

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

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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 06/25/2026
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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure two of three sampled residents (Resident 8 and Resident 13) reviewed for dialysis (a medical treatment that acts as an artificial kidney, filtering waste products, toxins, and excess water from the blood when a person's kidneys can no longer perform these tasks properly) received dialysis services consistent with professional standards of practice by failing to:-Ensure Resident 8 did not miss dialysis appointments due to transportation on 5/16/2026.-Ensure the licensed nurses (in general) conducted the pre (before) and post (after) dialysis assessments for Resident 8 and Resident 13.-Ensure Resident 13 did not receive more than 1000 milliliters (ml, a unit of measurement) of fluid per day as ordered by Resident 13's physician. These failures had the potential to delay critical treatment, compromise the accuracy of dialysis orders, and place Resident 8 and Resident 13 at risk for injury, fluid overload (is a condition where the body accumulates too much fluid, leading to swelling, high blood pressure, and potential heart and lung complications), infection, or other complications. Findings: a. During a review of Resident 8's admission Record, the admission Record indicated the facility readmitted the resident on 5/19/2026, with diagnoses that included metabolic encephalopathy (brain dysfunction caused by an chemical imbalance in the blood), end stage renal failure (ESRD, irreversible kidney failure), and diabetes (a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 8's Care Plan Report dated 2/13/2026, the Care Plan Report indicated Resident 8 needed hemodialysis related to ESRD. The Care Plan Report indicated a nursing intervention to assist the resident with dialysis pick up every Tuesday, Thursday, and Saturday of every week. During a review of Resident 8's Order Summary Report dated 3/6/2026, the Order Summary Report indicated for Resident 8 to receive dialysis on Tuesday, Thursday, and Saturday. During a review of Resident 8's History and Physical (H&P) dated 3/8/2026, the H&P indicated the resident had the capacity to make and understand complex decisions. During a review of Resident 8's Order Summary Report dated 4/21/2026, the Order Summary Report indicated to assist Resident 8 with curbside pickup outside of the facility every Tuesday, Thursday, (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and Saturday for dialysis services. During a review of Resident 8's Minimum Data Set (MDS, a resident assessment tool) dated 5/12/2026, the MDS indicated the resident required supervision (helper provides verbal cues or steadying assistance as resident completes activity) from staff to complete activities of daily living (ADLS, activities a person performs daily such as bathing, dressing, and toileting). The MDS indicated the resident received dialysis. During a review of Resident 8's Progress Note, dated 5/14/2026, the Progress Note indicated resident refused to attend a routinely scheduled dialysis appointment (5/14/2026). The Progress Note indicated that the Facility Medical Director (FMD) ordered a make-up dialysis and for the Social Services Department to arrange for transportation. During a review of Resident 8's Progress Note dated 5/15/2026, the Progress Note indicated resident left the facility for a make-up dialysis. The Progress Note indicated a Dialysis Communication Record was provided. During a review of Resident 8's Progress Note dated 5/15/26, the Progress Note indicated the resident left the facility for a make-up dialysis. During a review of Resident 8's Progress Note, dated 5/15/2026, the Progress Note indicated the resident returned from make-up dialysis the same day (5/15/2026). During a review of Resident 8's Progress Note, dated 5/16/2026, the Progress Note indicated Resident 8 missed a routinely scheduled dialysis appointment (5/16/2026) due to transportation not arriving. The Progress Note indicated the facility Medical Director was made aware that the staff (unidentified) would follow up the following Monday (5/18/26) to schedule a same-day make-up dialysis appointment. During a review of Resident 8's Progress Note, dated 5/18/2026, the Progress Note indicated a make-up dialysis was scheduled for 5/18/26 at 2 PM and for the Social Services Department to arrange for transportation. During a review of Resident 8's Order Details dated 5/18/2026, the Order Details indicated Received an order, may transfer out to hospital due to 2x [twice] missed dialysis treatment. During a review of Resident 8's Transfer Form dated 5/18/2026, the Transfer Form indicated an unplanned transfer to General Acute Care Hospital (GACH1) at 5:05 PM for missed dialysis. During an interview on 6/24/2026 at 10:55 AM with Licensed Vocational Nurse 6 (LVN6), LVN 6 stated it was important for residents (in general) to go to their dialysis appointments as scheduled. LVN 6 stated toxins (poisonous) build up in the body and fluid overload (a condition where the body accumulates too much fluid) can occur if residents missed their dialysis. During a concurrent interview and record review on 6/24/2026 at 10:55 AM with LVN6, Resident 8's (continued on next page)		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/25/2026 at 10:35 AM with the DON, the DON stated that Resident 13 was supposed to have a fluid restriction of 1000 ml per day and that if a resident (in general) was taking more than the ordered fluid restriction, nurses (in general) were supposed to be made aware and report to the physician via change of condition to be able to provide the proper care to the resident due to Resident 13 was at risk for fluid imbalances and overload. During a review of the facility's P&P, titled, Hemodialysis Residents, reviewed on 5/21/2026, P&P indicated that the facility would provide residents with safe, accurate and appropriate care, assessments and interventions to improve resident outcomes. During a review of the facility's P&P, titled, Fluid Restriction Management Policy, reviewed on 5/21/2026, P&P indicated that facility to ensure safe and effective management or resident requiring fluid restrictions by maintaining physician-ordered fluid limits, preventing complications related to fluid imbalance and promoting interdisciplinary communication. P&P also indicated that significant variances from the prescribed fluid restriction and non-compliance should be documented and reported to the physician. During a review of the facility's P&P, titled, Change in Condition, reviewed on 5/21/2026, P&P indicated that facility would promptly assess, document, and communicate any significant change in a resident's condition to ensure appropriate interventions are implemented and resident needs were addressed.		

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. Based on observation, interview, and record review, the facility failed to ensure four of four dumpsters were completely closed and not overfilled with trash. This failure had the potential to result in pests (organisms that cause harm to humans such as flies, cockroaches, and rodents) entering the facility and spreading diseases to residents. Findings: During a concurrent observation and interview on 6/22/26 at 7:58 a.m. in the outdoor garbage area, with the Dietary Manager (DM), four of four dumpster lids were partially open. The DM stated that garbage containers had to be completely closed when not in use, to prevent pests from getting inside. The DM stated open garbage containers attracted pests and that residents could get sick from diseases that pests spread. During an interview on 6/25/26 at 8:59 a.m. with the Administrator (ADM), the ADM stated that the city's trash pickup did not occur as regularly scheduled on the previous Friday, 6/19/26, because it was a holiday. The ADM stated that several days passed with no trash pickup from the city. During a concurrent interview and record review on 6/25/26 at 10:41 a.m., the facility's P&P titled, Garbage Disposal Policy, revised May 2025, was reviewed with the DM. The DM reviewed the P&P and stated that dumpsters were not to be filled beyond capacity to ensure that the lid could be completely closed. During a review of the facility's P&P titled, Garbage Disposal, revised May 2025, the P&P indicated for trash containers to be emptied regularly to prevent overflow.		

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on interviews, and record review, the facility failed to maintain ongoing competency for restorative nursing assistants (RNAs) by failing to, ensure a restorative nursing assistants training program was developed and implemented. This failure had the potential to compromise nursing competence among restorative nursing assistants which could adversely affect the quality and safety of care provided to residents. Findings: During an interview on 6/24/2026 at 12:45 PM with the Director of Staff Development (DSD), the DSD stated that restorative nursing assistants weighed the residents as part of their job description and daily assignments. The DSD stated that all in-service education provided to the staff were written and posted on the facility's Annual Staff Development Education calendar. During an interview on 6/25/2026 at 9:40 AM with RNA 1, RNA 1 stated that they (RNAs) did weigh the residents but could not remember the last time she was given an education on weighing residents. During an interview on 6/25/2026 at 11:27 AM with the Director of Nursing (DON), the DON stated RNAs were required to receive appropriate training to ensure competence in their duties and one of their primary responsibilities was weight assessment. The DON stated that all in-service trainings were scheduled and outlined in the facility's Annual Staff Development Education calendar. During a review of the facility's Annual Staff Development Education calendar for 2025 and 2026, the calendars indicated that the monthly topics provided by the DSD to the staff did not include topics on weight assessment. During a review of the RNA job description, dated 9/2011, the job description indicated that under the supervision of the rehabilitation department, DON, DSD and licensed nurses, the RNA was responsible for providing nursing care using the restorative nursing approaches learned through training and actual demonstration. The job description indicated the RNA's general role and responsibilities included weighing the residents monthly and as needed on a regular basis based on facility policy. During a review of the facility's policy and procedure (P&P) titled, In-service Education Policy, the P&P indicated, the facility will provide ongoing in-service education and training to ensure all employees maintain the knowledge and skills necessary to provide safe, quality, and regulatory-compliant resident care. To ensure staff are competent in performing their job responsibilities and remain current with federal, state and facility requirements, required in-service education will be provided during orientation, annually and as needed based on resident care needs or identified competency gaps.		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure care was provided in a manner that promoted or enhanced dignity and respect for two of 20 sampled residents (Resident 4 and Resident 41) by failing to:-Ensure barber services were provided for Resident 4, resulting in the resident not receiving grooming care needed to maintain personal dignity and appearance.-Ensure the facility communicated with Resident 41 regarding an active Out`on`Pass (OOP) order dated [DATE], resulting in the resident not being informed of the authorized pass and not being provided the opportunity to participate in planning and exercising their personal rights related to temporary leave from the facility.These failures resulted in Resident 4 not receiving needed grooming services to maintain dignity and appearance, and resulted in Resident 41 not being informed of an active Out`on`Pass (OOP) order dated [DATE], depriving the resident of the opportunity to participate in their care decisions and exercise personal rights. Findings: a. During a review of Resident 4's admission Record, the admission Record indicated the facility admitted Resident 4 on [DATE] with diagnoses that included major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest, essential hypertension (high blood pressure), difficulty in walking and hydronephrosis (a condition where one or both kidneys swell). During a review of Resident 4's History and Physical dated [DATE], the History and Physical indicated Resident 4 had the capacity to understand all decisions. During a review of Resident 4's Care Plan Report dated [DATE], the Care Plan Report indicated Resident 4 had decreased self-care ability. The Care Plan Report indicated to provide Resident 4 with assistance with personal care to improve hygiene and grooming. During a review of Resident 4's Minimum Data Set, (MDS-a resident assessment tool) dated [DATE], the MDS indicated Resident 4 had no acute changes in mental status. The MDS indicated Resident 4 needed supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently) for oral hygiene, upper body dressing and personal hygiene. During a concurrent observation and interview on [DATE] at 11:08 AM with Resident 4 inside resident's room, Resident 4 had uneven, overgrown facial hair and a noticeably unkempt appearance due to long hair. Resident 4 stated he (Resident 4) wanted to be shaved and groomed but had not seen the barber. During an interview on [DATE] at 9:23 AM with the Certified Nursing Assistant 9 (CNA 9), CNA 9 stated Resident 4'S facial hair was not neatly shaped, and haircut was not provided to the resident. (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 12:23 PM with the Social Services Director (SSD), the SSD stated daily rounding was conducted by the facility leaders using the checklist form as a quality of care and safety rounds. During an interview on [DATE] at 7:47 AM with the Director of Nursing (DON), the DON stated that Resident 4's care should include proper grooming to support the resident's dignity and promote the overall sense of well-being. During a review of the facility's policy and procedure (P&P) titled, Dignity, the P&P indicated each resident is cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, feeling self-worth and self-esteem. When assisting with care, residents are supported in exercising their rights. Residents are encouraged to maintain personal grooming styles. b. During a review of Resident 41's admission Record, the admission Record indicated the facility admitted the resident on [DATE], with diagnoses including but not limited to hepatic encephalopathy (a decline in brain function caused by severe liver disease or liver failure) liver cirrhosis (permanent scarring of healthy liver tissue, usually caused by long-term damage like excessive alcohol use, viral hepatitis, or fatty liver disease) and anemia (a condition where the body does not have enough healthy red blood cells). During a review of Resident 41's untitled history and physical document dated [DATE], the untitled history and physical document indicated Resident 41 was stable, alert, and oriented with no evidence of confusion. During a review of Resident 41's MDS dated [DATE], the MDS indicated Resident 41 made herself understood and understood others. The MDS indicated Resident 41's cognitive functioning (mental processes that enable people to think, understand, make decisions, and complete tasks) is intact. The MDS indicated Resident 41 participated in his care. During a review of Resident 41's Psychiatric Note dated [DATE], the Psychiatric Note indicated Resident 41 had the desire to go out on pass and to go to the store and handle personal concerns such as going to Social Security (a government program funded, provides financial support when retired). The Psychiatric Note indicated that Resident 41 may go out on pass according to the facility policy. The psychiatric note indicated Resident 41's behavior was table. During a review of Resident 41's Psychiatric Note dated [DATE], the Psychiatric Note indicated Resident 41 had a desire to go out on pass to go to the store and handle personal concerns such as going to social security office with a friend. The Psychiatric Note indicated that Resident 41 may go out on pass according to the facility's policy. The Psychiatric Note indicated Resident 4's behavior was stable. During a review of Resident 41's Order Summary Report dated [DATE], the Order Summary Report indicated Resident 41 had a physician's order, authorized to go out on pass for therapeutic purposes not to exceed four hours for one time dated [DATE]. (continued on next page)		

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 8:46 AM, with Resident 41 in Resident 41's Room, Resident 41 stated he (Resident 41) informed the nurses (unidentified) about wanting to go outside and was waiting for physician's OOP order. During an observation and interview on [DATE] at 2 PM, with Resident 41 at the facility's patio, Resident 41 appeared frustrated, as evidenced by facial grimacing and a disappointed tone of voice while stating he (Resident 41) had been waiting for one week to go out on pass. Resident 41 stated it was important for him to go out because it made him feel independent while residing at the facility. Resident 41 stated he (Resident 41) was still mobile and capable of making his own decisions. Resident 41 stated he (Resident 41) hoped that the nurses have been working on the order for him to go out and pass. During an interview on [DATE] at 3:37 PM with Licensed Vocational Nurse 7 (LVN 7), LVN 7 stated the OOP was important for residents (general) for their morale and allowed them to be normal while residing at the facility. During an interview on [DATE] at 3:44 PM with the Activities Director (AD), the AD stated if OOP was ordered by a physician, it was communicated to the resident (general). The AD stated the facility's social services assist with OOP accommodations. During a concurrent interview and record review on [DATE] at 3:56 PM, with the Director of Nursing (DON), Resident 41's physician's OOP order dated [DATE] was reviewed. The DON stated that the physician's OOP order dated [DATE] was an active order and should have been communicated to Resident 41. The DON stated it was important to accommodate Resident 41's personal preferences to achieve his own independent choices. During a concurrent interview and record review on [DATE] at 3:56 PM with the Social Service Director (SSD) Resident 41's physician's order dated [DATE] reviewed. The SSD stated upon admission, residents (in general) were made aware of the OOP was available to them. The SSD stated her (SSD) perception was the order had expired on [DATE]. The SSD stated that Resident 41's OOP order was active and should have been communicated to Resident 41 and cause no delay. The SSD stated there was a communication gap between social worker service and Resident 41. The SSD stated Resident 41 should not have been waiting with an active order. During review of the facility's policy and procedure (P&P) titled, Communication Policy, dated [DATE], the P&P indicated that the facility is committed to promoting timely respectful, and effective communication among employees, residents, families, physicians, and other healthcare providers to support safe, high-quality resident's (general) care. During review of the facility's policy and procedure (P&P) titled, Resident's Rights, dated [DATE], the P&P indicated policy statement that employees shall treat all residents with kindness, respect, and dignity. The P&P indicated policy interpretation and implementation, Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the residents' right to communication with and access to people and services, both inside and outside the facility and be informed of their care planning and treatment.		

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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** Based on observation, interview, and record review the facility failed to provide an environment that was free from accident hazards for one of seven sampled residents (Resident 82) by failing to: -Ensure Resident 82 did not have unattended veterinary liniment gel (medication applied to the skin designed to relieve muscle and joint pain in animals) container at bedside. This failure had the potential to result in unsafe medication administration to Resident 82. Findings: During a review of Resident 82's admission Record, the admission Record indicated the facility originally admitted Resident 82 on 12/15/2021 and was re-admitted on [DATE] with diagnoses including osteoarthritis (OA-common joint disease that occurs when the cartilage- that cushions the ends of bones wears down over time), spondylosis (spinal OA) and occipital neuralgia (type of nerve pain/headache). During a review of Resident 82's Minimum Data Set (MDS- a resident assessment tool) dated 3/23/2026, the MDS indicated Resident 82 had intact cognition (mental action or process of acquiring knowledge and understanding) for daily decision-making and from set up (helper sets up, resident completes activity) assistance from staff to being independent (resident completed the activity by themselves with no assistance from a helper) for activities of daily living (ADLs-bed mobility, surface transfer, eating, walk in room, dressing, toileting, and personal hygiene). During a review of Resident 82's VB-Nursing-Self Administration of Medication Screen for Clinical Appropriateness (VB-NSAMSCA) dated 5/12/2026, the VB-NSAMSCA indicated Resident 82 may not self-administer medications. During a review of Resident 82's History and Physical (H&P) dated 5/13/2026, the H&P indicated Resident 82 had fluctuating capacity to make and understand decisions. During a concurrent observation and interview on 6/22/2026 at 10:55 AM with Resident 82 and Restorative Nursing Assistant 1 (RNA 1), inside Resident 82's room, observed a white veterinary liniment gel container unattended at bedside. Resident 82 stated she (Resident 82) would apply the gel daily due to her (Resident 82) joint pain. RNA 1 stated that the facility was aware that Resident 82 had been using the gel. During a concurrent interview and record review on 6/22/2026 at 11:09 AM with Licensed Vocational Nurse 1 (LVN 1), Resident 82's Order Summary Report was reviewed. Resident 82's Order Summary Report indicated no physician order for veterinary liniment gel. LVN 1 stated Resident 82 was not supposed to have it (veterinary liniment) at bedside unattended and with no physician orders due to Resident 82 did not have capability to self-administer medications. During an interview with the Director of Nursing (DON) on 6/24/2026 at 8:39 AM, the DON stated it was important not to have unattended usage of medication at bedside due to the possibility of unsafe use of medication. The DON stated all medications were to be prescribed by the physician. During a review of facility's P&P, titled, Administering Medications reviewed on 5/21/2026, the P&P indicated that medications in the facility were to be administered in a safe and timely manner, and as prescribed. During a review of the facility's P&P titled, Self-Administration of Medications reviewed on 5/21/2026, the P&P indicated that any medications found at the bedside that are not authorized for self-administration are turned over to the nurse in charge for return to the family or responsible party. During a review of the facility's P&P titled, Safety and Supervision of Resident Self-Administration of Medications reviewed on 5/21/2026, the P&P indicated under safety measures that medications shall be stored in a secure location approved by the facility.		

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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. Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 66) reviewed for urinary catheter (a flexible tube inserted into the bladder to drain urine) received appropriate catheter treatment and services by failing to: -Ensure Resident 66's urinary catheter tubing did not have sediment (particles that may be indicative of an infection). This failure had the potential to result in the backflow of urine into Resident 66's bladder, which could cause urinary tract infections (UTI, common infections that happen when bacteria infect the urinary tract), and could negatively impact the delivery services provided to Resident 66. Findings: During a review of Resident 66's admission Record, the admission Record indicated the facility originally admitted Resident 66 on 9/22/2016 and re-admitted the resident on 5/19/2026 with diagnoses including paraplegia (paralysis of the legs and lower body), neurogenic bladder (dysfunction of the bladder) and urogenital implants (a medical device placed inside the body to support urinary functions). During a review of Resident 66's Order Summary Report dated 2/8/2023, the Order Summary Report indicated to change Resident 66's urinary drainage bag as needed for infection, obstruction, or when the closed system (the tip of the catheter inserted into the bladder, to the bag which catches urine, is closed and should not be disconnected) was compromised. During a review of Resident 66's Order Summary Report dated 2/8/2023, the Order Summary Report indicated to flush the urinary catheter with 30 milliliters (ml, a unit of measurement) of normal saline solution (NSS) as needed for obstruction, sediments and hematuria (blood in the urine). During a review of Resident 66's Order Summary Report dated 2/8/2023, the Order Summary Report indicated to monitor the urinary catheter for signs and symptoms of UTI such as amber color urine, foul urine odor, poor urine output and sediment every shift. During a review of Resident 66's Order Summary Report (list of physician orders) dated 1/11/2024, the Order Summary Report indicated to cleanse Resident 66's suprapubic catheter (is a tube inserted through the lower abdomen into the bladder to drain urine when normal urination is not possible) site with normal saline solution (NSS), pat dry, and apply dry dressing daily and as needed (PRN) every 8 hours. During a review of Resident 66's History and Physical (H&P) dated 5/21/2026, the H&P indicated Resident 66 had the capacity to make and understand decisions-medical and daily needs. During a review of Resident 66's Minimum Data Set (MDS- a resident assessment tool), dated 5/30/2026, the MDS indicated Resident 66 had intact cognition (mental action or process of acquiring knowledge and understanding) for daily decision-making and from dependent (helper does all the effort) to set up (helper sets up, resident completes activity) assistance from staff for activities of daily living (ADLs-bed mobility, surface transfer, eating, walk in room, dressing, toileting, and personal hygiene). The MDS indicated Resident 66 had a urinary catheter. During a review of Resident 66's Care Plan Report dated 6/17/2026, the Care Plan Report indicated Resident 66 was at risk for recurrent UTI. The Care Plan Report indicated nursing interventions included to flush the urinary catheter with 30 mLs of NSS as needed for obstruction, sediments, and hematuria. The Care Plan Report indicated to ensure the urinary catheter tubing was free of kinks and to monitor sediments and consistency of the urine. During an interview on 6/23/2026 at 1:02 PM with Resident 66, inside the resident's room, Resident 66 stated feeling uncomfortable in her (Resident 66) lower abdomen area and requested to check the urinary catheter tubing. During a concurrent observation and interview on 6/23/2026 at 2:17 PM with Certified Nursing Assistant 7 (CNA 7), inside Resident 66's room, observed Resident 66's urinary tubing had some dried sediments inside the urinary catheter tubing and yellowish colored urine was cloudy and stuck in the (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	tubing, unable to drain to the urinary catheter collection bag. CNA 7 stated urine was supposed to be free flowing and draining to the urinary catheter collection bag. During an interview with the Treatment Nurse 1 (TX 1) on 6/23/2026 at 2:24 PM, TX1 stated urine should be flowing freely into the urinary catheter collection bag and tubing should not have any sediments. TX 1 stated she (TX 1) was supposed to check it daily and flush the tubing per physician order and has not had any time to check the resident until now. During an interview with the Director of Nursing (DON) on 6/24/2026 at 8:39 AM, the DON stated that the licensed nurses (in general) were supposed to flush the urinary catheter tubing if urine was not draining properly and if there were any sediments in the tubing and added that it is important to monitor and check urinary catheter due to risk of infection. During a review of facility's policy and procedures (P&P) titled Urinary Catheter and Bedside Drainage Bag reviewed on 5/21/2026, the P&P indicated that facility shall provide appropriate care and maintenance of urinary catheters and bedside drainage bags according to physician orders, infection prevention standards and resident needs. P&P also indicated that facility would ensure that the draining tubing was free from kinks, loops or obstructions.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review, the facility failed to ensure accurate accountability of a controlled medication (medication with a high potential for abuse; medication use and possession of are controlled by the federal government) for one of three inspected medication carts (Medication Cart 1-Med Cart 1) by failing to: 1. Ensure Med Cart 1 had accurate documentation of Resident 28's Methadone Hydrochloride (HCl) [a controlled medication used to treat severe, long-lasting pain] medication on narcotic and hypnotic record (NHR- a document indicating continuous inventory and administration of controlled substances) after Licensed Vocational Nurse 4 (LVN 4) administered methadone HCl to Resident 28 on 6/25/2026 at 8:07 AM. This failure had the potential to result in controlled medications misuse, and diversion (the illegal or unauthorized shifting of prescription drugs from their intended, legal path into the wrong hands for recreational use, addiction, or profit). Findings: During a review of Resident 28's admission Record, the admission Record indicated the facility originally admitted Resident 28 on 11/21/2025 and re-admitted the resident on 6/1/2026 with diagnoses including bilateral lower limb (legs) cellulitis (bacterial skin infection), (chronic obstructive pulmonary disease (COPD-group of lung diseases that block airflow and make it difficult to breathe) and opioid (highly addictive, powerful type of medication to treat severe pain) dependence. During a review of Resident 28's History and Physical (H&P), dated 12/29/2025, the H&P indicated Resident 28 had complete ability to make and understand decisions. During a review of Resident 28's Order Summary Report (OSR-list of physician orders), dated 6/1/2026, the OSR indicated Resident 28 had a physician order for Methadone HCl oral 10 milligrams (mg), give 11 tablets to equal 110 mg total by mouth one time a day for pain management and hold if sleepy or if respiratory rate is less than 12 per minute. During a review of Resident 28's Minimum Data Set (MDS- a resident assessment tool), dated 6/8/2026, the MDS indicated Resident 28 had intact cognition (mental action or process of acquiring knowledge and understanding) for daily decision-making and from moderate (helper does less than half the effort) to supervision (helper provides verbal cues, touching and/or contact guard assistance as resident completes activity) assistance from staff for activities of daily living (ADLs-bed mobility, surface transfer, eating, walk in room, dressing, toileting, and personal hygiene). During a concurrent observation of a narcotic count of med cart 1, interview, and record review on 6/25/2026 at 11:29 AM with LVN 4, two methadone HCl bubble packs (packaging in which the medications are organized and sealed between a cardboard backing and clear plastic cover)(1 of 2 bubble pack and 2 of 2 bubble pack) were observed, both bubble packs were observed with two remaining doses of methadone HCl. A review of Resident 28's methadone HCl for 1 of 2 and 2 of 2 NHRs dated 6/25/2026, indicated both NHRs were supposed to have three remaining doses left. A review of Resident 28's methadone HCl administration history dated 6/25/2026, indicated methadone HCl was administered at 8:07 AM. LVN 4 stated he (LVN 4) forget to sign both 1 of 2 and 2 of 2 NHRs for methadone HCl when it was administered to Resident 28 on 6/25/2026 at 8:07 AM. LVN 4 stated when removing controlled medication, he (LVN 4) was supposed to sign and document under the NHR when methadone HCl was removed for accounting purposes. During an interview on 6/25/2026 at 3:20 PM with the Director of Nursing (DON), the DON stated that facility nurses were supposed to sign and document in the NHR as soon as removing a controlled medication for proper handling and accurate accounting of the controlled medication. During a review of facility's policy and procedures (P&P) titled Controlled Medication Count Policy reviewed on 5/21/2026, the P&P indicated facility staff were to ensure the safe storage, accurate accounting, and proper handling of controlled medication (continued on next page)		

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Centers for Medicare & Medicaid Services

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	while preventing diversion and maintaining regulatory compliance. The P&P also indicated under responsibilities that licensed nurses were to perform and document accurate controlled medication counts and report discrepancies immediately.		

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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 review, the facility failed to maintain infection control measures necessary to prevent the spread of infections by failing to:1. Ensure the staff wore full personal protective equipment (PPE-mask, gown, eye protection, gloves) per facility policy and procedures (P&P) titled , Enhanced Barrier Precautions (EBP) reviewed on 5/21/2026. By failing to ensure Certified Nursing Assistant 3 (CNA 3) wore a gown when providing personal basic care to Resident 97 who was on enhanced barrier precautions (EBP-infection control strategy for nursing home, requiring gowns and gloves to be used during high-contact care for residents with or at high risk for multidrug-resistant organisms [MDRO]).2. Ensure one out of one pill crushers located at the nurse's station was kept clean. These failures had the potential risk of medication cross-contamination from the pill crusher and negatively impact residents' safety and to result in the spread of disease and infection to residents, visitors, and facility staff.Findings: During a review of Resident 97's admission Record, the admission Record indicated the facility originally admitted Resident 97 on 8/3/2023 and re-admitted on [DATE] with diagnoses including aphasia (language disorder, affecting speaking and understanding language), dysphagia (difficulty swallowing food or liquid) and gastrostomy tube (GT- a flexible tube surgically inserted through the abdomen into the stomach for feeding, fluid, and medication administration). During a review of Resident 97's History and Physical (H&P), dated 2/18/2026, the H&P indicated Resident 97 lacked the ability to make healthcare decisions. During a review of Resident 97's Order Summary Report (OSR-list of physician orders) dated 4/27/2026, the OSR indicated Resident 97 was on EBP. The OSR indicated that gloves and a gown were needed during direct contact patient care to prevent MDRO transmissions. During a review of Resident 97's care plan dated 4/27/2026, care plan indicated Resident 97 was at risk for MDRO infection related to GT with interventions for facility staff to wear gowns and gloves while performing any care activity where close contact with the resident is expected to occur such as bathing, peri-care, assisting with toileting, changing incontinence briefs and mobility assistance. During a review of Resident 97's Minimum Data Set (MDS- a resident assessment tool), dated 5/23/2026, the MDS indicated Resident 97 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision-making and from moderate (helper does less than half the effort) to dependent (helper does all the effort) assistance from staff for activities of daily living (ADLs-bed mobility, surface transfer, eating, walk in room, dressing, toileting, and personal hygiene). During a review of facility's document titled, Residents on EBP, undated, facility's document indicated Resident 97 was on EBP. During a concurrent observation and interview on 6/25/2026 at 10:27 AM with Registered Nurse 1 (RN 1) and CNA 3, inside Resident 97's room, CNA 3 was observed assisting Resident 97 with personal (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	basic care and repositioning Resident 97 in the bed without wearing a gown. CNA 3 stated Resident 97 was on EBP and CNA 3 was supposed to wear a gown when assisting Resident 97's care. RN 1 stated it was important to wear a gown and gloves during close contacts due to possible infection control issues. During an interview on 6/25/2026 at 2:22 PM with Infection Preventionist Nurse (IPN), the IPN stated that when providing direct care to Resident 97, facility staff were supposed to wear gowns and gloves due to possible transmission of infection and Resident 97 was at high risk for MDRO infection. During an interview on 6/25/2026 at 3:20 PM with the Director of Nursing (DON), DON stated facility staff were supposed to wear gowns and gloves due to possible transmission of infection and Resident 97 was at high risk for MDRO infection. During a review of the facility's policy and procedure (P&P), titled, Enhanced Barrier Precautions (EBP) , reviewed on 5/21/2026, the P&P indicated that facility staff were to wear gown and gloves during high-contact resident care activities, including but not limited to dressing, bathing, and hygiene assistance, wound care, changing linens, toileting assistance, device care and transfers requiring extensive physical assistance. During a review of the facility's P&P titled, Infection Prevention and Control Program reviewed on 5/21/2026, the P&P indicated that facility was to establish, maintain, and provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Findings: During a concurrent observation and interview on 6/25/2026 at 10:31 AM with Licensed Vocational Nurse (LVN) 5 in the nurses' station, a pill crusher was observed with a reddish-brown color on the hinges and dark powder residue. LVN 5 stated that the pill crusher was dirty and required to be cleaned to prevent cross contamination of medications. During an interview on 6/25/2026 at 10:45 AM, with the Infection Preventionist Nurse (IPN), the IPN stated that the facility had an infection control program and practices such as monitoring of adherence to infection prevention standards, with a focus on safety and sanitation practices. During an interview on 6/25/2026 at 11:27 AM, with the Director of Nursing (DON), DON stated nurses were responsible for cleaning pill crushers to prevent medication cross contamination and non-medication items are prohibited in the medication rooms. During a review of the facility's P&P titled, Cleaning and disinfecting medical equipment, the P&P indicated that reusable medical equipment was to be cleaned and disinfected between resident use to reduce the risk of infection and maintain a safe environment.		

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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement and maintain an effective infection prevention and control program for one of five sampled residents (Resident 77) reviewed for immunizations, by failing to: 1. Ensure to re-offer Resident 77 the pneumococcal (Pneumonia [PNA]-infection that inflames air sacs in one or both lungs which may fill with fluid) vaccine yearly, in accordance with facility policy and procedures (P&P) titled Pneumococcal Vaccine reviewed by the facility on 5/21/2026 and the current standards of practice. This failure placed Resident 77 at a higher risk of acquiring and transmitting vaccine-preventable respiratory infections, including influenza and pneumonia, to other residents, visitors and staff within the facility. Findings: During a review of Resident 77's admission Record, the admission Record indicated the facility originally admitted Resident 77 on 5/18/2021 and was re-admitted on [DATE] with diagnoses including chronic respiratory failure (condition in which your blood does not get enough oxygen or has too much carbon dioxide), asthma (respiratory condition marked by spasms in the bronchi of the lungs, causing difficulty in breathing) and heart failure (a chronic condition in which the heart does not pump blood as well as it should). During a review of Resident 77's History and Physical (H&P), dated 1/29/2026, the H&P indicated Resident 77 had the capacity to make and understand medical decisions. During a review of Resident 77's Minimum Data Set (MDS- a resident assessment tool), dated 5/10/2026, the MDS indicated Resident 77 had intact cognition (mental action or process of acquiring knowledge and understanding) for daily decision-making and from set up (helper sets up, resident completes activity) assistance from staff to being independent (resident completed the activity by themselves with no assistance from a helper) for activities of daily living (ADLs-bed mobility, surface transfer, eating, walk in room, dressing, toileting, and personal hygiene). During a concurrent interview and record review on 6/25/2026 at 9:13 AM with the Infection Preventionist Nurse (IPN), Resident 77's immunization record was reviewed via CAIR (California Immunization Registry: secure web-based system that stores immunization records for children and adults in California) as of 6/25/2026. Resident 77's immunization record indicated last PNA vaccine was received on 2/3/2016 with recommendation for a second dose of PNA vaccine. Resident 77's medical record was reviewed, indicated PNA vaccine declination forms were signed on 5/20/2021 and 3/12/2023. The IPN stated that she (IPN) was supposed to re-offer PNA vaccine at least yearly and Resident 77 was at risk for PNA. The IPN stated the importance of offering and providing PNA vaccines to facility resident to provide residents protection against PNA. During an interview on 6/25/2026 at 9:31 AM with Resident 77, Resident 77 stated wanting to have PNA vaccine. During a review of facility's P&P, titled, Pneumococcal Vaccine reviewed by the facility on 5/21/2026, the P&P indicated that facility would offer pneumococcal vaccines to all residents to aid in preventing PNA infections. P&P also indicated administration of the PNA vaccines or revaccinations will be made in accordance with the current CDC (Centers for Disease and Prevention) recommendations. During a review of the facility's P&P titled, Infection Prevention and Control Program reviewed on 5/21/2026, the P&P indicated that the facility was to establish and maintain a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.		