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	01/27/2026

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of two sampled residents (Resident 1) received showers and grooming when requested.This deficient practice resulted in Resident 1 not receiving scheduled showers and had the potential to result in compromised personal hygiene, skin integrity, decreased dignity and psychosocial distress.Findings: During a review of Resident 1's admission Record, dated 1/27/2026, the admission record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses which included generalized muscle weakness, abnormality of gait (the way a person walks) and mobility (ability to move), cerebral infarction (stroke, loss of blood flow to a part of the brain), spondylosis lumbar region (age related wear and tear of the lower spine which can cause back pain and stiffness), history of fraction/internal fixation of the right femur (a past break of the right thigh bone that was surgically repaired with metal hardware), and osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage) of the right hip. During a review of Resident 1's History and Physical (H&P), dated 9/20/2025, the H&P indicated Resident 1 had fluctuating capacity to understand and make decisions. During a review of Resident 1's care plan titled Activities of Daily Living (ADLs), initiated on 10/27/2025, the care plan indicated Resident 1 required assistance with self-care and mobility due to decreased strength, limited balance, and reduced functional independence. The care plan interventions indicated Resident 1 required one-person assistance, including staff assistance with most bathing tasks such as washing and rinsing hard-to-reach areas. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 12/25/2025, the MDS indicated Resident 1's cognition (ability to think, remember, and reason) was intact. The MDS indicated Resident 1 was independent (completes the activity with no assistance) with eating, oral hygiene and personal hygiene, and required maximal assistance (helper does more than half the effort) for bathing and dressing of the upper and lower body. During a review of Resident 1's Interdisciplinary Team (IDT - a group of healthcare professionals from different healthcare roles who work together to plan and provide resident care) Conference Note dated 12/31/2025, the IDT note indicated Resident 1 preferred showers before 10:00 a.m. on Mondays, Tuesdays, Wednesdays, Thursdays, and Saturdays. The IDT note indicated Resident 1 prefered to be shaved every two days. The IDT note indicated the Director of Staff Development (DSD) would follow up to accommodate Resident 1's request. During an interview on 1/26/2026 at 1:57 p.m., with Certified Nursing Assistant (CNA) 1, CNA 1 stated Resident 1 was in Bed A. CNA 1 stated residents in Bed A were scheduled showers on Mondays and Thursdays during the 3 p.m. to 11 p.m. shift. CNA 1 stated the shower schedule was based on the resident's assigned bed. CNA 1 stated Resident 1 frequently asked for showers during the day shift, and she would remind the resident his showers were scheduled from 3 p.m. to 11 p.m. CNA 1 stated Resident 1 would become upset when he was informed of his shower schedule. CNA 1 further stated she was required to complete a shower sheet after providing showers, which included documentation of the (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's skin condition. CNA 1 stated the shower sheets would then be submitted to the charge nurse for review and signature. CNA 1 stated she was also required to document if the Resident required shower assistance in the ADL task flowsheet in the electronic health record (EHR), but the ADL task flowsheet would not indicate whether a shower was completed for the resident. CNA 1 stated if a shower sheet was not completed and turned into the charge nurse, the nursing staff would not know whether a resident received a shower. During an interview on 1/26/2026 at 2:10 p.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 stated CNAs completed shower sheets for residents who received showers. LVN 1 stated she reviewed the shower sheets and then submitted the shower sheets to the DSD. LVN 1 stated she did not document showers were performed in the EHR. LVN 1 stated if a shower sheet was not completed or available, there was no way to verify through the resident's medical record whether the resident received a shower. LVN 1 stated the shower sheets were maintained by the DSD and were not incorporated into the resident's chart. During a concurrent observation and interview on 1/27/2026 at 11:03 a.m., with Resident 1, Resident 1 was observed sitting in his wheelchair. Resident 1 stated he was not offered a shower on 1/19/2026, 1/22/2026, and 1/26/2026. Resident 1 stated staff were supposed offer him a shower but did not. Resident 1 stated when he reminded staff, staff would reply they were too busy or they were not his assigned nurse. Resident 1 stated staff also refused to shave him when he requested. Resident 1 stated on 1/26/2026, his scheduled shower day, he left the facility out on a pass in the morning and returned before lunch. Resident 1 stated he was never offered a shower upon his return. Resident 1 stated he asked to receive his showers during the day and requested an additional shower on Saturdays, which he had not yet received. Resident 1 stated he required staff assistance with showering and it frustrated him when nurses made excuses. Resident 1 stated he did not like putting on clean clothes without first taking a shower. During an interview on 1/27/2026 at 3:33 p.m., with the DSD, Resident 1's shower sheets for the month of January 2026 were reviewed. The shower sheets included documentation for multiple residents, with four residents listed on each page. The DSD stated shower sheets were not part of the resident's medical record. The DSD stated after being completed by nursing, the shower sheets were submitted to her and kept in her office and were not incorporated into the resident's medical record because multiple residents were listed on each sheet. The DSD stated she did not have shower sheets for Resident 1 for 1/18/2026 and 1/26/2026. The DSD stated she spoke with nursing staff regarding Resident 1's missed shower on 1/18/2026 and was told the CNA was unaware of the resident's preference to receive showers during the day. The DSD stated when residents return to the facility from out on pass, the resident should be offered a shower. The DSD stated the CNA assigned to Resident 1 on 1/26/2026 did not offer Resident 1 a shower. The DSD stated nurses were trained on shower schedules, resident preferences, and the shower documentation process. The DSD stated showers should be charted only once a day on the ADL task flow sheet and documentation should reflect the resident's preferences. The DSD stated nursing staff were not accommodating Resident 1's shower preferences. The DSD stated staff communication regarding showers was not clear. The DSD stated when residents did not receive showers, they did not feel clean and may be unhappy or dissatisfied. The DSD stated the facility was not providing the care Resident 1 expected to receive. During a review of the facility's policy and procedure (P&P), titled Quality of Life - Dignity, revised 8/2009, the P&P indicated each resident was to be cared for in a manner that promoted and enhanced quality of life, dignity, respect, and individuality. The P&P indicated residents were to be treated with dignity and respect at all times and assisted in maintaining and enhancing self-esteem and self-worth. The P&P further indicated residents were to be groomed as they wished to be groomed, including hair styles, nails, and facial hair. During a review of the facility's P&P (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	titled Resident Rights, revised 8/2009, the P&P indicated employees were to treat all residents with kindness, respect, and dignity. The P&P indicated residents were entitled to exercise their rights and privileges to the fullest extent possible. The P&P further indicated the facility was to make every effort to assist each resident in exercising his or her rights to assure the resident was always treated with respect, kindness, and dignity. During a review of the facility's P&P titled Activities of Daily Living (ADL), Supporting, revised 3/2018, the P&P indicated residents were to be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living. The P&P indicated appropriate care, and services were to be provided for residents unable to carry out ADLs independently, in accordance with the resident's plan of care, including support and assistance with hygiene, including bathing, dressing, grooming, and oral care.