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	07/29/2025

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 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. Based on interview and record review, facility failed to ensure the code (a numeric or alphanumeric sequence used as a security feature of authorized facility staff to enter the facility) used by facility staff to open the facility's gate and entrance door was changed, after an employee, Certified Nurse Assistant (CNA 1) was beaten by three (3) unidentified males (perpetrators) known by a facility employee (CNA 2) gained knowledge and access of the facility's code on 7/19/2025. This deficient practice had the potential for the perpetrators to return to the facility and placed all the residents and staff at risk for severe injuries due to the violent behavior, hospitalization and death.Findings:During an interview on 7/29/2025 at 7:49 a.m. with CNA 1, CNA 1 stated he believed CNA 2 provided the facility's gate code to her boyfriend on 7/19/2025 at (unknown time) after CNA 2 had purchased Starbucks for them (CNA 1 and CNA 2). CNA 1 told CNA 2 he would pay her back another time because he did not have change. CNA 1 stated that he heard a car alarm went off at the facilities parking lot. CNA 1 stated he went outside to check his car and observed CNA 2 start to approach him asking for her money. CNA 1 stated while CNA 2 was approaching him, the 3 perpetrators were observed entering the facility's gate. CNA 1 stated CNA 3 and the Treatment Nurse (TN), attempted to stop the 3 perpetrators from approaching him. CNA 1 stated one male perpetrator struck him on his head, punched his face, busted his lips, nose, and both eyes. CNA 1 stated he fell on the ground. During an interview on 7/29/2025 at 11:43 a.m. with the TN, the TN stated on 7/19/2025 at (unknown time), he witnessed CNA 2 use profanity out loud toward CNA 1. The TN stated the facility's parking lot gate required a code to open and enter. The TN stated only facility staff should know the gate code. The TN stated he wondered how the 3 perpetrators got in the facility's premises. The TN stated one of the unidentified perpetrators struck CNA 1. The TN stated him, and CNA 3 tried to block the 3 perpetrators from striking CNA 1. The TN stated he could not remember how many times CNA 1 was struck. The TN stated, him and CNA 3 assisted CNA 1 back inside the building.During an interview on 7/29/2025 at 1:17 p.m. with CNA 3, CNA 3 stated she saw CNA 1 was on the phone yelling and telling the person (unidentified) to come over to the facility. CNA 3 stated, while CNA 1 was yelling on the phone, the 3 perpetrators entered the facility's gated parking lot. CNA 3 stated she did not know how the 3 perpetrators entered the gate when only facility staff knows the gate code. CNA 3 stated she suspected CNA 2 provided the code to the 3 perpetrators. CNA 3 stated the facility did not change the code to the facility's gate and entrance door after the incident happened on 7/19/2025. CNA 3 stated not changing the code was a safety concern, placing other staff and residents at risk for theft and injury. CNA 3 stated what if they bring guns and hurt us (staff and residents)? During a review of the facility's Policy and Procedures (P&P) titled, Accidents and Incidents- Investigating and Reporting, dated 7/2017, the P&P indicated all incidents that occurred in the facility premises should be investigated. The P&P indicated one of the following data should be included: any corrective action taken. The P&P indicated the incident report should be reviewed by the Safety Committee for trends related to safety hazards in the facility and to analyze any individual resident vulnerabilities.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement infection prevention and control measures while changing the colostomy ([stoma] a surgical opening on the surface of the abdomen created to divert the flow of feces) bag (where the feces drain), for 1 of 1 sampled (Resident 1) who was on Enhanced Standard Precautions ([EBP] set of infection control measures designed to reduce the spread of certain multidrug-resistant organisms (MDROs) in healthcare settings including the use of gowns and gloves during high-contact resident care activities, including dressing, bathing, transferring, wound care, and device care, particularly nursing homes), by failing to: 1. Wash hands prior to donning (putting on) gloves.2. Change the gloves that were visibly soiled of feces, after cleaning the stoma.3. Clean the bedside table prior to putting on clean colostomy supplies.4. Remove gloves and wash hands prior to putting back the blanket, call light, bed handset (remote used to adjust the bed) and opening the curtain.5. Wash hands after and prior to leaving the resident's room. These deficient practices had the potential to result in spreading infection to other residents in the facility.Findings:During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including hypertension (high blood pressure), and diabetes mellitus (DM- abnormal blood sugar level).During a review of Resident 1's care plan titled, Resident 1 has a colostomy, initiated 9/13/2023, the care plan interventions indicated to change colostomy bag every shift. During a review of Resident 1's History and Physical (H&P) dated 9/13/2024, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1's Physician's Order Summary report dated 3/11/2025, the Physician's Order Summary report indicated EBP related to colostomy.During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 6/16/2025, the MDS indicated Resident 1 was able to understand and be understood by others. The MDS indicated Resident 1 was independent with eating and was dependent (helper does all the effort) for oral hygiene, toileting hygiene, shower/bathe self, upper/lower dressing, putting on/ taking off footwear and personal hygiene. The MDS indicated Resident 1 required partial/moderate assistance (helper does less than half the effort) with rolling from left to right and was dependent for sitting to lying, lying to sitting on side of the bed, sitting to stand, chair/bed to chair transfer, toilet transfer, tub/shower transfer. During a review of Resident 1's Physician's Order Summary report dated 9/18/2025, the Physician's Order Summary report indicated to change colostomy bag every shift. During a concurrent observation and interview on 7/29/25 at 11:25 a.m. with Treatment Nurse (TN), the TN was observed preparing to change Resident 1's colostomy bag. The TN went to the treatment cart (cart where supplies were stored) and got normal saline (NS, normal saline liquid solution used in healthcare settings), collected other treatment supplies, donned (put on) gloves, and entered Resident 1's room. The TN explained the procedure to Resident 1, pulled the curtain to provide privacy, pulled Residents 1's bedside table (containing Resident 1's water pitcher and water cup), and placed the clean colostomy bag, clean gauzes and small cups with NS. The TN proceeded to clean the stoma with wet gauze then disposed the dirty gauze in a plastic bag. The protruding stoma (portion of the intestine pushes through the stoma) was observed with remaining stool around the area. The TN took the clean colostomy bag with the same gloves, with some stools visibly noted on the right glove, and placed the new colostomy bag on stoma. The TN fixed Resident 1's blanket, call light, bed handset and pulled Resident 1's curtain open. The TN removed the gloves and threw the dirty items in the trash, sanitized both his hands and walked out of Resident 1's room. During an interview on 7/29/25 at 11:43 a.m. with TN, the TN stated that he did not sanitize his hands prior to entering Resident 1's room. The TN stated he did not clean the bedside table used to place the clean colostomy supplies. TN stated he did not change gloves after cleaning the colostomy stoma and did not wash or sanitize his hands after cleaning the stoma. The TN stated he did not clean the contacted areas after colostomy change was done. The TN stated he did not follow clean technique when changing Resident 1's colostomy bag. The TN stated not following the clean technique during colostomy bag change could lead to infections such as sepsis resulting in hospitalizations. During a review of the facility's Policy and Procedures (P&P) titled, Colostomy/ileostomy Care, dated 10/2010, the P&P in preparation indicated to review the resident's care plan to assess for any special needs of the resident. The P&P indicated to place clean equipment on the bedside stand, wash hands thoroughly, put on gown and gloves. The P&P indicated to remove the drainage bag, remove gloves, wash hands and put on clean gloves. The P&P indicated to