| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056023 | A. Building<br>B. Wing | 12/23/2025 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0552<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are fully informed and understand their health status, care and treatments.<br><br>(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 |
|---|---|---|
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| F 0552<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to obtain informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) from Responsible Party (RP) 1 prior to administering Depakote (an anticonvulsant medication used to treat seizures [a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness] and other behavioral conditions) for one of four sampled residents (Resident 2).This deficient practice resulted in the removal of RP 1's right to make decisions about the care and treatments Resident 2 received in the facility.Findings:During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 2's diagnoses included schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), schizophrenia (a mental illness that is characterized by disturbances in thought), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). The admission Record indicated Resident 2 had a responsible party (RP) 1.During a review of Resident 2's Minimum Data Set (MDS- a resident assessment tool), dated 11/20/2025, the MDS indicated Resident 2's cognition (process of thinking) was intact. The MDS indicated Resident 2 had hallucinations (perceptual experiences in the absence of real external sensory stimuli). The MDS indicated Resident 2 was independent with eating, oral hygiene, toileting, upper/lower body dressing, and personal hygiene. The MDS indicated Resident 2 was taking anticonvulsant medication (used to treat seizures [a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness] and other behavioral conditions).During a review of Resident 2's History and Physical (H&P), dated 5/18/2025, the H&P indicated Resident 2 did not have the capacity to understand and make decisions. During a review of Resident 2's Orders, start date 5/17/2025, the Orders indicated to administer Depakote (an anticonvulsant medication) 500 milligrams (mg, a unit of measurement) by mouth, once a day for mood disorder manifested by angry outbursts. During a concurrent interview and record review on 12/23/2025 at 3:21 p.m., with Registered Nurse (RN) 2, Resident 2's Informed Consent Verification for Antipsychotic, dated 6/16/2025 and 9/27/2025, were reviewed. Resident 2 did not have an Informed Consent Verification for Antipsychotic for his use of Depakote. RN 2 stated Depakote was an anticonvulsant medication used to treat Resident 2's behavior of angry outbursts. RN 2 stated prior to administering Depakote, the licensed nurse was responsible for verifying RP 1 gave informed consent. RN 2 stated RP 1 was responsible for making all of Resident 2's healthcare decisions. RN 2 stated informed consent was necessary to ensure RP 1 was aware of the risks and benefits of Depakote use to make an informed decision. During an interview on 12/23/2025 at 3:48 p.m., with the Quality Assurance (QA) Nurse), the QA Nurse stated the process of verifying informed consent started with Resident 2's physician obtaining informed consent from RP 1 upon ordering Depakote. The QA Nurse stated Resident 2's physician was responsible for explaining the risks and benefits of Depakote use and to answer any questions RP 1 could have. The QA Nurse stated the licensed nurse was responsible for verifying with RP 1 of their informed consent to administer Depakote to Resident 2. The QA Nurse stated by administering Depakote to Resident 2 without documentation informed consent was verified with RP 1, RP 1 may not be fully aware of the treatments given to Resident 2. During a review of the facility's Policy and Procedure (P&P) titled, Antipsychotic Medication Use, revised 7/2022, the P&P indicated, Residents and/or resident representatives will be informed of the recommendation, risks, benefits, purpose, and potential adverse consequences of antipsychotic medication use. Residents and/or representatives may refuse medications of any kind.During a review of the facility's P&P titled, Psychotropic Medication Use, revised 7/2022, the P&P indicated, Residents, families, and/or the representative are involved in the medication management process. Psychotropic medication management includes indications of use; dose (including duplicate therapy); duration; adequate monitoring for efficacy and adverse consequences; and preventing, identifying, and responding to adverse consequences. The P&P indicated, Residents and/or representatives have the right to decline treatment with psychotropic medications. The staff and physician will review the resident/representative the risks related to not taking the medication as well as appropriate alternatives. |

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| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to conduct monitoring for one of four sampled residents' (Resident 2) who had behaviors of angry outbursts.This deficient practice had the potential to result in the inaccurate assessment of the effectiveness of Resident 2's medication regimen.Findings:During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 2's diagnoses included schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), schizophrenia (a mental illness that is characterized by disturbances in thought), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). The admission Record indicated Resident 2 had a responsible party (RP) 1. During a review of Resident 2's Minimum Data Set (MDS- a resident assessment tool), dated 11/20/2025, the MDS indicated Resident 2's cognition (process of thinking) was intact. The MDS indicated Resident 2 had hallucinations (perceptual experiences in the absence of real external sensory stimuli). The MDS indicated Resident 2 was independent with eating, oral hygiene, toileting, upper/lower body dressing, and personal hygiene. The MDS indicated Resident 2 was taking anticonvulsant medication (used to treat seizures [a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness] and other behavioral conditions).During a review of Resident 2's History and Physical (H&P), dated 5/18/2025, the H&P indicated Resident 2 did not have the capacity to understand and make decisions.During a review of Resident 2's Orders, active on 12/24/2025, the Orders indicated to administer Depakote (an anticonvulsant medication) 500 milligrams (mg, a unit of measurement), by mouth once a day for mood disorder manifested by angry outbursts. During a review of Resident 2's Care Plan titled, Mood Disorder Manifested by Angry Outbursts, dated 6/17/2025, the Care Plan's indicated interventions were to monitor Resident 2's behavior episodes of mood disorder manifested by angry outbursts every shift and to document the frequency of the behavior.During a concurrent interview and record review on 12/23/2025 at 2:02 p.m., with Registered Nurse (RN) 2, Resident 2's Orders, dated 5/16/2025 through 12/23/2025, were reviewed. The Orders indicated from 5/16/2025 through 10/14/2025, Resident 2 was monitored for behavior episodes manifested by angry outbursts every shift. The Orders indicated to document the frequency of the behavior. RN 2 stated Resident 2's behavior monitoring was discontinued on 10/14/2025 and was never reordered. RN 2 stated the order prompted the licensed nurse to tally the frequency of behaviors every shift using the Behavior Monitoring Sheet. RN 2 stated monitoring and documenting Resident 2's behaviors allowed the healthcare team to determine the efficacy of Depakote and whether the medication dose had to be increased or decreased. RN 2 stated without proper monitoring, Resident 2 may experience more behaviors that are improperly managed. During a review of the facility's Policy and Procedure (P&P) titled, Antipsychotic Medication Use, revised 7/2022, the P&P indicated, The staff will observe, document, and report to the attending physician information regarding the effectiveness of any interventions, including antipsychotic medications. |

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| F 0907<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide enough space and equipment to meet each resident's needs<br><br>(continued on next page) |

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| F 0907<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide two of four sampled residents (Residents 1 and 4) with enough space to maneuver their wheelchairs around their room.This deficient practice resulted in Residents 1 and 4 becoming frustrated with one another when their wheelchairs continuously bumped into one another.Findings:1. During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was initially admitted on [DATE] and readmitted on [DATE]. Resident 1's diagnoses included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (stroke - caused by a blocked blood vessel in the brain) affecting the left side, generalized muscle weakness, and abnormalities of gait and mobility (irregular walking pattern). During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 11/13/2025, the MDS indicated Resident 1's cognition (process of thinking) was intact. The MDS indicated Resident 1 required moderate assistance (helper does less than half the effort) with toileting, upper body dressing, and personal hygiene. The MDS indicated Resident 1 used a wheelchair for mobility. During a review of Resident 1's History and Physical (H&P), dated 8/7/2025, the H&P indicated Resident 1 had the capacity to understand and make decisions.During an interview on 12/23/2025 at 12:22 p.m., with Resident 1, Resident 1 stated there was not enough space between his and Resident 2's area. Resident 1 stated Resident 2's wheelchair pushes against his when they are both in the room.2. During a review of Resident 4's admission Record, the admission Record indicated Resident 4 was admitted to the facility on [DATE]. Resident 4's diagnoses included generalized muscle weakness, cerebral infarction, and foot drop (difficulty in lifting the front part of the foot).During a review of Resident 4's MDS, dated [DATE], the MDS indicated Resident 4's cognition was intact. The MDS indicated Resident 4 required moderate assistance with oral hygiene, upper body dressing, and personal hygiene. The MDS indicated Resident 4 used a wheelchair for mobility. During a review of Resident 4's H&P, dated 9/20/2025, the H&P indicated Resident 4 had fluctuating capacity to understand and make decisions.During a concurrent observation and interview on 12/23/2025 at 1 p.m., with Resident 4, in Resident 1 and 4's room, Resident 4 was observed trying to maneuver his motorized wheelchair from the right side of his bed to the door to exit the room. Resident 1's wheelchair was pushed up against the left side of his bed. Resident 4's wheelchair pushed against the back and left side of Resident 1's wheelchair. Resident 4 stated his current room was very small which made it difficult for him to move around. Resident 4 stated Resident 1 and himself were constantly bumping each other's wheelchairs whenever either of them tried to move in their areas. Resident 4 stated we are close like sardines and the lack of accommodation was very frustrating. During an interview on 12/23/2025 at 2:21 p.m. with Resident 4, Resident 4 stated Resident 1 moved to a different room, however, while he maneuvered out of his area, their wheelchairs bumped together and made the side table unsteady and the water pitcher fell to the floor. During an interview on 12/23/2025 at 2:41 p.m., with the Social Services Director (SSD), the SSD stated based on her observation earlier that day, Resident 1 and Resident 4 did not have enough space to move around safely and comfortably in their room. The SSD stated Resident 1 and Resident 4 should have been accommodated to ensure their wheelchairs did not bump into one another. The SSD stated miscommunication and disagreements between Resident 1 and Resident 4 resulted due to the facility not providing enough space for their wheelchairs. During an interview on 12/23/2025 at 4:31 p.m., with the Administrator (ADM), the ADM stated providing enough space to each resident to maneuver in their room, especially in a wheelchair, was essential for their comfort. The ADM stated adequate space is not only important for the residents but also essential to allow the staff to safely move around the area to provide care. The ADM stated limited space could result in the residents feeling anxious, agitated, and/or frustrated.During a review of the facility's Policy and Procedure (P&P) titled, Quality of Life- Accommodation of Needs, dated 8/2009, the P&P indicated, The resident's individual needs and preferences shall be accommodated to the extent possible, except when the health and safety of the individual or other residents would be endangered. The P&P indicated, In order to accommodate individual needs and preferences, adaptations may be made to the physical environment, including the resident's bedrooms and bathrooms, as well as the common areas in the facility. |