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	04/30/2026

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow its Policy and Procedure (P&P) titled, Grievances/Complaints Filing which indicated the Administrator and staff will make prompt efforts to resolve grievances, for one of five sampled residents (Resident 2) when Resident 2 informed the facility that a Certified Nursing Assistant (CNA) 1 was disrespectful when CNA 1 provided Activities of Daily Living (ADL) care to Resident 2 on 4/27/2026.This deficient practice violated Resident 1's rights and could negatively impact the residents' feelings and sense of self-worth.Findings: During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was originally admitted to the facility on [DATE] and re-admitted on [DATE]. The admission Record indicated Resident 1's diagnoses included quadriplegia (paralysis from the neck down, including legs, and arms, usually due to a spinal cord injury) other disorders of nervous system (motor dysfunction (weaknesses, tremors, gait changes) and other ossification of muscle (bone tissue forms in soft tissues, following trauma or injury). During a review of Residents 2's Minimum Data Set (MDS - a resident assessment tool) dated 4/1/2026, the MDS indicated Resident 2 had no cognitive (ability to think and reason) impairment. The MDS indicated Resident 1 was dependent on staff for ADLs such as toileting hygiene, showering/bathing self, lower body dressing, toilet use, and transfers (the ability to transfer to and from a bed to a chair or wheelchair). During a review of Resident 2's History and Physical (H&P) dated 4/2/2026, the H&P indicated Resident 2 had the capacity to understand and make decisions. During a concurrent interview and interview on 4/29/2026 at 9:33 a.m. in Resident 2's room, Resident 2 stated he could not get up, was only able to move his arms slowly and needed assistance from staff for ADLs. Resident 2 stated on 4/26/2026 at around 7 p.m., CNA 1 was upset and asked Resident 1 why he pressed the call light. Resident 2 stated CNA 1 provided ADL care to the resident and verbalized profanity by saying f*** as CNA 1 was leaving the Resident's room. Resident 2 stated he reported the incident involving CNA 1 to the Activities Director (AD) on 4/27/2026. Resident 2 stated he told the AD that he (Resident 2), did not like the way CNA 1 treated him and it was disrespectful to use that type of language around the resident. Resident 2 stated he requested to speak with the Social Services Director (SSD) and the AD told him she would inform the SSD. During an interview on 4/29/2026 at 12:55 p.m., with the AD, the AD stated on 4/27/2026, Resident 2 told her he wanted to speak with the SSD. The AD stated Resident 2 informed her that over the weekend (exact day unknown), Resident 2 reported that CNA 1 used the F word while providing care. The AD stated she informed the SSD via phone text on 4/27/2026 at 11:19 a.m., to speak with Resident 2 regarding a complaint involving a nurse. The SSD responded on 4/27/2026 at 11:20 a.m., acknowledging the AD's text message and indicated she (SSD) was in a meeting. The AD stated it was not acceptable for staff to use profanity while providing resident care and that such behavior could make a resident feel disrespected. The AD stated she did not know whether the SSD spoke with Resident 2 or whether the Administrator was informed. The AD stated facility staff were responsible for speaking with residents promptly and attempting to resolve their concerns.During an interview on 4/29/2026 at 1:26 p.m., with the SSD, the SSD stated on 4/27/2026, the AD informed her that (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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 2 wanted to see her (the SSD). The AD stated she did not see Resident 2 on 4/27/2026 because it was a very busy day for her due to new admissions and meetings. The SSD stated that if the AD was aware of Resident 2's complaints regarding CNA 1, she (the SSD) could have reported it to the Administrator or Director of Staff Development (DSD) and attempted to resolve the issue. The SSD stated she did not have the opportunity to speak with Resident 2 until this day (4/29/2026). During an interview on 4/30/2026 at 4:46 p.m., with the Director of Nursing (DON), the DON stated the facility should immediately address resident's complaints. The DON stated grievances should be resolved in a timely manner to help prevent residents from suffering or experiencing discomfort. During a review of the facility's P&P titled, Grievances/Complaints, Filing dated 2017, the P&P indicated the Administrator, and staff will make prompt efforts to resolve grievances to the satisfaction of the resident and, or representative. Any resident, family member or appointed resident representative may file a grievance or complaint concerning care, treatment, behavior of other residents, staff members, or any other concerns regarding his or her stay at the facility. Grievances and/or complaints may be submitted orally or in writing.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement safety measures for three of five sampled residents (Residents 1, 3 and 4) by failing to: 1.Follow its policy and procedure titled, Pass Procedures - Sending Resident Out on Pass (OOP- temporary permission for a resident to leave the facility for a specified period), which indicated staff will obtain a physician's order allowing the resident to leave the facility, including the reason (medical or social), and complete the Release of Responsibility for Leave of Absence form.2). Develop an OOP care plan for Residents 1, 3 and 4. These failures had the potential to negatively affect Resident 1, 3 and 4's safety and well-being when going OOP. Findings:a). During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was originally admitted to the facility on [DATE] and re-admitted on [DATE]. The admission Record indicated Resident 1's diagnoses included epilepsy (neurological disorder characterized by seizures due to unusual electrical activity in the brain), chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing) and neutropenia (characterized by an abnormally low number of neutrophils, a type of white blood cell essential for fighting infections). During a review of Resident 1's History and Physical (H&P) dated 4/9/2026, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Residents 1's Minimum Data Set (MDS - a resident assessment tool) dated 4/1/2026, the MDS indicated Resident 1 had no cognitive (ability to think and reason) impairment. The MDS indicated Resident 1 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with Activities of Daily Living (ADLs) such as personal oral hygiene, toileting hygiene, dressing, toilet use and transfers (the ability to transfer to and from a bed to a chair, chair or wheelchair). During a review of Resident 1's Physician's order dated 4/13/2026, the Order indicated Resident 1 may go OOP, not to exceed 4 hours. The Order did not indicate the reason for the Resident's OOP. During a review of Resident 1's Progress Note dated 4/13/2026, the Note indicated Resident 1 left OOP on 4/13/2026 at 3:15 p.m. The Progress Note did not indicate that the Release of Responsibility for Leave of Absence form was completed for Resident 1. b). During a review of Resident 3's admission Record, the admission Record indicated Resident 3 was originally admitted to the facility on [DATE] and re-admitted on [DATE]. The admission Record indicated Resident 3's diagnoses included Hypertension (HTN-high blood pressure), Type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and Chronic kidney disease (occurs when the kidneys are damaged, impairing their ability to remove waste, balance electrolytes, regulate blood pressure, and produce hormones for red blood cells and bone health). During a review of Resident 3's H&P dated 1/6/2026, the H&P indicated Resident 3 had the capacity to understand and make decisions. During a review of Residents 3's MDS dated [DATE], the MDS indicated Resident 3 had no cognitive impairment. The MDS indicated Resident 3 required partial to moderate assistance (helper does less than half the effort. Helper lifts or holds trunk or limbs but provides less than half the effort with the ADLs such as toilet use, showering/bathing self, lower body dressing and transfers. During a review of Resident 3's Physician's order dated 4/17/2026, the Order indicated Resident 3 may go OOP for therapeutic purposes. During a review of Resident 3's undated Release of Responsibility for Leave of Absence form, the form indicated Resident 3 went OOP on 4/17 (no year indicated) at 2:20 p.m. The form did not indicate the time Resident 3 returned to the facility, a phone number where resident could be reached and the nurse's signature. c). During a review of Resident 4's admission Record, the admission Record indicated Resident 4 was originally admitted to the facility on [DATE] and re-admitted on [DATE]. The admission Record indicated Resident 4's diagnoses included epilepsy, congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	efficiently, sometimes resulting in leg swelling) and ESRD (End Stage Renal Disease-irreversible kidney failure). During a review of Resident 4's H&P dated 9/10/2025, the H&P indicated Resident 4 had fluctuating capacity to understand and make decisions. During a review of Residents 4's MDS dated [DATE], the MDS indicated Resident 4 had no cognitive impairment. The MDS indicated Resident 4 required partial to moderate assistance from staff with the ADLs such as dressing, toilet use, showering/bathing self, dressing and transfers. During a review of Resident 4's Physician's order dated 4/17/2026, the Order indicated Resident 4 may go OOP, not to exceed 4 hours. The Order did not indicate the reason for the residents' OOP. During an interview with Resident 4 on 4/29/2026 at 11:20 a.m., Resident 4 stated he had gone out on pass one or two times before. Resident 4 stated he believed the nurses signed an OOP form at the nurse's station. Resident 4 stated the nurses had not told him to sign or complete any form before going OOP. During a review of Resident 4's undated Release of Responsibility for Leave of Absence form, the form indicated on 4/17(no year indicated), Resident 4 went OOP to go a mobile phone store. The Form did not indicate the time Resident 4 returned to the facility, a phone number where the resident could be reached and the nurse's signature. During an interview on 4/29/2026 at 2:07 p.m., with Registered Nurse (RN) 1, RN 1 stated when residents requested to leave OOP, the nurse would call the physician to obtain an order. RN 1 stated it was important to indicate where the resident wanted to go in the physician's order. RN 1 stated there was a binder at the nurse's station with an OOP form (Release for Leave of Absence form) that must be completed accurately in all sections. RN 1 stated nurses must know the time the resident left and returned to the facility, resident's contact phone number, and the destination for the resident's safety. During an interview on 4/30/2026 at 10:53 a.m., with the Medical Doctor (MD), the MD stated the criteria for an OOP order is usually limited to four hours. The MD stated nurses must be assessed prior to going OOP to ensure the resident was self-responsible or had a family member going with them. The MD stated the facility must follow its P&P, and indicate a specific reason for the OOP and where the residents were going to ensure safety of the residents while OOP. During an interview on 4/30/2026 at 4:46 p.m., with the Director of Nursing (DON), the DON stated nurses needed to obtain an order for residents to go OOP. It was important to determine where the residents were going while OOP for resident safety. The DON stated when residents go OOP, the Resident (or RP) must sign the Release of Responsibility for Leave of Absence form. The DON stated licensed nurses must oversee to ensure the form was completed properly because it provided essential information for staff, including the time the resident left the facility, the destination, and the time the resident returned. The DON stated Resident 1 did not have a Responsibility for Leave of Absence form completed, and Resident 3 and 4's Release of Responsibility for Leave of Absence forms were not entirely completed. The DON stated it was also important to ensure licensed nurses developed a Care Plan for OOP to include interventions for nurses and address resident's mental capacity. The DON stated there were no OOP care plans developed for Residents 1, 3 and 4. During a review of the facility's P&P titled, Pass Procedures - Sending Resident Out on Pass, dated 2/2025, the P&P indicated the facility would obtain an order from the physician to allow the resident to leave the facility; include reason, medical or social. The P&P indicated the resident or responsible party is to sign the Acknowledge of the Release of Responsibility when OOP, prior to issuance of an OOP. The resident or responsible party is to list the location for the resident. This should be specific with an address or telephone number if resident going to a residence. The nurse receiving the resident is to have the resident/responsible party sign back in the OOP binder, verifying the resident has returned. The licensed nurse will advise the resident/responsible party to document the following in the OOP binder:Date and exact time the resident left the facilityWho accompanied the residentDestination and estimated time of returnPhone number where the resident can be reachedDate, time and condition of resident when he/she returned. During a review of the facility's P&P titled, Care Plans, Comprehensive person -Centered dated 3/2017, the P&P indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	psychosocial and functional needs is developed and implemented for each resident. The Care Plan will describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.