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	06/06/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure, interventions to monitor, one (1) of three (3) residents (Resident 1), aggressive behavior, impulsiveness and impulsivity were implemented as indicated in the resident's care plan titled, Positive toxicology screen (drug test) for amphetamine (a potent central nervous system stimulant that speeds up messages between the brain and the body) use with potential risk for altered behavior, impaired judgement, cardiovascular complications and safety concerns. This deficient practice placed Resident 1 at risk for injury.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 schizophrenia (a mental illness that is characterized by disturbances in thought) and anemia (a condition where the body does not have enough healthy red blood cells). During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool) dated 3/18/2026, the MDS indicated Resident 1 had intact cognitive (ability to think and process information) ability. The MDS indicated Resident 1 required supervision for oral hygiene, showering, upper/lower body dressing, putting on/taking off footwear and personal hygiene. The MDS indicated Resident 1 was independent for eating and toileting. During a review of Resident 1's care plan titled, Positive toxicology screen for amphetamine use with potential risk for altered behavior, impaired judgement, cardiovascular complications and safety concerns dated 6/4/2026, the interventions indicated to monitor the resident for agitation, impulsivity or aggressive behavior. During a concurrent interview and record review on 6/6/2026 at 5:11 PM with Registered Nurse (RN) 1, Resident 1's care plan titled, Positive toxicology screen for amphetamine use with potential risk for altered behavior, impaired judgement, cardiovascular complications and safety concerns, dated 6/4/2026, Resident 1's Medication Administration Record (MAR) from 6/1/2026 to 6/6/2026, and Resident 1's Progress Notes from 6/4/2026 to 6/6/2026 were reviewed. RN 1 stated Resident 1's progress notes and MAR had no documented evidence that aggressive behavior, impulsiveness and agitation were monitored as indicated in Resident 1's care plan. RN 1 stated that if the interventions in the resident's care plan were not done, Resident 1 could get hurt. During a concurrent interview and record review on 6/6/2026 at 6:56 p.m., with the Director of Nursing (DON), the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, revised 1/2026, Resident 1's care plan titled, Positive toxicology screen for amphetamine use with potential risk for altered behavior, impaired judgement, cardiovascular complications and safety concerns, dated 6/4/2026, Resident 1's MAR from 6/1/2026 to 6/6/2026 and Resident 1's Progress Notes from 6/4/2026 to 6/6/2026 were reviewed. The DON stated there was no documented evidence in Resident 1's Progress Notes and MAR that monitoring for aggressive behavior, impulsiveness and agitation were done, as indicated in Resident 1's care plan, and in the facility's P&P which indicated that a comprehensive, person-centered care plan should include measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs. The care plan should be developed and implemented for each resident, and assessments should be ongoing, and care plans are revised, as information about the residents and the residents' conditions change. The DON stated that (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 1's behavior was not monitored. The effectiveness of the interventions could not be assessed and his condition may worsen, could get injured if interventions for behavior monitoring were not followed. The DON stated that Resident 1 does not have monitoring for aggressive behavior, impulsiveness or agitation in his MAR or Progress Notes.