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 05/09/2024

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. 44309 Based on interview and record review, the facility failed to develop an individualized person-centered care plan to meet the resident's needs for one of five sampled residents (Resident 40). This deficient practice had the potential to lead to the inadequate care of Resident 40. Findings: A review of Resident 40's Admission Record (Face Sheet) indicated the facility admitted the resident on 7/20/2022, with diagnoses including Type II diabetes (a disease that occurs when the sugar level is high in the blood), unsteadiness on feet, and major depressive disorder (a mental health condition that causes a low mood and a loss of interest in activities that once brought joy). A review of the Physician's Orders dated 3/6/2024, indicated to administer insulin glargine (long-acting insulin, a medicine used to control the amount of sugar in the blood of patients with diabetes for the entire day) 20 units (a measurement for insulin) subcutaneously (SQ- to inject under all the layers of the skin) every 12 hours for Type II diabetes. A review of the Physician's Orders dated 3/7/2024, indicated to administer insulin lispro (a rapid-acting insulin, a medicine used to control the amount of sugar in the blood of patients with diabetes. It starts to work very quickly, and you take it before meals to stop your blood sugar from going too high) 5 units subcutaneously before meals for Type II diabetes. A review of the Situation Background Assessment and Recommendation Communication Form (SBAR- a written communication tool that helps provide important information) dated 3/7/2024, indicated Resident 40 had an elevated uncontrolled blood sugar of 495 milligrams per deciliter (mg/dl-unit of measurement [normal range for a diabetic according to American Diabetes Association: 80-130 mg/dl]). A review of Resident 40's Minimum Data Set (MDS - a comprehensive assessment and care screening tool) dated 3/25/2024, indicated the resident's cognitive skills for daily decision making was moderately impaired (decisions poor, cues/supervision required) and required maximal assistance with toileting hygiene, upper body dressing, showering and bathing. The MDS indicated Resident 40 required staff supervision when eating. (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: 056456	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2024
NAME OF PROVIDER OR SUPPLIER Palazzo Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 5400 Fountain Ave Los Angeles, CA 90029	

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 40's Care Plans on 5/8/2024, indicated there was no individualized person-centered care plan for hyperglycemia (abnormal high blood sugar) including measurable objectives, monitoring, or interventions to meet resident's needs. During a concurrent interview and record review on 5/8/2024 at 12:51 PM, with Registered Nurse Supervisor 1 (RN1), Resident 40's care plans were reviewed. RN 1 stated staff did not develop a care plan for hyperglycemia after Resident 40 had a change of condition (COC) on 3/7/2024. RN 1 stated licensed staff were required to develop a care plan with interventions for hyperglycemia and that the potential outcome was a lack of care and monitoring for Resident 40. During an interview on 5/8/2024 at 3:13 PM, the facility's Director of Nursing (DON) stated licensed staff were required to develop a care plan with appropriate interventions when a resident had a change of condition. The DON further stated licensed nurses were required to implement the care plan interventions and also to evaluate the effectiveness of the interventions. The DON stated, Licensed staff did not develop a care plan for Resident 40 after he had high blood sugar level on 3/7/2024, and the potential outcome was lack of care and delivery of necessary services. A review of the facility's undated policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, indicated assessments of the residents were ongoing and care plans were revised as information about the residents and the residents conditions changed. The interdisciplinary team reviews and updates the care plan when there was a significant change in the resident's condition.

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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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48661 Based on interview and record review, the facility failed to identify and ensure one of three closed record residents (Resident 75), who had an amputation site (surgical removal of part of the body, left lower leg), acute respiratory failure with hypoxia (a condition where you do not have enough oxygen in the tissues in your body), and a right lateral malleous (bony projection of the ankle) with arterial ulcer (injury to skin or underlying tissue caused by poor circulation, which in turn was caused by arterial insufficiency [reduced blood flow by the artery]) on the right lower leg, received necessary care and services in accordance with professional standards of practice by failing to: -Assess upon admission or on [DATE], and document the condition, description, and measurements of Resident 75's right lateral malleous arterial ulcer of the right lower leg, as documented on the Admission Data Collection form dated [DATE]. -Develop a comprehensive and person-centered Care Plan to include the Physician's Order for treatment to Resident 75's right lateral malleous arterial ulcer. - Follow the Physician's Order for treatment to Resident 75's right lateral malleous lower leg arterial ulcer (a painful, deep sore or wound in the skin of the lower leg or foot), cleanse with normal saline (a mixture of sodium chloride [salt] and water), pat dry, apply Medi honey (supports the removal of necrotic tissue and aids in wound healing), cover with dry dressing, every day shift for 21 days. -Assess respiratory status for accurate rate of oxygen administration and monitor Resident 75 for any changes in condition (shortness of breath), per the Continuous Oxygen Therapy care plan developed on [DATE]. As a result, Resident 75 did not receive treatment to the right lateral malleous arterial ulcer of the right lower leg for over two weeks and was transferred to General Acute Care Hospital (GACH) 2 for altered level of consciousness (ALOC, resident is not as awake, alert, or able to understand or react to the surrounding environment). At the GACH 2, Resident 75 complained of shortness of breath, required four liters per minute of oxygen via nasal cannula (NC, a device that gives you additional [supplemental] oxygen through your nose) with 92% oxygen saturation (amount of oxygen traveling through the body in your red blood cells, normal oxygen saturation for a healthy adult between 95% and 100%) and complained of right ankle pain. The GACH 2 Emergency Department Note dated [DATE], indicated Resident 75 developed soft tissue ulceration (formation of a break on the skin or on the surface of an organ) overlying the side of the smaller thinner calf bone (lateral malleous) with underlying osteomyelitis (inflammation or swelling of bone tissue that is usually the result of an infection), abnormal accumulation of fluid in the pleural space (the cavity between the lungs and chest wall) with pulmonary edema (fluid builds up in the lungs) and adjacent atelectasis (collapse of the whole lung or an area of the lung). Resident 75 died three days later on [DATE]. Findings: (continued on next page)

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F 0684

Level of Harm - Actual harm

Residents Affected - Few

A review of General Acute Care Hospital (GACH) 1 Hospitalist Progress Note dated [DATE], indicated Resident 75 was status post cardiac arrest (heart attack) and received two thoracenteses (procedure to remove fluid or air from around the lungs) with the last procedure on [DATE]. The GACH 1 progress note indicated Resident 75 was on three antibiotics for a diabetic infection of the left foot with questionable osteomyelitis (bone infection).

A review of Resident 75's GACH 1 Complex Case Manager Note dated [DATE], indicated the resident needed placement for physical therapy and wound care at the amputation site (surgical removal of part of the body, left lower leg). The note indicated Resident 75 should be able to return home with the help of family when independent.

A review of Resident 75's GACH 1 Physician's Transfer Orders form dated [DATE], indicated the resident had hypoxia (oxygen levels in the blood are lower than normal) when sleeping and required oxygen at two liters per minute when awake during the daytime. The Transfer Orders indicated the resident was not on antibiotics during to the transfer.

According to a review of the Admission Record to the facility Resident 75 was admitted on [DATE], with diagnoses including non-pressure chronic ulcer of the right lower leg (caused by poor circulation, which in turn was caused by venous or arterial insufficiency), after care following surgical amputation of the left lower leg and acute respiratory failure with hypoxia (a condition where you do not have enough oxygen in the tissues in your body).

A review of Resident 75's Minimum Data Set (MDS - a standardized assessment and care screening tool) dated [DATE], indicated Resident 75's cognition was intact (sufficient judgement and self-control to manage the normal demands of the environment) was dependent on facility staff with showering and transfers. The MDS indicated Resident 75 had one arterial ulcer (right leg), a surgical wound with application of nonsurgical dressings (left leg amputation) and required oxygen therapy.

A review of Resident 75's Admission Data Collection form documented by the Admission Nurse dated [DATE], indicated Resident 75 had clear lung sounds, no shortness of breath, and had 98% oxygen saturation on room air. The Admission Data Collection form indicated the resident was not on antibiotics, was a full code (if a person's heart stopped beating and/or they stopped breathing, all procedures would be provided to keep them alive), and had a right ankle diabetic ulcer. The Admission Data Collection form did not indicate Resident 75's right lateral malleous with arterial ulcer to the lower right leg.

A review of the Physician's Order dated [DATE], indicated for Resident 75 to receive treatment on the right lateral malleous with arterial ulcer (a painful, deep sore or wound in the skin of the lower leg or foot), cleanse with normal saline (a mixture of sodium chloride [salt] and water), pat dry, apply Medi honey (supports the removal of necrotic tissue and aids in wound healing), cover with dry dressing, every day shift for 21 days.

According to a review of Resident 75's Treatment Administration Record (TAR), Resident 75 received treatment to the right lateral malleous with arterial ulcer on [DATE]. Further review of the TAR indicated the resident did not receive the Physician's Ordered treatment from ,d+[DATE] to [DATE] (14 days).

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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 0684 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 75's History and Physical (H&P) dated [DATE], indicated Resident 75 had the capacity to understand and make decisions. A review of the Physician's Order dated [DATE], indicated Resident 75 was to receive oxygen at two liters per minute via NC continuously. May titrate up to three liters per minute, every shift for hypoxemic respiratory failure. A review of Resident 75's Admission Data Collection Form documented by the Treatment Nurse (Licensed Vocational Nurse 8) dated [DATE], indicated a head-to-toe assessment was completed, four days after admission. The form indicated the resident denied pain, wound care was rendered (but there was no indication of the location of the wound) and tolerated well. The Admission Data Collection form indicated the resident had a left below the knee amputation (BKA) with staples and a skin abrasion (the surface layers of the skin [epidermis] has been broken) on the left flank (space between the lowest rib and hip). The Admission Data Collection form documented by the Treatment Nurse did not indicate a right ankle diabetic ulcer on the Admission Data Collection form dated [DATE] documented by the Admission Nurse, nor did it indicate the condition, description, or any measurements of the right lateral malleous with arterial ulcer to the lower right leg. A review of a care plan dated [DATE] indicated Resident 75 wanted to return the the community. The care plan intervention indicated to assess discharge plan needs with the resident and Interdisciplinary Team members. According to a review of Resident 75's Continuous Oxygen Therapy care plan developed on [DATE], for the resident's acute respiratory failure with hypoxia, the goal indicated for the resident to have no signs or symptoms of poor oxygen absorption. The care plan interventions indicated to monitor for signs and symptoms of respiratory distress and assess respiratory status for rate, depth, and ease and report to the doctor. A review of Medication Administration Record (MAR) dated [DATE] indicated Resident 75 received two liters of oxygen via nasal cannula and on the evening shift the resident's oxygen saturation was 98%, but the oxygen inhalation section indicated 96%. The MAR dated [DATE] indicated on the morning shift Resident 75's oxygen saturation was 98% but the oxygen inhalation was 96% and during the night shift (same date) the oxygen saturation was 98% and oxygen inhalation was 97%. This indicated discrepancies in the monitoring of the resident's respiratory status. A review of Resident 75's At Risk for Skin Breakdown care plan developed on [DATE] (almost three weeks after admission), for the resident's right lower leg with scattered arterial ulcers, had a goal for the resident to minimize the risk of skin breakdown every day. The care plan interventions indicated handling the resident gently during care, keep skin clean, dry, and comfortable at all times, and report any redness or open area. The care plan did not include the Physician's Order to provide treatment every day for 21 days to the right lateral malleous with arterial ulcer of the resident's right lower leg. A review of Resident 75's Social Services Note dated [DATE], indicated discharge planning was in progress with the resident's family member and the discharge plan was to go to a lower level of care. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 75's Weekly Wound Note dated [DATE], indicated the resident's right lateral malleous with arterial ulcer of the resident's right lower leg had scant amount of serosanguineous (contains both blood and liquid part of blood [serum]) exudate (fluid that leaks out of blood vessels into nearby tissues), the surrounding skin condition was normal, and not painful. The Weekly Wound Note indicated all needs were attended to and there were no signs or symptoms of infection. According to a review of the TAR dated [DATE], Resident 75's right lateral malleous with arterial ulcer of the resident's right lower leg was provided treatment. This indicated the resident did not receive treatment for the arterial ulcer for over one month, as the last treatment documented was [DATE]. Further review of the TAR indicated Resident 75 did not receive the Physician's Ordered treatment from [DATE] to [DATE]. A review of Resident 75's Weekly Wound Note dated [DATE], indicated the resident's right lateral malleous with arterial ulcer of the resident's right lower leg had scant amount of serosanguineous exudate, the surrounding skin condition was fragile (which indicated a change). The Weekly Wound Note indicated all needs were attended to and there were no signs or symptoms of infection. A review of the MAR dated [DATE] for the morning shift indicated there was no documentation regarding Resident 75's oxygen saturation. For the afternoon shift the MAR indicated the resident received oxygen at two liters per minute, the oxygen saturation was 97% and under oxygen inhalation was 98%. A review of Resident 75's Nursing Progress Note dated [DATE] at 11:05 AM, indicated the resident was alert and oriented, did not have signs or symptoms of acute distress or pain, and the resident's vital signs were within normal limits. The Nursing Progress Note indicated the resident was receiving oxygen via NC (with no documentation regarding the amount of oxygen administered to the resident) and the oxygen saturation was 97%. A review of the Change of Condition (COC, a sudden clinically important decline from a patient's baseline in physical, cognitive, or functional abilities) Record dated [DATE] at 8:15 PM, indicated Resident 75 was found on the floor in a supine position (lying on the back or with the face upward). The COC indicated the resident did not have shortness of breath and was on continuous oxygen. The COC indicated under the vital signs portion the resident had an oxygen saturation of 97% and was on room air. The COC indicated at 8:25 PM, Resident 75 was noted with altered level of consciousness (the resident is not as awake, alert, or able to understand or react to the surrounding environment) and the facility obtained doctor's orders to send the resident out for a computerized tomography scan (CT, diagnostic imaging procedure to produce images of the inside of the body) of the head. According to a review of the Physician's Order dated [DATE], Resident 75 was to be transferred to the GACH due to altered level of consciousness. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	A review of the GACH 2 Emergency Department Note dated [DATE], indicated Resident 75 presented with cough, congestion and required four liters per minute of oxygen via NC at baseline (this indicated the facility should have given the resident four liter of oxygen continuously). The ED Note indicated an x-ray of the chest was done with findings including bilateral pleural effusions (abnormal accumulation of fluid in the pleural space) with pulmonary edema and adjacent atelectasis (collapse of the whole lung or an area of the lung). The note indicated an x-ray of the right ankle was done with findings including soft tissue ulceration (formation of a break on the skin or on the surface of an organ) overlying the lateral malleous (the bone on the outside of the fibula) with underlying lateral malleous osteomyelitis. A review of Resident 75's GACH 2 H&P Note dated [DATE], indicated the resident complained of shortness of breath required four liters of oxygen via NC with 92% oxygen saturation and complained of right ankle pain due to osteomyelitis. A review of Resident 75's GACH 2 Discharge Summary Note dated [DATE], indicated the resident was admitted to GACH 2 with shortness of breath and right ankle pain. The Note indicated a diagnoses of acute respiratory failure with hypoxia, severe bilateral pleural effusion, and chronic osteomyelitis. The note indicated the resident expired (the last emission of breath, death) on [DATE] (three days after transfer from the facility). During a concurrent interview and record review, on [DATE] at 11:58 AM with the Quality Assurance (QA) Nurse, Resident 75's Physician's Order Report dated [DATE] was reviewed. The QA Nurse stated the treatment order for the resident's right lateral malleous with arterial ulcer of the resident's right lower leg should have been clarified with the physician. The QA Nurse stated instead of the treatment order indicating every 21 days for 21 days, the order should have indicated every day for 21 days. During a review of Resident 75's Admission Data Collection Form dated [DATE], the QA Nurse stated the licensed nurse did not perform an accurate assessment for Resident 75 and was missing some assessments on the form. The QA Nurse stated there was no admission assessment regarding Resident 75's right lateral malleous with arterial ulcer of the resident's right lower leg. During a concurrent interview and record review, on [DATE] at 12 PM, a review of Resident 75's TAR dated [DATE] and [DATE] were reviewed. The QA Nurse stated the first treatment for the right lateral malleous with arterial ulcer of the resident's right lower leg given to Resident 75 was on [DATE] and no other treatment was provided for the remainder of the month. The QA Nurse stated if the treatment was not documented then the treatment was not provided, and based on the TAR, the treatment was not given to Resident 75. The QA Nurse stated treatment for the month of April was documented on [DATE] and not documented on any other day. The QA Nurse stated the TAR looked like the staff was providing treatment every 21 days. During an interview on [DATE] at 12:16 PM, when asked about the importance of Resident 75's care plan for the right lateral malleous with arterial ulcer of the resident's right lower leg, the Director of Nursing (DON) stated the purpose of the care plan was to identify Resident 75's wounds and identify interventions for those wounds. The DON stated if the care plan was not initiated upon admission, the facility could not show what interventions were carried out for each wound, and the outcome could result in the resident having an infection. (continued on next page)

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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 0684 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 12:45 PM, during an interview, when asked about the Physician's Order for Resident 75's treatment of the right lateral malleous with arterial ulcer of the resident's right lower leg, the Medical Director (MD) stated the treatment order should have been clarified with the physician because the facility follows a protocol when writing orders. The MD stated instead of the treatment order indicating every 21 days for 21 days, the order should have indicated every day for 21 days. During a concurrent interview and record review on [DATE] at 3:17 PM with LVN 4, Resident 75's Physician's Order Report dated [DATE] was reviewed. LVN 4 stated the protocol was to provide treatment every day and the facility staff would re-evaluate on the 21st day. LVN 4 stated the frequency, and the schedule type was incorrect on the order and the order should have been clarified with the physician. During a review of Resident 75's TAR, dated [DATE] and [DATE], LVN 4 stated if the treatment was not documented, then the treatment was not done. LVN 4 stated, It was not okay that the treatment was not provided, as this could cause Resident 75's wound to get worse or infected and could cause pain. During an interview on [DATE] at 3:48 PM, the MD stated the treatment for osteomyelitis was six weeks of antibiotics unless the source of the osteomyelitis was known. The MD stated for Resident 75 the osteomyelitis was in the left leg and that was why the resident underwent a BKA. The MD stated after surgery, if there were no complications, then antibiotics would not be needed and that was why Resident 75 was not transferred to the facility with antibiotic orders. The MD stated once the infection was gone, the treatment was to discontinue antibiotics and let the resident heal. During an interview on [DATE], with LVN 8 (treatment nurse) who completed Resident 75's Admission Data Collection Form on [DATE], stated upon admission Resident 75 had scattered ulcers, and a lateral malleous arterial ulcer to the right lower leg. LVN 8 stated the resident's right lower leg ulcers were not documented on the Admission Assessment completed by LVN 8 and was not an accurate assessment because the Admission Data Collection Form did not reflect all of Resident 75's wounds. When asked about the Physician's Order for Resident 75's treatment, LVN 8 stated the Physician's Order was incorrect, as LVN 8 obtained the order from the MD and stated the order was inputted incorrectly. LVN 8 stated it was important to clarify the physician's orders and if the resident did not receive the treatment as ordered, the resident was at risk for infection. A review of the facility's undated policy and procedures (P&P) titled, Admission Assessment and Follow Up: Role of the Nurse, indicated steps to conduct an admission assessment include a list of active medical diagnoses and patient problems, especially those most related to reasons for admission to the facility and those affecting function, quality of life, ability to participate in activities, and to socialize. The policy indicated to include current medications and treatment, to reconcile the list of medications from the medications history, admitting orders, and the previous MAR from previous institution according to established procedures. The policy indicated to contact the Attending Physician to communicate and review the findings of the initial assessment and any other pertinent information and obtain admission orders that are based on these findings. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	A review of the facility's undated P&P titled, Care Plans, Comprehensive Person-Centered, indicated the interventions were derived from a thorough analysis of the information gathered as part of the comprehensive assessment. The policy indicated the care plan interventions were chosen only after gathering proper sequencing of events, careful consideration of the relationship between the residents problem areas and their causes, and relevant clinical decision making. The policy indicated when possible, interventions address the underlying source of the problem area, not just symptoms or triggers. A review of the facility's P&P titled, Treatment Nurse - LVN Job Description, dated [DATE], indicated to provide treatment and therapeutic services per the physician's orders and to meet with and solicits advice from the Medical Director, DON, and wound care consultants concerning care of residents.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 48661 Based on observation, interview, and record review, the facility failed to ensure one of four sampled residents (Resident 1), who recieved treatment for a right heel deep tissue injury (DTI - purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from prolonged pressure and/or shear), received necessary care and services per the comprhensive assessment and in accordance with professional standards of practice by failing to: -Implement the 'At Risk for Further Impaired Skin Integrity' Care Plan interventions, including to monitor / document / report changes in wound color, drainage, odor, sensation, or pain, and measurement of the DTI weekly, for 16 days (from 6/4 - 6/20/2024). This deficient practice caused an increased risk in complications of Resident 1's plan of care. Findings: A review of Resident 1's Admission Record indicated the facility originally admitted the resident on 5/21/2024 and readmitted the resident on 6/4/2024, with diagnoses including pressure-induced deep tissue damage (pressure ulcer - prolonged pressure to an area of skin and underlying tissue) of right heel, dementia (loss of cognitive functioning - thinking, remembering, and reasoning - to such an extent that the loss interferes with a person's daily life and activities), and lack of coordination (not able to move different parts of the body together well or easily). A review of the 'At Risk for Further Impaired Skin Integrity' Care Plan initiated 5/22/2024, indicated the focus was related to Resident 1's right heel deep tissue injury (DTI -purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from prolonged pressure and/or shear). The care plan interventions indicated to keep area dry and clean and to monitor / document / report changes in wound color, drainage, odor, sensation, or pain. The interventions also indicated to document the treatment weekly, including the measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate (fluid that leaks out of blood vessels into nearby tissues) and any other notable changes or observations. A review of Resident 1's Minimum Data Set (MDS - a standardized resident assessment and care screening tool) dated 5/28/2024, indicated the resident had severe cognitive impairment (problems with a person's ability to think, learn, remember and make decisions). The MDS indicated Resident 1 was dependent on facility staff for toilet hygiene, showering, and lower body dressing. The MDS indicated the resident was at risk for developing a pressure ulcer, had one or more unhealed pressure ulcers, and the resident was receiving treatment for one unstageable DTI (the stage of the wound is not clear, the base of wound is covered with tissue and pus that may be yellow, gray, green brown or black). A review of Resident 1's Admission Assessment by the Treatment Nurse dated 6/4/2024, indicated the resident had a right heel DTI with 100% purple discoloration. The Admission Assessment indicated there were no open areas noted and the resident had bilateral lower extremity hyperpigmentation (usually harmless skin condition that causes darker patches of skin than the surrounding area). The Admission Assessment indicated wound care was rendered, well tolerated, and the resident denied pain. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to a review of the Physician's Order dated 6/5/2024, Resident 1 was to have treatment to the right heel DTI, cleanse with normal saline (a crystalloid fluid that was a mixture of water and salt) and pat dry. Apply betadine (topical antiseptic medication that contains povidone-iodine as the active ingredient), cover with abdominal (ABD) pad, and wrap with Kerlix (a brand of bandage rolls made from 100% woven gauze that could be used for wound care), every day shift for 21 days. A review of Resident 1's medical record and the Nursing Progress Notes dated from 6/4 - 6/20/2024 (16 days), indicated there was no documentation for the resident's right heel DTI regarding the color, drainage, odor, sensation, measurement including width, length, depth, and exudate (fluid that leaks out of blood vessels into nearby tissues), per the care plan. A review of Resident 1's medical record and Treatment Admin Record (TAR) dated June 2024 indicated there was no documentation including color, drainage, odor, sensation, measurement including width, length, depth, and exudate of Resident 1's right heel DTI. During an observation on 6/27/2024 at 10:49 AM, Licensed Vocational Nurse (LVN) 8 provided wound care to Resident 1 in the resident's room. Resident 1's right heel DTI was observed with no exudate and the resident did not show signs or symptoms of pain during the treatment. During a concurrent interview, LVN 8 stated she would document the treatment in the TAR, but LVN 8 did not document the description of the DTI. During a concurrent interview and record review on 6/27/2024 at 12:15 PM with the Director of Nursing (DON), Resident 1's 'At Risk for Further Impaired Skin Integrity' Care Plan was reviewed. The DON stated there was no documentation for the resident's weekly treatment to the right heel DTI, per the care plan interventions. The DON stated if there was no documentation, the facility would not know if the wound was improving or if the facility was providing the appropriate care to the resident. The DON stated this would cause a risk of infection or worsening of the wound. During a concurrent interview and record review on 6/27/2024 at 1:01 PM with LVN 8, Resident 1's Progress Notes were reviewed. LVN 8 stated there was no documentation for the resident's weekly treatment to the right heel DTI, per the care plan interventions, since the resident's re-admission. LVN 8 stated, if there was no documentation, that could potentially affect Resident 1's progress because the facility would not know if the wound was improving or if the treatment needed to be changed. LVN 8 stated Resident 1 could decline. A review of the facility's policy and procedure (P&P) titled, Charting and Documentation, dated 1/18/2024, indicated the following information was to be documented in the resident medical record: objective observations; treatments or services performed; and progress toward or changes in the care plan goals and objectives. The P&P indicated documentation of procedures and treatments would include care-specific details, including: the date and time the procedure / treatment was provided; the assessment data and / or any unusual findings obtained during the procedure / treatment; and how the resident tolerated the procedure / treatment. A review of the facility's P&P titled, Wound Care, dated 1/18/2024, indicated the following information had to be recorded in the resident's medical record: the type of wound care given; the date and time the wound care was given; all assessment data (wound bed color, size, and drainage) obtained when inspecting the wound; and how the resident tolerated the procedure. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's P&P titled, Care Plans, Comprehensive Person-Centered, dated March 2022, indicated assessment of the residents were ongoing and care plans were revised as information about the residents and the resident's condition changes. The P&P indicated the interdisciplinary team reviews and updates the care plan: when the resident had been readmitted to the facility from a hospital stay.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48429 Based on observation, interview and record review, the facility failed to ensure one of six sampled residents (Resident 64), who had a history of falls, received services to prevent accidents and falls by failing to: -Implement the Risk for Falls Care Plan interventions dated 12/5/2023, including a yellow star on the wall above the headboard, a gold star on the name plate, a yellow fall risk wristband, yellow non-skid socks, and a yellow star on the wheelchair. -Revise and Update the Risk for Falls Care Plan after a fall on 2/16/2024. -Implement the facility's Falls and Fall Risk Managing policy to include a resident-centered fall prevention plan to reduce the specific risk factor of falls for Resident 64. These deficient practices caused an increased risk for falls and Resident 64's actual fall on 2/16/2024, which resulted in the resident's skin abrasion on the right anterior forearm (the main bone of the upper arms). Findings: A review of the Admission Record indicated, Resident 64 was admitted to the facility on [DATE], with diagnoses including primary generalized osteoarthritis (a degenerative joint disease that worsens over time often resulting in chronic pain), difficulty in walking, pain in left knee, and history of falling. A review of the At Risk for Falls Care Plan revised 12/5/2023, related to generalized osteoarthritis, left knee pain, generalized weakness, and history of falling, indicated Resident 64 had a fall on 2/16/2024 (from the wheel chair). The care plan interventions included the facility falling star program: which included a yellow star on the wall above headboard, a gold star on name plate, a yellow fall risk wristband, a yellow non-skid sock, and a yellow star on wheelchair. A review of Resident 64's Change in Condition Evaluation (COC) form dated 2/16/2024, indicated Resident 64 had a fall and suffered a skin abrasion on the right anterior forearm (the main bone of the upper arms). A review of the Minimum Data Set (MDS-a comprehensive assessment and screening tool), dated 3/10/2024, indicated Resident 64 was cognitively intact, required substantial/maximal assistance with toileting hygiene, shower/bathe self, lower body dressing, and putting on/taking off footwear. A review of the Progress Notes dated 4/8/2024, indicated Resident 64 may have two floor mats to prevent injury in the event of a fall. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 5/8/2024 at 11:14 AM, Resident 64 was up in hallway sitting in wheelchair with two Restorative Nursing Assistants (RNAs). Resident 64 was observed without wearing the non-skid yellow socks, no fall risk wristband, or a yellow star on the wheelchair. Upon observation of Resident 64's room, there was no gold star on Resident 64 name plate, no fall mats observed and no yellow star above the wall on Resident 64's headboard, per the Falls Care Plan interventions. During an interview on 5/8/2024 at 12:35 PM, the Quality Assurance Nurse (QA Nurse) stated that all new admissions were placed on the falling star program for 72 hours. During a concurrent interview and record review on 5/8/2024 at 4 PM, with the Director of Nursing (DON), Resident 64's care plan, dated 12/2/2023 was reviewed. The DON stated Resident 64's care plan for at risk for falls and the falling star program should have been updated or revised after Resident 64's fall. The DON stated the care plan interventions should have been implemented including a yellow star on wall above headboard, a gold star on name plate, a yellow fall risk wristband, a yellow non-skid sock, and a yellow star on wheelchair. The DON stated that not having an updated care plan placed Resident 64 at increased risk for anther fall with injury. A review of the facility's policy and procedure (P&P) titled, Falls and Fall Risk, Managing, revised 3/2018, indicated the staff with the input of the attending physician will implement a resident-centered fall prevention plan to reduce the specific risk factor of falls for each resident at risk or with a history of falls, if a systemic evaluation of a resident's fall risk identifies several possible interventions, the staff may choose to prioritize interventions. A review of the facility's P&P titled, Care Plans, Comprehensive Person-Centered, revised 7/2017 indicated assessments of residents were ongoing and care plans were revised as information about the residents' conditions change. The interdisciplinary team reviews and updates the care plan when there was a significant change in the residents' condition, and when the desired outcome was not met, or at least quarterly in conjunction with the required quarterly MDS assessment.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43851 Based on interview and record review, the facility failed to provide appropriate treatment and services for the resident's change in condition of loose stools for one of two sampled residents (Resident 74). Resident 74 continued to receive a laxative (medication used to treat constipation) and experience frequent loose stools without appropriate intervention. This deficient practice had the potential for Resident 74 to become dehydrated (a condition that occurs when you lose more fluid than you take in, not having enough water to carry out its normal functions) and potentially cause kidney damage, brain damage, and/or death. Findings: A review of Resident 74's Admission Record indicated the facility admitted the resident on 3/16/2024 with diagnoses that included multiple myeloma (a rare blood cancer), moderate protein-calorie malnutrition (occurs when an individual does not eat enough protein and energy to meet their nutritional needs), Type II diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), dependence on renal dialysis (a type of treatment that helps your body remove extra fluid and waste products from the blood when the kidneys are not able to), difficulty in walking, and major depressive disorder (a persistent feeling of sadness and loss of interest that can interfere with daily activities of living). A review of the Physician's Order dated 3/16/2024 indicated the resident was to receive Polyethylene Glycol 3350 [MiraLAX, a laxative used to treat constipation) powder 17 grams by mouth every 12 hours for constipation. A review of Resident 74's History & Physical dated 3/18/2024, indicated the resident had the capacity to understand and make decisions. A review of Resident 74's Minimum Data Set (MDS, a standardized assessment and care screening tool) dated 3/23/2024, indicated the resident had severely impaired cognition (problems with a person's ability to think, remember, use judgement, and make decisions) and required substantial / maximal assistance for toileting hygiene and showering / bathing self. The MDS indicated Resident 74 was frequently incontinent of urine and bowel and there was no constipation present. According to a review of the March Medication Administration Record (MAR), Resident 74 received MiraLAX every 12 hours from 3/17 - 3/31/2024. A review of the March Documentation Survey Report (DSR) indicated Resident 74 had a large loose bowel movement on 3/18, 3/23, 3/24, 3/29, 3/30 and 3/31/2024. A review of the Nursing Progress Note dated 4/12/2024, indicated Certified Physician Assistant (PA-C) 1 assessed Resident 74 had constipation and that the resident was to receive MiraLAX. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the April MAR indicated Resident 74 received MiraLAX every 12 hours from 4/1/2024 - 4/30/2024. There was no documentation that indicated Resident 74's physician was notified the resident had loose bowel movements prior to 4/30/2024. A review of the April DSR indicated Resident 74 had a large loose bowel movement on 4/3, 4/4, 4/5, 4/23, 4/24, and two large loose bowel movements on 4/22/2024. The DSR indicated Resident 74 had a small loose bowel movement on 4/12, 4/13, 4/15, 4/21, 4/30 and two small loose bowel movements on 4/17 and 4/29/2024. This indicated Resident 74 had 13 loose bowel movements for the month of April. According to a review of Resident 74's Food and Nutrition Progress Note dated 4/29/2024, the facility Registered Dietitian (RD) spoke to the resident's dialysis RD who indicated Resident 74 had diarrhea and recommended a stool binder (medication that help control diarrhea). The Food and Nutrition Progress Note indicated the MiraLAX was not needed due to Resident 74's diarrhea. The progress note further indicated Resident 74 was not eating much due to the diarrhea. A review of Resident 74's Nursing Progress Note dated 4/30/2024, indicated the resident was seen by the RD with recommendations that included, as needed diarrhea mediation due to the resident complaining of diarrhea at the dialysis center. The progress note indicated Resident 74 was not able to be assessed at the time because the resident was out for an appointment. The progress note indicated the staff assigned to Resident 74 were interviewed, who indicated the resident did not complain of any diarrhea and had no episodes of diarrhea that day or the days prior. The progress note further indicated Resident 74's physician was aware and agreed with the recommendations. A review of Resident 74's Change in Condition (COC) Evaluation form dated 5/1/2024 at 11:20 AM, indicated the resident had another loose bowel movement and the vitals signs [measurements of the body's most basic functions which include: body temperature, heart rate, respiration (breathing) rate, blood pressure, and oxygen saturation (blood oxygen level)] were assessed to be within normal limits. The COC form indicated the resident's abdomen was soft with no distension (swollen outward) and no complaints of any pain during the diarrhea episodes. The Change of Condition Evaluation indicated Resident 74's physician personally checked the resident and provided new orders for Polyethylene Glycol 3350 powder 17 grams as needed. A review of the Physician's Order dated 5/1/2024, indicated Resident 74 was to receive Polyethylene Glycol 3350 powder 17 grams by mouth every 12 hours as needed for constipation. A review of Resident 74's MAR dated 5/1/2024 - 5/7/2024, indicated the resident stopped receiving MiraLAX every 12 hours and did not receive any as needed doses of MiraLAX from 5/1/2024 - 5/7/2024. According to a review of the May DSR, Resident 74 had a large loose bowel movement on 5/1, and a small loose bowel movement on 5/5 and 5/7/2024. During an interview on 5/7/2024 at 1:42 PM, Certified Nursing Assistant (CNA) 1 stated he had been working at the facility for [AGE] years, and Resident 74 was part of his permanent assignment. CNA 1 stated Resident 74 did not have diarrhea that day and stated the resident had a bowel movement once today and it was a regular bowel movement. CNA 1 stated Resident 74 had a lot of diarrhea last month, but could not remember the exact date. CNA 1 stated he notified the charge nurse but could not indicate who the charge nurse was. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/8/2024 at 6:51 AM, Resident 74 stated he gets diarrhea when he has chemotherapy and/or dialysis. Resident 74 stated the diarrhea was getting better and stated he was not having much anymore. Resident 74 stated he was feeling good with no pain. Resident 74 stated he was not sure if he was getting a laxative and that the nursing staff help him when he needs to get cleaned up after going to the bathroom. During an interview on 5/8/2024 at 3:31 PM, Licensed Vocational Nurse (LVN) 3 stated she was taking care of Resident 74 and there was no mention of Resident 74 having loose stools / diarrhea last month. LVN 3 stated Resident 74 had not had any diarrhea that day. LVN 3 stated Resident 74 was receiving MiraLAX twice a day, but indicated the orders for MiraLAX were changed to as needed. LVN 3 stated prior to giving a resident MiraLAX she would ask them if they were having diarrhea, loose stools, or any stomach pain. LVN 3 stated if the resident was having loose stools / diarrhea she would not give them MiraLAX because it was a laxative and would make the resident have more loose stools. On 5/9/2024 at 10 AM, during a concurrent interview and record review, Resident 74's MAR for 3/2024, 4/2024, and 5/2024 were reviewed with the Director of Nursing (DON). The DON stated Resident 74 was previously receiving MiraLAX twice a day and stated the order for MiraLAX was changed to as needed, because Resident 74 was complaining of diarrhea. Resident 74's DSR for 3/2024, 4/2024, and 5/2024 were reviewed with the DON. The DON stated the documentation on the reviewed DSRs indicated Resident 74 was in fact experiencing frequent loose stools and no documentation that Resident 74 was having hard stools. The DON stated when a resident had constipation their stools would be hard and they may have a hard time having a bowel movement. The DON stated when a resident had loose stools the stools could be a paste and would not be formed. The DON stated Resident 74 should not receive MiraLAX with loose stools and stated the resident's physician should have been notified of the loose stools sooner. The DON stated there was a risk for Resident 74 to become dehydrated if he received MiraLAX and continued to have loose stools/diarrhea. The DON stated MiraLAX is a laxative, which would make loose stools worse. During a telephone interview on 5/9/2024 at 10:44 AM, the RD stated when she spoke to the RD from the dialysis center on 4/29/2024, she was informed Resident 74 was having diarrhea. The RD stated it was the first time she was made aware Resident 74 was experiencing diarrhea. The RD stated Resident 74 was receiving chemotherapy and the resident's diarrhea could be coming from the chemotherapy. The RD stated Resident 74 did not need the MiraLAX because he was having diarrhea. The RD stated there was a risk of Resident 74 becoming dehydrated if he continued to have frequent loose stools and taking a laxative could make diarrhea worse. A review of the facility's policy and procedure titled,Change in a Resident's Condition or Status, revised 2/2021, indicated to promptly notify the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status (changes in level of care, resident rights, etc.). The nurse would notify the resident's attending physician or physician on call when there has been a (an): accident or incident involving the resident; discovery of injuries of an unknown source; adverse reaction to medications; significant changes in the resident's physical/emotional/mental condition; need to alter the resident's medical treatment significantly; refusal of treatment or medications two (2) or more consecutive times; and / or specific instruction to notify the physician of changes in the resident's condition, except in medical emergencies, notifications will be made within twenty-four (24) hours of a change occurring in the resident's medical/mental condition or status. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's undated policy and procedure titled, Bowel (Lower Gastrointestinal Tract) Disorders - Clinical Protocol, indicated as part of the initial assessment, the staff and physician will help identify individuals with previously identified lower gastrointestinal tract conditions and symptoms. This should include a review of gastrointestinal problems during any recent hospitalization s, results of previous barium studies, endoscopies, etc. The staff and physician will identify risk factors related to bowel dysfunction; for example, severe anxiety disorder, recent antibiotic use, or taking medications that are used to treat, or may cause or contribute to, gastrointestinal erosion, bleeding, diarrhea, dysmotility, etc. The staff an physician will monitor the individual's response to interventions and overall progress; for example, overall degree of comfort or distress, frequency and consistency of bowel movements, and the frequency, severity, and duration of abdominal pain etc. The physician will adjust interventions based on identification of causes, resident responses to treatment, and other relevant factors.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 48661 Based on observation, interview, and record review, the facility failed to provide necessary respiratory care services for one of three sampled residents (Resident 72) by failing to ensure Resident 72's nasal cannula (NC, device that gives you additional oxygen through your nose) tubing was labeled and stored in a plastic bag. This deficient practice had the potential for Resident 72 to experience complications associated with oxygen therapy, such as infection and respiratory distress. Findings: A review of Resident 72's Admission Record indicated the facility initially admitted the resident on 2/12/2024 and readmitted the resident on 4/29/2024 with diagnoses that included acute respiratory failure with hypoxia (a condition where you do not have enough oxygen in the tissues in your body), dependence on supplemental oxygen (treatment that provides you with extra oxygen to breath in), and cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area). A review of Resident 72's Oxygen Therapy care plan developed on 2/13/2024, indicated the resident had acute hypoxemic respiratory failure. The goal was to have no signs or symptoms of poor oxygen absorption. The care plan interventions indicated changing the residents position every two hours to facilitate lung secretion movement, give medications as ordered by the physician, and to monitor for signs and symptoms of respiratory distress. The care plan interventions further indicated Resident 72 was to receive oxygen at two liters per minute via NC to keep oxygen saturation (amount of oxygen present in the blood) above 93%, continuously. A review of Resident 72's Minimum Data Set (MDS - a standardized assessment and care screening tool) dated 2/19/2024, indicated the resident's cognitive skills for daily decision making were severely impaired (never/rarely made decisions). The MDS indicated the resident was dependent on help for oral/toileting/personal hygiene, dressing, showering, and transfers. The MDS further indicated Resident 72 was receiving oxygen therapy. A review of Resident 72's Physician's Order dated 4/20/2024, indicated for the resident's oxygen tubing to be changed on Monday of every week during the night shift. A review of Resident 72's Physician's Order dated 4/29/2024, indicated for the resident to receive oxygen at two liters per minute via NC to keep oxygen saturation above 93%, continuously. During an observation on 5/6/2024 at 9:46 AM, in Resident 72's room, the resident's NC tubing was observed not labeled and hanging over the resident's tube feeding machine. During an observation on 5/7/2024 at 9:45 AM, in Resident 72's room, the resident's NC tubing was observed not labeled and placed inside the resident's bedside drawer. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview, on 5/7/2024 at 9:59 AM, Licensed Vocational Nurse (LVN) 2 stated Resident 72's NC tubing should have been labeled with the date, otherwise the staff would not know how long the tubing was being used for. LVN 2 stated the resident's NC should not be inside the bedside drawer because Resident 72 could be at risk for infection if the NC was not stored properly. LVN 2 stated the NC should have been changed every week or as needed but should always be labeled and placed in a protective bag. During an interview on 5/7/2024 at 10:33 AM, Registered Nurse (RN) 1 stated the NC tubing should have been inside a plastic bag so the NC tubing would not get dirty and would not touch the floor. RN 1 stated the NC tubing should have been labeled and the tubing should have been changed once a week or as necessary. RN 1 stated Resident 72 could be at risk for infection if the NC tubing was exposed for more than seven days and not placed inside a bag. During an interview on 5/9/2024 at 4:54 PM, the Director of Nursing (DON) stated the NC tubing should have been inside a plastic bag and labeled with the date. The DON stated the NC tubing should have been changed every Monday or as needed. The DON stated Resident 72 was at risk for infection if the NC tubing was not labeled or inside a bag. A review of the facility's policy and procedures (P&P) titled, Departmental (Respiratory Therapy) - Prevention of Infection, reviewed 1/18/2024, indicated Infection Control Considerations Related to Oxygen Administration: Change the oxygen cannula and tubing every seven (7) days, or as needed and keep the oxygen cannula and tubing used as needed in a plastic bag when not in use.

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NAME OF PROVIDER OR SUPPLIER Palazzo Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 5400 Fountain Ave Los Angeles, CA 90029	

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49130 Based on observation, interview, and record review, the facility failed to provide pharmaceutical services to meet the resident's needs for one of four sampled residents (Resident 78). Resident 78, who was at risk for malnutrition, did not receive 17 doses of Megestrol Acetate Suspension medication (used to stimulate appetite, increasing the feeling to have more food) during medication administration, per physician's order. The facility also failed to maintain accurate medication administration records, per facility's policies and procedures (P&P) titled, Administering Medications, the policy Documentation of Medication Administration, and the policy Pharmacy Services Overview. As a result, Resident 78 had significant weight loss with the potential for malnutrition and hospitalization . Findings: A review of Resident 78's Admission Record indicated the resident was admitted to the facility on [DATE], with diagnoses including intracranial (within the skull) abscess (a pocket of pus) and granuloma (a cluster of white blood cells and tissue due to infection), hearing loss, pressure-induced deep tissue damage of sacral region, and gastroesophageal reflux disease (GERD - a short medical term for a condition when stomach acid flows back into esophagus [the tube connecting mouth and stomach]) without esophagitis (inflammation of esophagus). A review of Resident 78's History and Physical, dated 4/3/2024, indicated resident had the capacity to understand and make decisions. A review of the weight records dated 4/3/2024 indicated Resident 78 weighed 165 pounds. According to a review of the Minimum Data Set (MDS, a standardized assessment and care screening tool) dated 4/8/2024, Resident 78 had intact cognition (ability to understand and make decisions) and was dependent on the facility staff for moderate to maximal assistance for activities of daily living (ADL - tasks of everyday life that include personal and oral hygiene, toileting, showering, and dressing). A review of Resident 78's Mini Nutrition Evaluation, dated 4/10/2024, indicated a score of 10 indicating the resident was at risk for malnutrition. A review of the Unplanned Weight Loss care plan dated 4/17/2024, and the Risk for Poor PO (by mouth) Intake care plan dated 4/19/2024, indicated the facility interventions were to administer medication as ordered, megestrol acetate oral suspension 400 mg/10 mL, give 10 mL by mouth one time a day for appetite stimulant. A review of the Physician's Order Summary Report dated 4/20/2024, indicated Resident 78 was to receive Megestrol Acetate Oral Suspension (a mixture where solid particles do not dissolve completely in a liquid solution) 400 milligrams (mg - a unit of measurement) / 10 milliliter (mL - a unit of measurement), give 10 mL by mouth one time a day for appetite stimulant. (continued on next page)

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the medication pass observation on 5/7/2024 at 9:48 AM, Licensed Vocational Nurse (LVN) 1 prepared to administer the medications for Resident 78. LVN 1 did not have the Megestrol Acetate Oral Suspension in the medication cart (Med Cart Station 2). During a concurrent interview, LVN 1 stated Resident 78's Megestrol Acetate suspension was not available to administer to the resident. LVN 1 stated if the medication was not available to administer, code 9 was entered with notes explaining why the medication was not administered. LVN 1 stated Megestrol was previously administered on 5/6/2024. During a medication reconciliation review on 5/7/2024 at 12:16 PM, Resident 78's current physician's orders dated 4/30/2024 and Medication Administration Record (MAR - log of all medications given to resident)) for the month of May 2024 were reviewed. Resident 78's MAR indicated the Megestrol scheduled at 9 AM daily, was marked as administered on 5/7/2024, even though the medication was not available in stock. During a concurrent interview and record review on 5/7/2024 at 12:23 PM with LVN 1, the MAR and the Administration Detail for 5/7/2024 were reviewed. LVN 1 stated she inaccurately marked Megestrol Acetate as administered at 10:10 AM by mistake, when the medication was not in stock to be administered. LVN 1 stated this inaccurate representation of administration record would fail to treat Resident 78 and could lead to significant weight loss if he missed multiple doses of Megestrol. LVN 1 stated Resident 78 would experience body weakness and problems with performing activities of daily living if the resident was losing weight and did not receive the appetite stimulant as ordered. A review of Resident 78's MAR dated from 4/1/2024 to 5/7/2024, indicated documentation that the resident was administered 18 doses of Megestrol Acetate Suspension by nine different licensed nurses, when the medication was not available in stock. A review of the weight records dated 5/7/2024 indicated Resident 78 weighed 156 pounds, which was more than a five percent weight loss in one month. A review of facility's document titled,Rx Delivery Receipt, (a pharmacy document indicating pharmacy deliveries to the facility) dated 5/7/2024, indicated Megestrol Acet 40 mg/mL Susp 1 package of quantity 240 was delivered to facility for Resident 78 on 5/7/2024 at 12:52 PM. During an interview on 5/8/2024 at 10:07 AM, the Director of Nursing (DON), stated Resident 78's Megestrol Acetate was to improve the resident's appetite and help him eat better. The DON stated if a medication was not available, the facility staff was supposed to document code 9, inform the physician and request pharmacy if there were any alternatives. The DON stated if there was a mistake of documentation, it can be stroked out with a progress note to indicate that there was an error in documentation. The DON stated she did not have documentation of the pharmacy delivery for Megestrol prior to 5/7/2024 and that all LVNs were aware that documentation on administered medications should only happen after they were administered. The DON stated she did not know why the Megestrol doses were marked as administered in absence of the medication being in stock. The DON stated Resident 78 would start to feel weak, dizzy and if continued to lose weight then there would be a risk for hospitalization if the resident did not eat because of not receiving the ordered medication. During a telephone interview on 5/8/2024 at 1:47 PM, the Registered Pharmacist (RPH) stated Megestrol Acetate was requested by the facility on 4/19/2024 but was not delivered to the facility. The RPH stated Megestrol for Resident 78 was recently delivered to facility on 5/7/2024. (continued on next page)

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/8/2024 at 3:01 PM, LVN 3 stated the initials on the MAR were her initials but did not recall if she did or did not have the medication for the resident. LVN 3 stated if the medication was documented as given on the MAR, but not actually administered, that was inaccurate. LVN 3 stated not receiving the medication as ordered would cause the resident to not be able to eat well, lose weight, would be unable to do normal ADLs, potentially become hypoglycemic and would not heal to be able to fight infections. During an interview on 5/9/2024 at 10:44 AM, Resident 78's Representative (RR) stated the resident had not been eating well because nothing tastes good to him. The RR stated she remembered Resident 78's weight on 3/5/2024 to be 182 pounds, which reduced to 156 pounds on 5/9/2024. On 5/9/2024 at 11:09 AM, during an interview, Resident 78 stated he was given one drink which was a brown colored drink. Resident 78 stated he had not received a white colored Megestrol drink until the day before on 5/8/2024. During an interview on 5/9/2024 at 12:50 PM, the Medical Director (MD) stated Resident 78 was not his patient, but the facility requested for a second opinion to reevaluate the care. The MD stated Resident 78 was losing weight, not gaining weight, and that he was not aware of the false documentation of the medication administration. The MD stated Resident 78 refused Megestrol on 5/8/2024 and complained about not sleeping well so the MD prescribed a different medication to treat the weight loss and possible depression. During an interview on 5/9/2024 at 3:43 PM, the Registered Dietician (RD) stated she remembered speaking with Resident 78 on 4/17/2024 but did not document anything because there were no complaints. The RD stated, Resident 78's PO intake was good at 50-100% based on how nurses documented. We gave him appetite stimulant Megace around second or third week of April. His PO became more stable at 50-75% consistently for all meals. The RD stated Resident 78 was on antibiotics and healing from a wound, which was why he was losing weight. The RD stated there was a note on 5/8/2024 of significant weight loss because antibiotics cause appetite loss. The RD stated if Resident 78 continued to lose weight, he would not heal, and infection would potentially recur and place resident at risk for being malnourished. A review of the facility's P&P titled, Pharmacy Services Overview, undated, indicated nursing staff communicate prescriber orders to the pharmacy and were responsible for contacting the pharmacy if a resident's medication was not available for administration. Borrowing medications from other residents or from the emergency medication supply because of a failure to order or reorder a medication was not acceptable practice. The policy indicated medications were received, administered and disposed of according to all applicable state and federal laws. A review of the facility's P&P titled, Administering Medications, dated April 2019 indicated medications were administered in accordance with prescriber orders, including any required time frame. A review of the facility's P&P titled, Documentation of Medication Administration, dated April 2007, indicated administration of medication must be documented immediately after (never before) it was given. Documentation must include, as a minimum, date and time of administration, reason (s) why a medication was withheld, not administered, or refused (as applicable).

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48429 Based on interview and record review, the facility failed to provide documented justification for the continuation of an antidepressant medication Effexor (a medication used to treat major depressive disorder, anxiety, and panic disorder) beyond 30 days for one of six sampled residents (Resident 64). This deficient practice had the potential to cause Resident 64 to receive an unnecessary medication that can lead to adverse side effects. Findings: A review of the Admission Record indicated Resident 64 was admitted to the facility on [DATE], with diagnoses that included major depressive disorder, recurrent and unspecified (constant loss of interest in daily activities or things once liked), primary generalized osteoarthritis (a degenerative joint disease that worsens over time often resulting in chronic pain), difficulty in walking, and pain in left knee. A review of the Mood Disturbance Care Plan related to diagnosis of depression, manifested by verbalization of sadness was 12/4/2023. The goal indicated Resident 64 would be free of signs and symptoms of depression, anxiety, or sad mood by the review date, but no review date was indicated. The care plan interventions indicated to administer medications as ordered and monitor for side effects and effectiveness, arrange for a psych consult, follow up as indicated, assess, record, and report signs and symptoms of depression to doctor including hopelessness, anxiety, sadness, insomnia, anorexia, verbalizing negative statements, repetitive anxious or health-related complaints, and tearfulness. A review of the Physician's Order Summary Report, dated 12/4/2023, indicated Resident 64 was to receive Effexor extended release (XR) oral capsule 150 MG (a unit of measurement of mass metric system) one time a day for depression, manifested by verbalization of sadness. According to a review of the Medication Administration Record (MAR), dated from 12/4/2023 - 3/9/2024, Resident 64 received Effexor (XR) 150 MG daily and there were no episodes of the resident's verbalization of sadness. A review of the Consultant Pharmacist's Medication Regimen Review (MRR), dated 1/1/2024 through 3/9/2024 indicated no recommendations, actions, or rationale for the daily administration of Effexor HCL XR 150 MG. A review of the Minimum Data Set (MDS- a comprehensive assessment and care screening tool), dated 3/10/2024, indicated Resident 64 was cognitively intact (able to make decisions) and required substantial/maximal assistance with toileting hygiene, shower/bathe self, lower body dressing, and putting on and taking off footwear. A review of the Consultant Pharmacist MRR dated from 3/10/2023 - 4/30/2024 indicated for Resident 64 there were no recommendations, actions, or rationale (a set of reasons for actions) for the daily administration of Effexor HCL XR 150 MG. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to a review of the facility's Psychotropic and Sedative/Hypnotic Utilization by Resident form, dated 4/30/2024, Resident 64 was receiving Effexor HCL 150 MG daily for depression manifested by verbalization of sadness and the next evaluation was 6/1/2024. A review of the MAR dated from 3/10/2023 through 5/8/2024 indicated Resident 64 had no behavior episodes of verbalization of sadness while taking Effexor XR 150 MG daily. During a concurrent interview and record review on 5/8/2024 at 3:36 PM with Director of Nurses (DON), the facility's policy and procedure (P&P) titled, Medication Regimen Reviews, revised 5/2019 was reviewed. The policy indicated the consultant pharmacist reviews the medication regimen of each resident at least monthly. The consultant pharmacist performs a medication regimen review (MRR) for every resident in the facility receiving medication. The consultant pharmacist provides a written report to the attending physicians for each resident identified as having a non-life-threatening medication irregularity. The report contains: resident's name, medication, identified irregularity, and the pharmacist recommendation. The DON stated, there was no documentation of a Gradual Dose Reduction (GDR) for Resident 64. The DON stated it was important to have a GDR to make sure the resident needs the medications they were prescribed.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49130 Based on observation, interview, and record review, the facility failed to ensure residents were free from significant medication errors for one of four sampled residents (Resident 78) by not having the medication Megestrol Acetate Oral Suspension (a medication available as mixture where solid particles do not dissolve completely in a liquid solution, used to stimulate appetite increasing the feeling to have more food) available for administration for 17 days. This failure resulted in significant weight loss for Resident 78 and had the potential to result in malnutrition and hospitalization . Findings: A review of Resident 78's Admission Record indicated the resident was admitted to the facility on [DATE], with diagnoses including intracranial (within the skull) abscess (a pocket of pus) and granuloma (a cluster of white blood cells and tissue due to infection), hearing loss, pressure-induced deep tissue damage of sacral region, and gastroesophageal reflux disease (GERD - a short medical term for a condition when stomach acid flows back into esophagus [the tube connecting mouth and stomach]) without esophagitis (inflammation of esophagus). A review of Resident 78's History and Physical, dated 4/3/2024, indicated resident had the capacity to understand and make decisions. A review of the weight records dated 4/3/2024 indicated Resident 78 weighed 165 pounds. According to a review of the Minimum Data Set (MDS, a standardized assessment and care screening tool) dated 4/8/2024, Resident 78 had intact cognition (ability to understand and make decisions) and was dependent on the facility staff for moderate to maximal assistance for activities of daily living (ADL - tasks of everyday life that include personal and oral hygiene, toileting, showering, and dressing). A review of Resident 78's Mini Nutrition Evaluation, dated 4/10/2024, indicated a score of 10 indicating the resident was at risk for malnutrition. A review of the Unplanned Weight Loss care plan dated 4/17/2024, and the Risk for Poor PO (by mouth) Intake care plan dated 4/19/2024, indicated the facility interventions were to administer medication as ordered, megestrol acetate oral suspension 400 mg/10 mL, give 10 mL by mouth one time a day for appetite stimulant. A review of the Physician's Order Summary Report dated 4/20/2024, indicated Resident 78 was to receive Megestrol Acetate Oral Suspension (a mixture where solid particles do not dissolve completely in a liquid solution) 400 milligrams (mg - a unit of measurement) / 10 milliliter (mL - a unit of measurement), give 10 mL by mouth one time a day for appetite stimulant. (continued on next page)

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the medication pass observation on 5/7/2024 at 9:48 AM, Licensed Vocational Nurse (LVN) 1 prepared to administer the medications for Resident 78. LVN 1 did not have the Megestrol Acetate Oral Suspension in the medication cart (Med Cart Station 2). During a concurrent interview, LVN 1 stated Resident 78's Megestrol Acetate suspension was not available to administer to the resident. LVN 1 stated if the medication was not available to administer, code 9 was entered with notes explaining why the medication was not administered. LVN 1 stated Megestrol was previously administered on 5/6/2024. During a medication reconciliation review on 5/7/2024 at 12:16 PM, Resident 78's current physician's orders dated 4/30/2024 and Medication Administration Record (MAR - log of all medications given to resident)) for the month of May 2024 were reviewed. Resident 78's MAR indicated the Megestrol scheduled at 9 AM daily, was marked as administered on 5/7/2024, even though the medication was not available in stock. During a concurrent interview and record review on 5/7/2024 at 12:23 PM with LVN 1, the MAR and the Administration Detail for 5/7/2024 were reviewed. LVN 1 stated she inaccurately marked Megestrol Acetate as administered at 10:10 AM by mistake, when the medication was not in stock to be administered. LVN 1 stated this inaccurate representation of administration record would fail to treat Resident 78 and could lead to significant weight loss if he missed multiple doses of Megestrol. LVN 1 stated Resident 78 would experience body weakness and problems with performing activities of daily living if the resident was losing weight and did not receive the appetite stimulant as ordered. A review of Resident 78's MAR dated from 4/1/2024 to 5/7/2024, indicated documentation that the resident was administered 18 doses of Megestrol Acetate Suspension by nine different licensed nurses, when the medication was not available in stock. A review of the weight records dated 5/7/2024 indicated Resident 78 weighed 156 pounds, which was more than a five percent weight loss in one month. A review of facility's document titled,Rx Delivery Receipt, (a pharmacy document indicating pharmacy deliveries to the facility) dated 5/7/2024, indicated Megestrol Acet 40 mg/mL Susp 1 package of quantity 240 was delivered to facility for Resident 78 on 5/7/2024 at 12:52 PM. During an interview on 5/8/2024 at 10:07 AM, the Director of Nursing (DON), stated Resident 78's Megestrol Acetate was to improve the resident's appetite and help him eat better. The DON stated if a medication was not available, the facility staff was supposed to document code 9, inform the physician and request pharmacy if there were any alternatives. The DON stated if there was a mistake of documentation, it can be stroked out with a progress note to indicate that there was an error in documentation. The DON stated she did not have documentation of the pharmacy delivery for Megestrol prior to 5/7/2024 and that all LVNs were aware that documentation on administered medications should only happen after they were administered. The DON stated she did not know why the Megestrol doses were marked as administered in absence of the medication being in stock. The DON stated Resident 78 would start to feel weak, dizzy and if continued to lose weight then there would be a risk for hospitalization if the resident did not eat because of not receiving the ordered medication. During a telephone interview on 5/8/2024 at 1:47 PM, the Registered Pharmacist (RPH) stated Megestrol Acetate was requested by the facility on 4/19/2024 but was not delivered to the facility. The RPH stated Megestrol for Resident 78 was recently delivered to facility on 5/7/2024. (continued on next page)

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/8/2024 at 3:01 PM, LVN 3 stated the initials on the MAR were her initials but did not recall if she did or did not have the medication for the resident. LVN 3 stated if the medication was documented as given on the MAR, but not actually administered, that was inaccurate. LVN 3 stated not receiving the medication as ordered would cause the resident to not be able to eat well, lose weight, would be unable to do normal ADLs, potentially become hypoglycemic and would not heal to be able to fight infections. During an interview on 5/9/2024 at 10:44 AM, Resident 78's Representative (RR) stated the resident had not been eating well because nothing tastes good to him. The RR stated she remembered Resident 78's weight on 3/5/2024 to be 182 pounds, which reduced to 156 pounds on 5/9/2024. On 5/9/2024 at 11:09 AM, during an interview, Resident 78 stated he was given one drink which was a brown colored drink. Resident 78 stated he had not received a white colored Megestrol drink until the day before on 5/8/2024. During an interview on 5/9/2024 at 12:50 PM, the Medical Director (MD) stated Resident 78 was not his patient, but the facility requested for a second opinion to reevaluate the care. The MD stated Resident 78 was losing weight, not gaining weight, and that he was not aware of the false documentation of the medication administration. The MD stated Resident 78 refused Megestrol on 5/8/2024 and complained about not sleeping well so the MD prescribed a different medication to treat the weight loss and possible depression. During an interview on 5/9/2024 at 3:43 PM, the Registered Dietician (RD) stated she remembered speaking with Resident 78 on 4/17/2024 but did not document anything because there were no complaints. The RD stated, Resident 78's PO intake was good at 50-100% based on how nurses documented. We gave him appetite stimulant Megace around second or third week of April. His PO became more stable at 50-75% consistently for all meals. The RD stated Resident 78 was on antibiotics and healing from a wound, which was why he was losing weight. The RD stated there was a note on 5/8/2024 of significant weight loss because antibiotics cause appetite loss. The RD stated if Resident 78 continued to lose weight, he would not heal, and infection would potentially recur and place resident at risk for being malnourished. A review of the facility's P&P titled, Pharmacy Services Overview, undated, indicated nursing staff communicate prescriber orders to the pharmacy and were responsible for contacting the pharmacy if a resident's medication was not available for administration. Borrowing medications from other residents or from the emergency medication supply because of a failure to order or reorder a medication was not acceptable practice. The policy indicated medications were received, administered and disposed of according to all applicable state and federal laws. A review of the facility's P&P titled, Administering Medications, dated April 2019 indicated medications were administered in accordance with prescriber orders, including any required time frame. A review of the facility's P&P titled, Documentation of Medication Administration, dated April 2007, indicated administration of medication must be documented immediately after (never before) it was given. Documentation must include, as a minimum, date and time of administration, reason (s) why a medication was withheld, not administered, or refused.

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 49130 Based on observation, interview, and record review, the facility failed to ensure safe storage of a bottle of Dorzolamide-Timolol Ophthalmic Solution (a medication in the form of eye drops with a combination of two medications used for treatment of high pressure in the eyes), according to the manufacturer's requirements affecting Resident 7 in one of two medication room refrigerators inspected (Medication Room Station 1). This failure to store medications per the manufacturers' requirements increased the risk that Resident 7 could have received medication that had become ineffective or toxic due to improper storage possibly leading to eye complications or hospitalization . Findings: During a concurrent observation and interview on 5/7/2024 at 4:05 PM of Station 1 Medication Room Refrigerator, with Licensed Vocational Nurse (LVN) 7, the following medication was found in the refrigerator at 40-degree Fahrenheit (F - a unit of measurement for temperature) not stored in accordance with manufacturer's requirements: -One bottle of Dorzolamide-Timolol 22.3 milligrams (mg - a unit of measurement) / 6.8 mg per milliliter (mL - a unit of measurement) Ophthalmic Solution for Resident 7. According to the manufacturer's product labeling, Dorzolamide-Timolol should be stored between 68-degree F to 77-degree F. LVN 7 stated Dorzolamide-Timolol eye drops should not be in the refrigerator. LVN 7 stated she would call the pharmacy to inform them and request replacement. LVN 7 stated this inappropriate storage of eye drops could make the medication ineffective and would not improve resident's eye condition. During an interview on 5/8/2024 at 10:32 AM, the Director of Nursing (DON) stated Dorzolamide -Timolol ophthalmic solution should not have been stored in the refrigerator. The DON stated the eye drops would not be effective to treat the elevated eye pressure and had the risk of causing eye irritation, redness, and other eye complications for Resident 7 because it was not stored in accordance with manufacturer's guidelines. A review of the facility's policy and procedure (P&P) titled, Storage of Medications, dated April 2019, indicated drugs and biologicals used in the facility were stored in locked compartments under proper temperature, light and humidity controls.

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 05/09/2024
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)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 43851 Based on observation, interview, and record review, the facility failed to ensure food stored in the kitchen were dated and labeled. This deficient practice had the potential to cause food-borne illnesses for all residents who receive food from the kitchen. Findings: During the initial kitchen tour on 5/6/2024 at 8:10 AM, the following items were observed unlabeled and undated in the walk in refrigerator: -two bags of unopened whole wheat bread loaves, -one opened bag of whole wheat bread, -one opened bag of hamburger buns, -seven bags of frozen broccoli, -13 bags of frozen spinach, 10 bags of frozen mixed vegetables, -4 bags of frozen peas, 5 bags of frozen carrots, and 2 bags of cauliflower. During a concurrent interview, the Dietary [NAME] (DC) stated the opened and unopened bags of bread were undated and unlabeled. The DC stated the bags of frozen vegetables were undated and unlabeled. The DC stated all food stored in the kitchen should be labeled and dated to know how long the food was good for. The DC stated all food should be dated and labeled to prevent food-borne illness. During an interview on 5/9/2024 at 10:20 AM, the Director of Nurses (DON) stated all food stored in the kitchen should be labeled and dated to ensure kitchen staff know which foods were safe for the residents to eat and prevent food-borne illness. A review of the facility's policy and procedure titled, Labeling and Dating of Foods, dated 2023, indicated all food items in the storeroom, refrigerator, and freezer need to be labeled and dated. Food delivered to facility needs to be marked with a received date. Note that the delivery sticker is dated, and it can serve as the delivery date for the product. Newly opened food items will need to be closed and labeled with an open date and used by the date that follow the various storage guidelines within this section-specifically the Dry Goods Storage Guidelines (page 6.9), Refrigerated Storage guidelines (page 6.16), Produce Storage Guidelines (page 6.18), and Freezer Storage Guidelines (page 6.20).