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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>056023 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                    | (X3) DATE SURVEY COMPLETED<br><br>02/25/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Avalon Villa Care Center |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>12029 Avalon Blvd<br>Los Angeles, CA 90061 |  |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| (X4) ID PREFIX TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)  |
| <p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Reasonably accommodate the needs and preferences of each resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44294</b></p> <p>Based on observation, and interview, the facility failed to address a resident's request to move to a different room for one out of six residents (Resident 1.) This resulted in Resident 1 having feelings of anger and hurt feelings for three days.</p> <p>Findings:</p> <p>During a review of Resident 1 ' s Admission Record, the Admission Record, indicated Resident 1 was admitted to the facility on [DATE], with diagnoses including muscle weakness and major depressive disorder (persistent feelings of sadness, hopelessness, low mood, loss of interest or pleasure in activities that were once enjoyable, changes in appetite, sleep, energy levels, difficulty concentrating, making decisions, and feeling worthless)</p> <p>During a review of Resident 1 ' s Minimum Data Set ([MDS], a federally-mandated residentassessment and care screening tool), dated 10/30/24, the MDS indicated Resident 1 was able to understand and be understood by others. The MDS indicated Resident 1 was independent with eating and required set up for oral hygiene, and personal hygiene. The MDS indicated Resident 1 was dependent with toileting and putting on taking off footwear. The MDS indicated Resident 1 required maximal assistance with shower/bathing and dressing.</p> <p>During a review of Resident 2 ' s Admission Record, the Admission Record, indicated Resident 2 was admitted to the facility on [DATE], with diagnosis of cerebrovascular disease (group of conditions that affect the blood vessels and blood supply to the brain) and unspecified focal traumatic brain injury with loss of consciousness (brain injury caused by an external force, with a specific area of the brain affected, and a period of unconsciousness, but the exact details of the injury and duration of unconsciousness are not specified)</p> <p>During a review of Resident 2 ' s MDS, dated [DATE], the MDS indicated Resident 2 was usually able to understand and be understood by others. The MDS indicated Resident 2 was independent with eating, oral hygiene, and personal hygiene. The MDS indicated Resident 2 was required moderate assistance toileting and supervision with shower/bathing, dressing and putting on/taking off footwear.</p> <p>(continued on next page)</p> |

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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>During an interview on 2/19/2025 at 12:13 p.m., with Resident 1, Resident 1 stated she had reported to the Certified Nurse Assistant (CNA 5) on a Monday (date not specified) that her roommate (Resident 2) was making her feel angry and was hurting her feelings, and that she wanted to change rooms. Resident 1 stated CNA 5 told her to just ignore Resident 2 because Resident 2 ' s mentation was not good, and Resident 2 did not mean what she said. Resident 1 stated she also reported her wishes to change rooms to Licensed Vocational Nurse (LVN 1) that morning around 8:00 a.m. (date not specified) because Resident 2 was hurting her feelings and was making her angry. Resident 2 stated the facility still had not moved her.</p> <p>During an interview on 2/19/2025 at 1:22 p.m., with LVN 1, LVN 1 stated Resident 1 had complained to her about her roommate (Resident 2) one morning (date unspecified). LVN 1 stated she told Resident 1 that Resident 2 was confused. LVN 1 stated she had not reported the room change request to anyone yet because she just had returned from lunch. LVN 1 stated Resident 2 requested her former room, but Resident 2 ' s former room was already occupied.</p> <p>During an interview on 2/21/2025 at 9:15 a.m. with Social Services Director (SSD), the SSD stated she was aware Resident 2 wanted her former room back, but that room had been used for new admission. SSD stated she did not know the reason of Resident 2 ' s room change request.</p> <p>During an interview on 2/21/2025 at 3:25 p.m., with CNA 5, CNA 5 stated on Monday (date unspecified), Resident 5 told her about her hurt and angry feelings, but she told her (Resident 1) to not pay attention to Resident 2 because Resident 2 was not mentally there. CNA 5 told Resident 2 that she would look into a room change but she could not go back to her former room because it was being used for isolation and as soon as it came available, she would request for her to be transferred.</p> <p>During a review of the facility ' s policy and procedures (P&amp;P) titled, Room Change/Roommate Assignment, dated 1/2022, the P&amp;P indicated, changes in room or roommate assignment shall be made when the resident requests the change.</p> |

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| <p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44294</b></p> <p>Based on interview and record review, the facility failed to develop an individualized plan of care for one of 6 residents (Residents 5) who had both hands skin itchiness and swelling.</p> <p>This deficient practice resulted in the unresolved skin itchiness and swelling and led to Resident 5's worsening skin condition and multiple hospitalizations.</p> <p>Findings:</p> <p>During a review of Resident 5's Admission Record, the Admission Record, indicated Resident 5 was admitted to the facility on [DATE], with diagnoses of muscle weakness and hyperlipidemia (high cholesterol)</p> <p>During a review of Resident 5's History and Physical (H&amp;P), dated 10/20/2024, the H&amp;P indicated Resident 5 had fluctuating capacity to understand and make decisions.</p> <p>During a review of Resident 5's Minimum Data Set ([MDS], a federally mandated assessment and care screening tool), dated 10/30/2024, the MDS indicated Resident 5 was able to understand and be understood by others. The MDS indicated Resident 5 was dependent with eating and required set up for oral hygiene, and personal hygiene. The MDS indicated Resident 5 required maximal assistance with shower/bath, dressing, and putting on taking off footwear.</p> <p>During a review of Resident 5's Change of Condition (COC) dated 1/19/2024, the COC indicated Resident 5 had itchiness on the face, neck and hands. The COC indicated Resident 5 had puffiness in the face. The COC indicated the itching was persistent and unrelieved by topical or mild antihistamines.</p> <p>During a review of Resident 5's COC dated 1/25/2025, the COC indicated Resident 5 had severe itching on the skin, with redness and 8/10 (tool used to assess pain where 0 is no pain and 10 is intolerable pain) pain on both arms.</p> <p>During a review of Resident 5's COC dated 2/18/2025, the COC indicated Resident 5 had allergic reactions on both hands with severe itching, redness and scaly skin.</p> <p>During a concurrent interview and record review on 2/21/2025 at 2:08 p.m., with Licensed Vocational Nurse (LVN 4), LVN 4 stated there was no care plan created for Resident 5 regarding the skin condition on her both hands. LVN 4 stated the care plan could have provided interventions on how to manage resident's skin problems. LVN 4 stated Resident 5 did not have a care plan to manage and monitor Resident's skin and did not have any interventions in place to monitor and follow up with doctor when set goals were not met. LVN 4 stated the interventions indicated in the care plan could have assisted the staff to help resident meet the care needs and goals.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>During a review of the facility policy and procedure (P&amp;P) titled, Care Plans, Comprehensive Person-Centered, dated 3/2017, the P&amp;P indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs should be developed and implemented for each resident.</p> |

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| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44294</b></p> <p>Based on observation, interview and record review the facility failed to:</p> <ol style="list-style-type: none"> <li>1. Document in the progress notes, Change of Condition Evaluation (COC) assessment for one of five residents (Resident 5), who was sent out to a General Acute Care Hospital (GACH) on 1/9/2025 due to shortness of breath.</li> <li>2. Carry out the physician ' s order dated 2/11/2024 for a Dermatology (skin specialist) consult for Resident 5.</li> <li>3. Create a non-pressure skin assessment form as indicated in the facility ' s policy and procedure (P&amp;P) titled, Skin Tears - Abrasions and Minor Breaks, Care of for Resident 5.</li> </ol> <p>These failures resulted in the provision of poor-quality care, worsening condition of Resident 5 ' s skin condition on both hands and multiple hospitalization s.</p> <p>These failures had the potential to affect in maintaining the highest practicable physical, mental and psychosocial well-being of Resident 5.</p> <p>Findings:</p> <p>During a review of Resident 5 ' s Admission Record, the Admission Record, indicated Resident 5 was admitted to the facility on [DATE], with diagnoses including muscle weakness and hyperlipidemia (high cholesterol).</p> <p>During a review of Resident 5 ' s History and Physical (H&amp;P), dated 10/20/2024, the H&amp;P indicated Resident 5 had fluctuating capacity to understand and make decisions.</p> <p>During a review of Resident 5 ' s Minimum Data Set ([MDS], a federally mandated resident assessment tool), dated 10/30/24, the MDS indicated Resident 5 was able to understand and be understood by others. The MDS indicated Resident 5 was dependent with eating and required set up for oral hygiene, and personal hygiene. The MDS indicated Resident 5 required maximal assistance with shower/bath, dressing, and putting on taking off footwear.</p> <p>During a review of Resident 5 ' s GACH 1 Emergency Department (ED) notes dated 1/9/2025, the ED note indicated Resident 5 was evaluated due to shortness of breath for the past few days.</p> <p>During a review of Resident 5 ' s Order Details dated 1/10/2025, the order indicated a Benadryl (Diphenhydramine HCL) Allergy capsule 25 milligrams (mg- metric unit of measurement, used for medication dosage and/or amount), 1 capsule by mouth every eight (8) hours as needed for itching was ordered for five (5) days that had been completed.</p> <p>During a review of Resident 5 ' s Medication Administration Record (MAR) for 1/2025, the MAR indicated Resident 5 was given Benadryl onse on 1/11/2025 at 4:38 a.m.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>During a review of Resident 5 ' s physician order dated 1/18/2025, the order indicated another Benadryl Allergy Capsule, 50 mg by mouth every 8 hours as needed for allergies.</p> <p>During a review of Resident 5 ' s, the MAR indicated Resident 5 was given total of seven (7) doses of Benadryl.</p> <p>During a review of Resident 5 ' s clinical record, the clinical records indicated the following Change of Conditions (COC):</p> <p>1). On 1/19/2024, the COC indicated Resident 5 had itchiness to face, neck and hands and puffiness in face. The COC indicated the itching was persistent andunrelieved by topical or mild antihistamines. The COC indicated clinician ' s recommendation was to provide Benadryl as needed.</p> <p>2). On 1/25/2025, the COC indicated Resident 5 had severe itching on the skin, with redness and 8/10 (tool used to assess pain where 0 is no pain and 10 is intolerable pain) pain on both arms. The COC notes indicated the Medical doctor ordered cephalexin (antibiotic to treat infections) 500 mg every 6 hours for seven days.</p> <p>On 2/7/2025, Resident 5 ' s progress notes indicated that Family Member (FM) who was at bedside, requested forResident 5 to be transferred out to GACH 2 due to Resident 5 ' s swelling in the face, arms/hands and had a cracked skin on bilateral hands.</p> <p>During a review of Resident 5 ' s GACH 2 ' s emergency department (ED) notes dated 2/8/2025, the ED notes indicated Resident 5 was admitted to GACH 2 due to rashes of both hands. The ED notes indicated to evaluate both hands for improvement on mupirocin and if no improvement, to prescribe steroid cream. The ED notes also indicated to ensure follow up with a Dermatologist (skin specialist).</p> <p>During a review of Resident 5 ' s licensed nurse progress notes dated 2/8/2025 at 8:30 a.m., the progress notes indicated Resident 5 returned from GACH 2, with new order for Mupirocin 2% topically TID (three times a day) for 5 days for bilateral hands.</p> <p>During a review of Resident 5 ' s licensed nurse progress notes dated 2/8/2025 at 5:14 a.m., the licensed nurse progress notes indicated GACH 2 called with report provided regarding Resident 5 ' s GACH 2 ' s treatment. The licensed nurse progress notes indicated the physician had requested Resident 5 to do a follow up appointment with a family doctor one week after Resident 5 return and to seea Dermatologist.</p> <p>During a review of Resident 5 ' s order summary dated 2/11/2024, the order indicated dermatology consult and treatment as needed for skin irritation.</p> <p>During a review of Resident 5 ' s clinical records, the clinical record, the progress notes did not indicate Resident 5 was seen by a Dermatologist as ordered by the physician.</p> <p>On 2/18/2025, another COC indicated Resident 5 had allergic reactions on bilateral (both) hand with severe itching, redness and scaly skin. The COC notes indicated recommendation for Resident 5 to be transferred to GACH 3.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>During a review of Resident 5 ' s GACH 3 ED notes dated 2/19/2025, the ED note indicated Resident 5 was admitted to GACH 3 due to dry flaky skin on hands and feet.</p> <p>During an interview on 2/20/2025 at 1:41 p.m., with Family Member (FM 1), FM 1 stated that Resident 5 had been complaining of both hands itching since 1/8/2025. FM 1 stated the facility had done nothing to help Resident 5. FM 1 stated that Resident 5 ' s transfer to GACH 2 on 2/8/2025 and GACH 3 on 2/19/2025 were because of her (FM1) request due to her observations that Resident 5 ' s hands had worsened. FM1 stated Resident 5 had been complaining of itching since 1/8/2025, and Resident 5 ' s hands felt itchier and were already bleeding and swollen.</p> <p>During a concurrent interview and record review on 2/21/2025 at 2:08 p.m., with Licensed Vocational Nurse (LVN 4), LVN 4 stated there was no care plan created for Resident 5 regarding the skin condition on her both hands. LVN 4 stated the care plan could have provided interventions on how to manage resident ' s skin problems. LVN 4 stated the interventions indicated in the care plan could have assisted the staff to help resident meet the care needs and goals. LVN 4 stated Resident 5 did not have a care plan to manage and monitor Resident ' s 5 skin and did not have any interventions in place to monitor and follow up with doctor when set goals were not met.</p> <p>During an interview on 2/25/2025 at 10:33 a.m., with Resident 5, Resident 5 stated she felt neglected because of the condition of her skin on the hands. Resident 5 stated both hands had been very itchy to the point of it bleeding. Resident 5 stated the facility would not do anything for my hands. Resident 5 closed her eyes, and stated she felt extremely sad. Resident 5 stated she did not know how many days she suffered with the itchiness and ended up in the hospital.</p> <p>During a concurrent interview and record review on 2/25/2025 at 3:41 p.m., with Registered Nurse (RN 2), the progress notes dated 1/9/2025, COC for 2/7/2025 and COC for 2/18/2025 were reviewed. RN 2 stated Resident 5 ' s progress notes did not indicate notes, reasons why Resident 2 was sent to GACH on 1/9/2025, however, the notes dated 1/11/2025, indicated Resident 5 was being monitored for readmission and had an order for Benadryl dated 1/10/2025 for itchiness. RN 2 stated there was no COC made when Resident 5 was transferred to GACH 2 on 2/7/2025. RN 2 stated on 2/8/2025, the progress notes indicated Resident 5 was returning to the facility and that Resident 5 needed to follow up with the primary care physician and dermatologist. RN 2 stated there was a physician ' s order dated 2/11/2025 for Resident 5 to see a dermatologist. RN 2 stated Resident 5 ' s clinical records did not indicate an appointment was made or any notes indicating the facility had attempted to call to schedule a Dermatologist ' s appointment. RN 2 stated Resident 5 was seen by a Dermatologist, Resident 5 would have started the proper treatment and was properly diagnosed . RN 2 stated the COC for 2/18/2025 was written the same way and had no proper assessments documented prior to Resident 2 being sent out to GACH 3. RN 2 stated whenever there are changes in the skin, the licensed staff were supposed to create a non-pressure skin assessment for the resident. RN 2 stated the licensed staff had not created the non-pressure skin assessment for Resident 5. RN 2 stated if they had done the non-pressure skin assessment for Resident 5, it would have flagged them (licensed personnel) to monitor, re-assess and act when there was no improvement noted on Resident 5 ' s skin and to have followed up with the Dermatologist.</p> <p>During a review of the facility ' s P&amp;P titled, Skin tears - Abrasions and Minor Breaks, Care of, dated 9/2013, the P&amp;P indicated the purpose of procedure was to guide the prevention and treatment of abrasions, skin tears, and minor breaks in skin. The P&amp;P indicated to generate non-pressure form and complete.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Ensure that residents are free from significant medication errors.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44294</b></p> <p>Based on interview and record review, the facility failed to ensure one of four sampled residents (Resident 4), was administered scheduled medications (Losartan, hypertension [high blood pressure] medicine) and Aspirin (medicine to prevent blood clots and for cerebrovascular accident [CVA] prophylaxis), on 2/21/2025.</p> <p>This deficient practice had the potential to cause complications of hypertensive crisis and CVA that could lead to resident ' s hospitalization and death.</p> <p>Findings:</p> <p>During a review of Resident 4 ' s Admission Record, the Admission Record, indicated Resident 4 was admitted to the facility on [DATE], with diagnoses of essential hypertension (high blood pressure) and hyperlipidemia (high cholesterol).</p> <p>During a review of Resident 4 ' s care plan dated 8/2/2022, the care plan indicated Resident 4 had altered cardiovascular (related to the heart and blood vessels) status related to hyperlipidemia and hypertension. One of the interventions indicated to give Losartan Potassium Oral tablet 50 milligram (mg- metric unit of measurement, used for medication dosage and/or amount) 1 tablet by mouth, two times a day for hypertension.</p> <p>During a review of Resident 4 ' s Care plan dated 2/7/2024, the care plan indicated Resident 4 was on Aspirin for CVA prophylaxis. One of the interventions indicated to give Aspirin, 1 tablet by mouth in the morning.</p> <p>During a review of Resident 4 ' s Minimum Data Set ([MDS], a standardized assessment and care screening tool), dated 2/6/2025, the MDS indicated Resident 4 ' s was able to understand and be understood by others. The MDS indicated Resident 4 ' s was independent with eating and oral hygiene and set up or dressing. The MDS indicated Resident 4 required moderate assistance for toileting, shower/bath, and supervision for putting on /taking off footwear and personal hygiene.</p> <p>During a review of Resident 4 ' s order summary report for 2/2025, the order summary indicated an order dated 8/2/2023, to administer losartan potassium oral tablet 50 mg, 1 tablet by mouth two times a day for hypertension, hold for SBP (systolic blood pressure) less than 110 and Aspirin tablet 81 mg, 1 tablet by mouth in the morning for CVA prophylaxis (measures taken to prevent or protect against disease or illness).</p> <p>During a review of the Medication Administration Record (MAR) for 2/2025, the MAR for Aspirin and Losartan dated 2/21/2025, indicated one (1), which indicated the resident was away from facility /out on pass with meds.</p> <p>During an interview on 2/21/2025 at 10:46 a.m., with Resident 4, Resident 4 stated the Licensed Vocational Nurse (LVN 4) did not want to give Resident 4 ' s medication prior to going out to her appointment (not specified) on 2/21/2025 (time not specified).</p> <p>(continued on next page)</p> |   |  |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>056023   | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                    | (X3) DATE SURVEY COMPLETED<br><br>02/25/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Avalon Villa Care Center   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>12029 Avalon Blvd<br>Los Angeles, CA 90061 |  |
| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. |  |   |  |
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| <p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Resident 4 stated she asked LVN 4 for her blood pressure medication (Losartan) and LVN 4 ignored her. Resident 4 stated she was concerned of the blood pressure as it would go high whenever she did not take her medication. Resident 4 stated LVN did not care.</p> <p>During a concurrent interview and record review on 2/21/2025 at 12:07 p.m., with LVN 3, the Medication Admin Audit Report for 2/21/2025 was reviewed. LVN 3 stated the assigned licensed nurse for Resident 4 that morning was LVN 4. LVN 3 stated that according to the administration details, LVN 4 documented at 10:58 a.m. that the resident was not available. LVN 3 stated the latest the staff would document the medication was administered would have been at 10:00 a.m. LVN 3 stated, if the licensed nurse were aware that Resident 4 had appointment, the licensed nurse should prioritize giving the medications.</p> <p>During a concurrent interview and record review on 2/21/2025 at 12:10 p.m., with LVN 4, the Medication Admin Audit Report for 2/21/2025 was reviewed. LVN 4 stated she documented at 10:58 a.m. that the Losartan and Aspirin 81 mg (medicine for CVA prophylaxis) were not given to Resident 4 because when she (LVN 4) went to check on Resident 4, she had already left to her appointment. LVN 4 stated she did not offer Resident 4 her medications (Losartan and Aspirin) because the resident was busy with a Certified Nurse Assistant (CNA) and was on the bedside commode. LVN 4 stated Resident 4 could suffer from a stroke due to missing the blood thinner (aspirin) and the hypertension (losartan) medication doses. LVN 4 stated she should have offered Resident 4 all her medications before Resident 4 left the facility.</p> <p>During a review of the facility ' s policy and procedures (P&amp;P) titled Administering Medications, dated 2012, the P&amp;P indicated medications should be administered in a safe and timely manner, and as prescribed. The P&amp;P indicated medications must be administered within one (1) hour of their prescribed time, unless otherwise specified.</p> |   |  |

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| NAME OF PROVIDER OR SUPPLIER<br><br>Avalon Villa Care Center   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>12029 Avalon Blvd<br>Los Angeles, CA 90061 |  |
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| <p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44294</b></p> <p>Based on observation, and interview, the facility failed to provide safe and comfortable environment for two of six sampled residents (Resident 4 and Resident 5) by failing to ensure the resident restrooms (A &amp; B) were in good repair.</p> <p>This deficient practice caused Resident 4 to feel uncomfortable and avoid using the restroom because of her fear of getting an infection. This deficient practice also placed Resident 4 and Resident 5 at risk for accidents or falls.</p> <p>Findings:</p> <p>During a review of Resident 4's Admission Record, the Admission Record indicated Resident 4's was admitted to the facility on [DATE], with diagnoses including hypertension (high blood pressure), muscle weakness, urinary tract infection (UTI- an infection in the bladder/urinary tract) and falls.</p> <p>During a review of Resident 4's Minimum Data Set (MDS-a resident assessment tool), dated 2/6/25, the MDS indicated Resident 4 was able to understand and be understood by others. The MDS indicated Resident 4 was independent with eating and oral hygiene. The MDS indicated Resident 4 was independent for Activities of Daily Living (ADLs) such eating, oral hygiene, bed mobility (the ability to roll from lying on back to left and ride side and return to lying on back on the bed) and sitting up on side of bed. The MDS indicated Resident 4 required partial/moderate assistance (staff does less than half the effort) for toileting and showering.</p> <p>During an interview on 2/20/2025 at 3:58 p.m., with Resident 4, Resident 4 stated the restroom (A) was falling apart and she did not use it because she was afraid, she might get an infection. Resident 4 stated she wished the bathrooms would look better so she would feel more comfortable using them, instead of using a commode (portable toilet designed to be placed at the bedside).</p> <p>During a concurrent interview and observation on 2/21/2025 at 10:25 a.m., with Certified Nursing Assistant (CNA 3), CNA 3 stated the baseboards in Restroom A had been broken for several months and it made the rooms look old, dirty and not home-like. CNA 3 stated the cracks could lead to bugs crawling into the rooms and that was not sanitary.</p> <p>During a review of Resident 5's Admission Record, the Admission Record, indicated Resident 5's was admitted to the facility on [DATE], with diagnoses including multiple sclerosis (MS-a chronic, progressive disease involving damage to the nerve cells in the brain and spinal cord) and muscle weakness.</p> <p>During a review of Resident 5's Minimum Data Set MDS dated [DATE], the MDS indicated Resident 5's was able to understand and be understood by others. The MDS indicated Resident 5's was dependent with eating and required set up or clean-up assistance for ADLs such as oral hygiene, and showering, dressing and personal hygiene.</p> <p>(continued on next page)</p> |   |  |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>056023 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                    | (X3) DATE SURVEY COMPLETED<br><br>02/25/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Avalon Villa Care Center |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>12029 Avalon Blvd<br>Los Angeles, CA 90061 |  |

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| <p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>During an interview on 2/20/2025 at 1:41 p.m., with Resident 5's Family Member (FM 1), FM 1 stated Resident 5's restroom (B) had a hole on the wall and the floors were falling apart. FM 1 stated, Resident 5 was also in another room and the restroom's (A) baseboard was falling apart. FM 1 stated it did feel safe nor sanitary having Resident 5 living in such conditions. FM 1 stated bugs could crawl up in the holes of the wall.</p> <p>During a concurrent interview and observation on 2/21/2025 at 2:17 p.m., with Maintenance Supervisor (MS), MS stated the bottom of the door frame in the bathroom (B) appeared wet and corroded. MS stated the paint was also peeling off and the bottom part of the door was almost completely gone which acts to support the door. MS stated, the restroom (A) had similar issues with the door edges and wall falling apart with wood that were chipped and multiple layers of paint were chipped of the door. MS stated the restrooms needed to be fixed to be presentable and to provide a home-like environment for the residents.</p> <p>During a concurrent interview and observation on 2/21/2025 at 3:25 p.m., with CNA 5, CNA 5 stated restroom B had cracked, uneven floors and could place residents at risk for tripping and falling.</p> <p>During a review of the facility's Policy and Procedures (P&amp;P) titled Quality of Life - Homelike Environment dated 4/2014, the P&amp;P indicated residents would be provided with a safe, clean, comfortable and homelike environment. The P&amp;P indicated the facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include cleanliness and order.</p> |