand sanitizer outside of the rooms. CNA 1 stated his action can cause infection control issues. During an interview on 7/22/2026 at 1:26 pm with CNA 2, CNA 2 stated hand hygiene is important for prevention of spread of infections, staff should have perform hand hygiene before and after entered resident's room. During an interview on 7/22/2026 at 1:35 pm with Licensed Vocational Nurse (LVN) 1, LVN 1 stated hand washing is important for infection control, all staff should follow their policy, and not doing proper hand hygiene can increase the risk of spread of infections. During an interview on 7/22/2026 at 1:45 pm with Director of Nursing (DON), the DON stated staff should perform hand hygiene before and after entering the resident's room, especially in between the residents' rooms. Failed to do so will increase the risk of spreading infection among residents. During a review of the facility's policy and procedure (P&P) titled handwashing/ hand hygiene, dated 10/2025, the P&P indicated, hand hygiene should be performed before touching a resident; after touching a resident; after touching the resident environment or belonging.		