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	03/12/2026

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide care and services that meet professional standards of practice for one of three sampled residents (Resident 1) by failing to provide interventions for Resident 1 and notify the physician when the resident:Had an altered level of consciousness, was unresponsive to commands and unable to accept medication. Experienced labored breathing after a previous Change in Condition (COC) for Oxygen (O2) desaturation (drop in O2 saturation [O2 sat- a measurement of how much oxygen the blood is carrying as a percentage]).This deficient practice had the potential to result in Resident 1 not receiving selective lifesaving or comfort measures and could lead to death. Findings:During a review of Resident 1 admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE] and readmitted on [DATE]. The admission Record indicated Resident's diagnoses included diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), influenza (respiratory infection caused by a virus that affect the nose, throat and sometimes the lungs), and chronic obstruction pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing).During a review of Resident 1's Care Plan titled, (Resident 1) has Asthma (a chronic [long term] lung disease that make it difficult to breath)/COPD, nasal congestion. dated [DATE], the Care Plan nursing interventions indicated to observe for signs and symptoms of respiratory insufficiency: anxiety, confusion, shortness of breath and referral to the physician as needed. During a review of Resident 1's Physician Orders for Life Sustaining Treatment (POLST- a form that contains written medical orders for healthcare professionals regarding specific medical treatments that can or cannot be done at the end-of life) dated [DATE], the POLST indicated Resident 1 was a DNR (do not resuscitate- a medical order written by a doctor to instruct health care providers not to do cardiopulmonary resuscitation [CPR] if breathing stops or the heart stops beating) and to provide selective treatment (medical treatment, IV [intravenous-given directly into the blood stream] antibiotics [medication used to treat infection] and IV fluids as indicated. May use non-invasive positive airway pressure (delivery of oxygen into the lungs via positive pressure without the need for endotracheal intubation [insertion of a flexible tube through the mouth or nose into the trachea (windpipe) to maintain an open airway and enable mechanical ventilation) and transfer to hospital if comfort needs could not be met in current location. During a review of Minimum Data Set (MDS- a resident assessment tool) dated [DATE], the MDS indicated Resident 1 was able to understand and be understood by others. The MDS indicated Resident 1 was independent with Activities of Daily Living (ADLs) such as bed mobility, transfers and walking. During a review of Resident 1's Physician's Orders dated [DATE], the Orders indicated Resident 1 may O2 two liters per minute (L/min- a unit of measurement) via nasal cannula (N/C- a small plastic tube, which fits into the person's nostrils for providing supplemental O2 as needed for O2 saturation of less than 93% on room air. During a review of Resident 1's Change in Condition Evaluation (COC) dated [DATE], the COC indicated on [DATE] at 4:33 p.m., Resident 1's O2 sat was 88%.(normal resting range 95-100%, below normal 90-94%, low/hypoxemia [low levels of O2 in the blood which can lead to shortness of breath and confusion] below 90%). The COC indicated O2 was delivered with a non-rebreather (medical (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	device used in emergencies to deliver high concentration of O2 to residents in severe respiratory distress) and (changed to) to nasal cannula (N/C- a small plastic tube, which fits into the person's nostrils for providing supplemental O2) when stabilized. During a review of Resident 1's Progress Notes dated [DATE] at 7:00 p.m., The Progress Notes indicated at 6:33 p.m., Resident 1 had O2 desaturation (a drop in O2 sat) of 88%. O2 was delivered via (non)rebreather at 3 L/min and O2 sat increased to 96%. O2 was changed to N/C and O2 was 95-96%. The Notes indicated the physician was notified and an order was obtained to make Resident 1 comfortable and continue to monitor. During a review of Resident 1's Progress Notes dated [DATE] at 10:50 p.m., the Progress Notes indicated at 6 p.m., Resident 1 had one episode of vomiting and continuous cough that lasted for few minutes. Resident 1 had an O2 sat of less than 94% (not specified), the Registered Nurse (RN) Supervisor was notified and O2 was administered. The Progress Notes indicated Resident 1 was monitored for decline. During a review of Resident 1's Progress Notes dated [DATE] at 11:35 p.m., the Progress Notes indicated Resident 1 was unable to accept medication due to partial waking and unresponsive to commands. The Progress Notes did not indicate any interventions were provided nor that the physician was notified about the resident's condition. During a review of Resident 1's Progress Notes dated [DATE] at 11:46 p.m., the Progress Notes indicated, upon (Licensed Vocational Nurse [LVN] 2) initial rounds (first purposeful check of a resident by staff to confirm the resident's safety and needs), Resident 1 was observed on a non-rebreather mask receiving O2 at 8 L/min with labored breathing noted. Attempts were made to obtain vital signs; however, vital signs were unable to be obtained. At approximately 11:46 p.m., resident was reassessed and was found unresponsive with no palpable pulse and no chest rise. No code was initiated due to residents' DNR status. The Progress Notes did not indicate any interventions were provided to the resident nor that the physician was notified regarding the resident's labored breathing identified on initial assessment. During an interview on [DATE] at 4:00 p.m., with Registered Nurse Supervisor (RNS) 1, RNS 1 stated on [DATE] at 8:30 p.m., he was alerted by LVN 1 that Resident 1's O2 sat was 88% on room air and he administered O2 to Resident 1 with a non-rebreather mask at 3 L/min and the resident's O2 sat increased to 96%. RNS 1 stated he then decreased the O2 to 2 L/min via N/C, and Resident 1's O2 sat remained at 95-96 %. RNS 1 stated he notified the physician about the Resident's low O2 sat and the administration of O2 to Resident 1.During an interview on [DATE] at 1:10 p.m., with Certified Nurse Assistant (CNA) 2, CNA 2 stated on [DATE] during her initial rounds at approximately 11:00 p.m., Resident 1 was having labored breathing. Resident 1 was on O2 with a non-rebreather mask. CNA 2 stated she notified the LVN (not specified) about Resident 1 having labored breathing and the LVN notified her that the resident was a DNR. CNA 2 stated on [DATE] at approximately 12:00 a.m. she was called to clean Resident 1 because the resident expired. During an interview on [DATE] at 4:15 p.m., with LVN 1, LVN 1 stated on [DATE] at approximately 6:00 p.m., he was alerted by Resident 1's roommate that Resident 1 was choking. LVN 1 stated, Resident 1 vomited and was coughing and O2 sat was low. LVN 1 stated he notified the RN supervisor and O2 was administered which improved Resident 1's O2 sat. RNS 1 was aware of the changes in Resident 1's condition but LVN 1 did not know if the physician was made aware of the changes in Resident ?s condition.During an interview on [DATE] at 9:20 a.m. with Resident 1's Physician (MD 1), MD 1 stated (on [DATE]) he was informed about Resident 1's COC regarding the low O2 sat which was stabilized with O2 therapy. MD 1 stated he instructed staff to continue monitoring the resident. MD 1 stated he was surprised when he received a second call from the facility (on [DATE]) at around 12:00 a.m. informing him that Resident 1 had passed away. MD 1 stated Resident 1 should have been transferred to the hospital if her condition had not improved. During an interview on [DATE] at 10:00 a.m., with LVN 2, LVN 2 stated on [DATE] (at 11:46 p.m.) she documented that Resident 1 was on O2 with non-rebreather mask, however that was incorrect documentation. LVN 2 stated on [DATE], she made her initial round at approximately 11:20 p.m. to 11:30 p.m. and Resident 1 was receiving O2 through N/C. Resident 1 was gasping for air and had no palpable pulse. RN supervisor was notified; no code was initiated because (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident was a DNR. LVN 2 stated she was not informed by CNA 2 that Resident 1 was having labored breathing at 11:00 p.m. because she arrived at the facility late that evening. During a concurrent interview and record review on [DATE] at 10:26 a.m., with the Director of Nursing (DON), Resident 1's Progress Notes dated [DATE] were reviewed. The DON stated Resident 1 had another significant COC and should have been transferred to the hospital. During a review of the facility's policy and procedure (P&P) titled, Change in a Resident's Condition or Status, dated 2/2021. The P&P indicated that facility promptly notifies the resident's attending physician of changes in the resident's medical/mental condition and/or status. The nurse will notify the resident's attending physician or physician on call when there has been a significant change in the resident's physical/emotional/mental condition, need to alter the resident's medical treatment significantly and need to transfer the resident to the hospital/treatment center. The nurse will record in the resident's medical record information relative to changes in the resident's condition or status.During a review of the facility's Charge Nurse (LVN) Job Description dated 2023, the Job Description indicated LVN duties and responsibilities included consulting with the resident's physician in providing the resident's care and treatment as necessary, implementing established nursing objectives and standards, making periodic checks to evaluate the resident's physical status and notify the resident's physician when the resident is involved in an incident. The LVN must possess the ability to plan, organize and implement goals, objectives, P&Ps etc. that are necessary for providing quality care, and must be able to relate information concerning a resident's health. During a review of the facility's RN Job Description dated 2023, the Job Description indicated RN duties and responsibilities included ongoing review of the resident's well-being and concerns and report to the appropriate department or inter-disciplinary (IDT-a group of healthcare professionals from different disciplines who work together to manage the resident's care).