STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555399	A. Building B. Wing	03/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avondale Villa Post-Acute	788 Holmes Street Livermore, CA 94550

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on observation, interview and record review the facility failed to ensure an injury of unknown origin was reported as required by law for one of three sampled residents (Resident 1). This failure resulted in Resident 1' s facial bruise, which was of unknown origin, not being reported to California Department of Public Health (CDPH), local law enforcement and Ombudsman. Resident 1's Minimum Data Set (MDS, a resident assessment instrument used to identify resident care problems to be addressed in an individualized care plan), dated 12/29/25, indicated, Resident 1 was severely cognitively impaired. MDS also indicated, Resident 1 required substantial assistance from caregivers (caregiver does more than half the effort to complete task) with eating, oral hygiene and moving in bed and was totally dependent on caregivers (caregiver does all of the effort to complete task) for toileting, showering and transferring to a wheelchair.During a concurrent observation and interview on 3/10/26 at 1:50 p.m. in Resident 1's room, Resident 1 laid in bed, was awake, alert and continuously spoke aloud. Resident 1 responded to questions by ceasing to speak, turning and looking at speaker and then continued speaking aloud. During an interview on 3/9/26 at 1:42 p.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated, CNA 1 took care of Resident 1 and noticed Resident 1 had a bruise near Resident 1's lip. CNA 1 stated, bruise was small, more than one 1/4 inch and less than 1/2 inch in diameter. CNA 1 stated, CNA 1 told the charge nurse Resident 1 had a bruise near lip and charge nurse said bruise had already been reported. CNA 1 also stated, CNA 1 did not know what caused bruise.During an interview on 3/9/26 at 1:46 p.m. with CNA 2, CNA 2 stated, CNA 2 took care of Resident 1 on 2/3/26 and 2/4/26. CNA 2 stated, on 2/3/26 CNA 2 did not notice any discoloration or bruise on Resident 1. CNA 2 stated, CNA 2 noticed Resident 1 had a bruise on 2/4/26, which was purple and was the size of half of a nickel. CNA 2 stated, CNA 2 reported the bruise to Licensed Vocational Nurse (LVN) 2, who said bruise had already been reported. CNA 2 also stated, CNA 2 did not know what had caused bruise. During an interview on 3/9/26 at 2:13 p.m. with CNA 3, CNA 3 stated, CNA 3 was assigned to Resident 1 on 2/3/26 and 2/4/26 on the evening shift. CNA 3 stated, CNA 3 did not notice a bruise on Resident 1 on 2/3/26. CNA 3 stated, on 2/3/26 Resident 1 used a spoon to partially feed dinner to self and CNA 3 also fed Resident 1 dinner. CNA 3 stated, CNA 3 washed Resident 1's face and brushed Resident 1's teeth after dinner and Resident 1's chin was clear. CNA 3 stated, on 2/4/26 the day shift staff showed CNA 3 the bruise on the chin. CNA 3 stated, the bruise was dark purple, small and round and about 1/4 inch in diameter. CNA 3 stated, CNA 3 did not know what caused the bruise and believed no one knew how the bruise happened. During an interview on 3/9/26 at 2:05 p.m. with LVN 1, LVN 1 stated Resident 1 had a purple, egg shaped bruise, sized approximately 1/2 inch. LVN 1 stated, LVN 2, the night shift nurse, reported the bruise on 2/4/26. LVN 1 stated, LVN 1 called Resident 1's Resident Representative on 2/4/26. LVN 1 stated, LVN 1 monitored the bruise and did not know what caused the bruise. During an interview on 3/9/26 at 2:21 p.m. with LVN 2, LVN 2 stated, LVN 2 worked the night shift on 3/4/26. LVN 2 stated, a CNA notified LVN 2 that Resident 1 had a bruise. LVN 2 stated, LVN 2 looked at the bruise, which was purplish blue, irregular in shape, the size of a coin and close to the lip on Resident 1's chin. LVN 2 stated, LVN 2 did not know what caused the bruise. During an interview on 3/10/26 at 1:41 p.m. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with Administrator (ADM), ADM stated, the cause of the bruise was unknown. ADM stated, Resident 1's doctor and family were notified of the bruise. ADM stated, the bruise was not reported to CDPH, local law enforcement or the Ombudsman. During a concurrent interview and record review on 3/10/26 at 1:44 pm with ADM, the facility's policy and procedure (P&P) titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, dated Revised September 2022, was reviewed. The P&P indicated, All reports of resident abuse (including injuries of unknown origin) . are reported to local, state, and federal agencies (as required by current regulations) . 1. If . injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. 2. The administrator .immediately reports his or her suspicion to the following persons or agencies: a. the state licensing/certification agency responsible for surveying/licensing the facility; b. the local/state ombudsman . e. Law enforcement officials. ADM stated, ADM had frequent communication with CDPH, but not about Resident 1's bruise. During a review of Resident 1's SBAR & Initial COC/Alert Charting & Skilled Documentation (SBAR), dated 2/4/26, the SBAR indicated, around 0630, during routine room checks, reported by NA that there's a new skin issue with Resident. LN noted skin discoloration located in the left chin area purplish blue in color. No complaints of pain noted, no s/s of distress noted. Resident is sleeping in bed whole shift. Notified MD, supervisor and DON am shift nurse will notify RP. During a review of Resident 1's Skin Assessment (Non-Pressure Injury) (SA), dated 2/4/26, the SA indicated, on 2/4/26 a skin discoloration located in the lower left chin area was observed.