STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056023	A. Building B. Wing	06/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avalon Villa Care Center	12029 Avalon Blvd 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.

(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. Based on interview, and record review, the facility failed to implement an individualized person-centered plan of care with measurable objectives, timeframe, and interventions for one of three sample residents (Resident 1) after Resident 1 went into Resident's 2 room and took Resident 2's personal belongings. This failure had the potential to negatively affect the delivery of necessary care and services. Findings: During a review of Resident 1's admission Record dated 6/1/2025, the admission Record indicated the facility admitted Resident 1 on 6/1/2025, with diagnoses including encephalopathy unspecified (problem with how your brain is working), traumatic brain injury (TBI-a disruption in the normal function of the brain that can be caused by a bump, blow, or jolt to the head) and psychoactive substance use (harmful or excessive use of drugs that affect the brain). During a review of the Minimum Data Set (MDS- a resident assessment tool), dated 6/7/2025, the MDS indicated Resident 1's cognition (thought process) was severely impaired. The MDS indicated Resident 1 required partial, moderate assistance (helper does more than half the effort) from staff for activities of daily living (ADLs - routine tasks/activities such as bathing, dressing, toileting and eating a person performs daily to care for themselves). During a review of Progress Notes dated 6/5/2025 at 12:10 p.m. indicated Resident 1 was found in Resident's 2 room looking through Resident's 2 personal belongings. During a review of Resident1's Care Plans, the care plans did not indicate a care plan addressing the resident's behavior of going into other resident's rooms and taking other resident's belongings. During a concurrent interview and record review on 6/17/2025 at 2:29 p.m. with the Director of Nursing (DON), the facility's policy and procedure (P &P) titled, Care Plans, Comprehensive Person-Centered, dated December 2016 was reviewed. The DON stated, a care plan addressing Resident 1 going into other resident's room and going through other residents' belongings was not developed. The DON stated not having a care plan for Resident 1 going into patient's rooms and going through other resident's belongings had the potential for repeat behavior of going into other resident's rooms and a resident-to-resident altercation can happen. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056023	A. Building B. Wing	06/17/2025

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Avalon Villa Care Center	12029 Avalon Blvd Los Angeles, CA 90061

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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	During a review of the facility's policy and procedure (P &P) titled, Care Plans, Comprehensive Person-Centered, dated December 2016 indicated each resident will have a comprehensive care plan developed that includes goals, measurable objectives and timetables to meet their medical, nursing, mental, and psychosocial need identified during the comprehensive assessment. The care plan must describe services that are provided to the resident to attain or maintain the resident's highest practicable, physical, mental and psychosocial well-being.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056023	A. Building B. Wing	06/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview and record review, the facility failed to ensure one of three sample residents' (Resident 2) clinical record was maintained by not documenting reporting a change of condition to the attending physician and psychiatrist. This deficient practice had the potential to result in delay of communication between the staff and provision of care/intervention to the resident. Findings: During a review of Resident 2's admission Record dated 4/23/2025, the admission Record indicated the facility admitted Resident 2 on 4/23/2025, with diagnoses including traumatic brain injury (TBI-a disruption in the normal function of the brain that can be caused by a bump, blow, or jolt to the head), epilepsy (neurological condition that causes recurring seizures due to abnormal electrical activity in the brain), alcohol abuse (excessive consumption of alcohol) and major depressive disorder (a common and serious medical illness that can significantly impact how a person feels, thinks, and acts). During a review of the physician's history and physical (H&P) dated 4/25/2025, indicated Resident 2 has the capacity to understand and make decisions. During a review of the Minimum Data Set (MDS - a resident assessment tool), dated 4/29/2025, the MDS indicated Resident 2's cognition (thought process) was intact. The MDS indicated Resident 2 required partial, moderate assistance (helper does more than half the effort) from staff for activities of daily living (ADLs - routine tasks/activities such as bathing, dressing, toileting and eating a person performs daily to care for themselves). During a review of Resident 2's Progress Notes dated 6/11/2025 indicated documentation of the resident's verbal and physical aggression but there was no documentation the incident was reported to the physician or the psychiatrist. During a concurrent interview and record review on 6/17/25 at 2:42 p.m. with the DON, the DON stated the incident was verbalized to Resident 2's Primary Care Physician (PCP) and attending facility's psychiatrist however the incident should have been documented since if it's not documented, it is not done. When information is not documented the next person would not know and the chain of communication would be broken. During a review of the facility's policy and procedure (P&P) titled, Change in a Resident's Condition or Status dated December 2016, indicated the nurse will notify the resident's primary physician, and representative of changes in the resident's medical/mental condition and/or status.