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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056023 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 09/11/2025 |
| NAME OF PROVIDER OR SUPPLIER Avalon Villa Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 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.

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
| <p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>Based on observation, interview, and record review, the facility failed to ensure one of four sampled residents (Resident 4), was not laying in soiled diaper for over five hours. This deficient practice resulted in Resident 4 feeling pissed off with the potential to affect the resident's dignity. Findings: During a review of Resident 4's admission Record, the admission Record indicated the facility admitted the resident on 5/19/2022 with diagnoses including nondisplaced spiral fracture of shaft of left tibia (shinbone) and closed fracture (a type of leg injury where the tibia breaks in a spiral pattern due to a twisting force, and the broken ends remain aligned without moving out of place, with the skin remaining closed), chronic obstructive pulmonary disease (COPD - a chronic lung disease causing difficulty in breathing), diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing) and schizophrenia (a mental illness that affects a persons, thoughts, feelings and behaviors). During a review of Resident 4's Minimum Data Set (MDS- a resident assessment tool), dated 8/28/2025, the MDS indicated Resident 4's cognition (process of thinking) was intact. The MDS indicated Resident 4 was not able to complete activities of daily living (ADLs) such as bathing, dressing and toileting, and required maximum (helper does more than half the effort) assistance from staff. During a concurrent observation and interview on 9/10/2025 at 11:20 p. m. with Resident 4, in Resident 4's room, Resident 4 was observed to be awake, fidgeting and visibly uncomfortable. Resident 4 stated, I am pissed off because I have been laying in a soiled diaper for more than 5 hours. Resident 4 stated she wanted to be changed. During a concurrent observation and interview on 9/10/2025 at 11:30 a.m., Certified Nurse Assistant (CNA) 1, was observed walking into Resident 4's room and stated she would let the resident's assigned CNA know that the resident needed assistance. CNA 1 did not provide care to Resident 4. During an interview on 9/10/2025 at 11:45 a.m., with Director of Nursing (DON), the DON stated, the facility policy states, 2 minutes is how long the residents wait to be changed. During an interview on 9/10/2025 at 1:25 p.m. with Certified Nursing Assistant (CNA) 2, CNA 2 stated she was busy with other residents and could not assist Resident 4. CNA 2 stated Resident 4 was not provided dignity and was not able to invoke her rights. During a review of the facility's policy and procedure (P&P), titled Quality of Life-Dignity, revised 8/2009, the P&P indicated, Residents shall be treated with dignity and respect at all times. During a review of the facility's policy and procedure (P&P), titled Residents Rights, revised 12/2016, the P&P indicated, Employees shall treat all residents with kindness, respect and dignity.</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>Reasonably accommodate the needs and preferences of each resident.</p> <p>Based on observation, interview and record review, the facility failed to ensure that one of four sampled residents (Resident 4) had call lights answered in a timely manner. This failure had the potential to result in Resident 4 having a risk for skin injury or skin breakdown. Findings: During an observation on 9/10/2025 at 11:23 a.m., outside the resident's room, a light and an audible tone was ringing, indicating a call light needed to be answered. The call light was not answered by staff until 11:50 a.m. During a review of Resident 4's admission Record, the admission Record indicated the facility admitted Resident 4 on 5/19/2022 with diagnoses including nondisplaced spiral fracture of shaft of left tibia and closed fracture [a type of leg injury where the tibia (shinbone) breaks in a spiral pattern due to a twisting force, and the broken ends remain aligned without moving out of place, with the skin remaining closed], chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing) diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing, and schizophrenia (a mental illness that is characterized by disturbances in thought) During a review of Resident 4's Minimum Data Set (MDS-a resident assessment tool), dated 8/28/2025, the MDS indicated Resident 4's cognition (process of thinking) was intact. The MDS indicated Resident 4 was not able to complete activities of daily living (ADLs) routine tasks such as bathing, dressing and toileting, and required maximum (helper does more than half the effort) assistance from staff. During a concurrent observation and interview on 9/10/2025 at 11:20 p.m. with Resident 4, in Resident 4's room, Resident 4 was observed in bed awake, fidgeting and visibly uncomfortable and stated, I am pissed off because I have been laying in a soiled diaper for more than 5 hours. Resident 4 stated she wanted to be changed. During a concurrent observation and interview on 9/10/2025 at 11:30 a.m., Certified Nurse Assistant (CNA) 1, was observed walking into Resident 4's room and stated she would let the resident's assigned CNA know that the resident needed assistance. CNA 1 did not provide care to Resident 4. During an Interview on 9/10/25 at 11:55 a.m. with CNA 1, CNA 1 stated any staff can answer the call lights when other assigned staff was busy. CNA 1 stated she was assigned to Resident 4's roommate but not Resident 4 who had the issue. During an interview with Director of Nursing (DON) on 9/10/2025 at 11:45 am, the DON stated the facility policy stated call lights were to be answered within 2 minutes. The DON stated then a resident's call light is not answered in a timely manner, that can mean something happened to the resident and the resident needed assistance right away. During a review of the facility's policy and procedure (P&P), titled Answering the Call Light, revised 9/2022, the P&P indicated, Answer the call system immediately</p> | | |

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| <p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> | <p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation, interview, and record review, the facility failed to ensure kitchen staff wore appropriate hair covering in the food service or preparation areas of the kitchen. This deficient practice had the potential to result in improper food safety practice and could lead to food contamination, and possible foodborne illness in residents who received food from the kitchen. Findings: During a concurrent observation and interview on 9/11/2025 at 12:25 p.m., in the kitchen, Dishwasher 1 was observed with facial hair. Dishwasher 1 was not wearing the required hair coverings while working in the dishwashing area, located near the food preparation station. Dishwasher 1 stated he did not realize that his hair netting had slipped out of place, and believed his facial hair was still covered. During an interview on 9/11/2025 at 12:45 p.m., in the kitchen, with Assistant Dietary Supervisor (ADS) 1, ADS 1 stated a hair covering not properly secured could result in hair falling into the residents' food, clean dishes, or food preparation area, and increased the risk of food contamination. During a review of the facility's policy and procedures (P&P) titled Preventing Foodborne Illness-Employee Hygiene and Sanitary, undated, the P&P indicated food services employees would follow appropriate hygiene and sanitary procedures to prevent the spread of foodborne illness. The P&P indicated all employees who handle, prepare or serve food must wear hair nets and/or beard restraints to keep hair from contacting exposed food, clean equipment, and utensils.</p> | | |

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| <p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> | <p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>Based on observation, interview, and record review, the facility failed to maintain an effective pest control program to ensure the environment was free of cockroaches. This deficient practice had the potential to place all residents in the facility at risk for exposure to cockroach-borne contaminants (unsafe, harmful substances) and unsanitary conditions Findings: During a concurrent observation and interview on 9/11/2025 at 3:40 p.m., in the hallway, with the Director of Nursing (DON), observed one live cockroach crawling up on the wall near the kitchen in the main hallway. The DON stated the hallway was regularly used by residents to access the dining room and activity area. The DON stated failure to identify and address live cockroaches in a resident accessible hallway created the potential for unsanitary conditions and the spread of cockroaches into food preparation and/or residents' living spaces. The DON stated the facility's pest control company provided monthly services. The DON stated the maintenance supervisor was responsible for following up with the pest control company for pest issues. During a concurrent interview and record review on 9/11/2025 at 3:55 p.m., with the Maintenance Supervisor (MS), the pest control company service invoices, dated 6/2025 through 9/2025, were reviewed. The service invoices indicated that the pest control company provided weekly services focused primarily in the kitchen areas. The MS stated the pest sightings in the hallway had not been addressed because the hallways were not prioritized like the kitchen. The MS stated the pest control company provided weekly services and provided invoices during the visits, with recommendations for the following visits, such as site-specific treatment plans, identifying unresolved problem areas, and proposed corrective actions. The MS stated he could not provide information regarding the facility's effort to implement pest control recommendations or to ensure cockroaches were eliminated. During an interview on 9/11/2025 at 4:45 p.m., with the Administrator (ADM), the ADM stated the pest control company came to the facility on a regular basis as a part of the ongoing pest control program. The ADM stated services were conducted routinely; however, the ADM could not provide documentation indicating that specific areas of concern, such as the main hallway near the kitchen, were evaluated or treated. During a review of the facility's policy and procedures (P&P) titled Pest Control, revised 5/2008, the P&P indicated the facility would maintain an effective pest control program to ensure the facility was free of pests and rodents.</p> | | |