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	11/21/2025

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 a Hemodialysis Emergency Kit (HD [E-kit], a kit containing essential supplies necessary to manage the dialysis line in case of emergency, like bleeding) was at the bedside of 1 of 4 sampled residents, Resident 1, who had a permacath (a special catheter used for short-term dialysis treatment) for HD treatment.This failure had the potential to cause delay in providing intervention should complication like excessive bleeding from hemodialysis access site occur which could be life-threatening and can result in hospitalization or death. Findings: 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 end stage renal disease (ESRD, kidney failure), cardiac pacemaker (an electronic device that is implanted in the body to monitor heart rate and rhythm) and muscle weakness. During a review of Resident 1's Minimum Data Set (MDS- an assessment and care planning tool) dated 9/19/2025, the MDS indicated Resident 1 had clear speech, had difficulty communicating some words or finishing thoughts but was able, if prompted or given time. The MDS indicated Resident 1 required supervision or touching assistance with eating, oral hygiene and personal hygiene. During a Review of Resident 1's untitled and undated care plan, the care plan indicated Resident 1 has a permacath hemodialysis access on the right upper chest related to ESRD. The care plan goal indicated Resident 1 would have immediate intervention should any signs and symptoms of complications from dialysis occur. The care plan interventions indicated to monitor right upper chest permacath site for signs/symptoms of infection such as drainage, redness, irritation, pain and swelling, dialysis E-kit at bedside in the event bleeding occur at the access site, apply pressure, call 911 and notify medical doctor. During a concurrent observation and interview on 11/21/2025 at 12:05 p.m. with Licensed Vocational Nurse (LVN 1), LVN 1 was looking for Resident 1's Hemodialysis E-kit at the bedside but was unable to find it (E-kit). LVN 1 stated not having the hemodialysis E-kit at the resident's bedside can cause delay in providing life-saving measures during an emergency. During a review of the facility's policy and procedures (P&P) titled Hemodialysis Access Care, dated 10/2010, the P&P indicated in case of an emergency, an emergency kit should be at the bedside of a dialysis resident, that contains a clamp, tape, 4x4s (square-shaped pieces of fabric, each side measuring 4 inches) and kerlix (a white gauze dressing).

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