

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056023	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/16/2025
NAME OF PROVIDER OR SUPPLIER Avalon Villa Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>46505</p> <p>Based on interview and record review, the facility failed to ensure licensed nurses had competencies and skill sets to care for residents by failing to ensure:</p> <ol style="list-style-type: none"> 1. The facility checked and verified the license for Registered Nurse (RN 1), who was had probationary status (RN allowed to practice under certain restrictions). 2. RN 1 completed mandatory competencies and assessments. <p>This failure had the potential for 113 residents in the facility to not receive proper and safe care.</p> <p>Findings:</p> <p>During a review of the California Board of Registered Nursing (BRN) Licensing Details, dated 4/11/2025, the details indicated Registered Nurse (RN 1) ' s license was current but revoked, stayed, and on probation.</p> <p>During a review of the California BRN letter, dated 5/8/2023, the letter indicated RN 1 was approved for employment as a RN supervisor based on the conditions which included:</p> <p>RN 1 to work a maximum of 40 hours with no overtime, was supervised by a list of RN (including RN 2) and the RN must be aware of the cause of the probation and must have reviewed a copy of the approval letter, was audited four times a month for documentation, and had work performance evaluations submitted to the BRN. The letter indicated to notify the board if there were any changes, and the changes had to be approved by the BRN prior to implementation.</p> <p>During interviews with the Director of Staff Development (DSD) on 4/10/2025 at 11:57 a.m. and 4:44 p.m., the DSD stated she has been working at the facility for about 7 years. The DSD stated, RN 1 was under probation and did not know the stipulation of RN 1 ' s probation. The DSD stated, RN 1 worked the evening shift but sometimes RN 1 would work overtime and stay to cover the night shift when there was a staffing need. The DSD stated nurses ' licenses should be verified annually and could not remember when RN 1 ' s license was last checked. The DSD stated the facility had only completed nursing competencies upon hire until 2/2025.</p> <p>(continued on next page)</p>

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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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of RN 1 ' s employee file, there was no supporting documentation of nursing skills and competencies completed. The file did not the facility monitored and audited RN 1 ' s documentation and work performance.</p> <p>During an interview with Director of Nursing (DON) 2 on 4/15/2025 at 1:20 p.m., DON 2 stated she just started working at the facility and was unaware of RN 1 ' s license being on probation.</p> <p>During an interview with RN 2 on 4/15/2025 at 1:14 p.m., RN 2 stated RN 2 has worked with RN 1 and never had to supervise RN 1 because RN 1 was also a RN supervisor.</p> <p>During an interview with the administrator (ADM) on 4/15/2025 at 4:19 p.m., the ADM stated he was not aware of RN 1 ' s license being on probation beforehand, and the previous DON (DON 1) and RN 1 did not inform him about the probation.</p> <p>During a subsequent interview with DON 2 on 4/16/2025 at 3:19 p.m., DON 2 stated, DON 1 should have verified the licenses for nurses. DON 2 stated she was not sure how often licenses were supposed to be checked. DON 2 stated not being aware of RN 1's probation was a violation because RN 1 was not supposed to work overtime or without another RN supervision.</p> <p>During a review of the facility ' s policy and procedure (P&P) titled, Licensure, Certification, and Registration of Personnel, dated 4/2007, the P&P indicated a copy of the recertification must be filed in the employee ' s personnel record. The P&P indicated should the background investigation reveal that the employee does not hold a current unencumbered (free of disciplinary limitations) license, the employee would be discharged , and appropriate stated and federal officials would be notified of such information.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46505</p> <p>Based on interview and record review, the facility failed to ensure one of four sampled resident's (Resident 1) clinical records was maintained in accordance with professional standards of practice by failing to ensure the documented times accurately reflected when Resident 1's Vital Signs (measurements that reflect the body's functional status including blood pressure, heart rate, temperature, respirations) were obtained and when Resident 1's Change of Condition occurred on 4/11/2025.</p> <p>This deficient practice had the potential to result in a lack of or a delay in communication between staff and adversely affect the provision of care/interventions for Resident 1.</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record, the Admission Record indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 1's diagnoses included chronic obstructive pulmonary disease (COPD- a chronic lung disease causing difficulty in breathing), paroxysmal arterial fibrillation (a fast, irregular heartbeat), and heart failure (a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling).</p> <p>During a review of Resident 1's History and Physical (H&P) dated 4/8/2025, the H&P indicated Resident 1 had the capacity to understand and make decisions.</p> <p>During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 4/12/2025, the MDS indicated Resident 1 was able to understand and be understood by others. The MDS indicated Resident 1 required substantial/maximal assistance (staff does more than half the effort) for activities of daily living (ADLs) such as eating, oral hygiene, toileting hygiene, dressing and transfers.</p> <p>During a review of Resident 1's Order Summary Report dated 4/16/2025, the Order Summary Report indicated on 4/8/2025, the physician ordered to administer nitroglycerin tablet sublingual (under the tongue) 0.4 milligram (mg, a unit of measurement) one tablet under the tongue every five minutes as needed for chest pain for three doses and if ineffective (did not work) after three doses, call 911.</p> <p>During a review of Resident 1's Medication Administration Record (MAR) dated 4/15/2025, the MAR indicated nitroglycerin was administered on 4/11/2025 at 2:00 p.m. and it was ineffective. The MAR indicated, on 4/11/2025 at 2:05 p.m. a second dose was administered, and it was effective.</p> <p>During a review of Resident 1's Vital Signs Report dated 4/16/2025, the Vital Signs Report for Resident 1 indicated the following:</p> <p>Resident 1's blood pressures were taken on 4/10/2025 at 9:20 p.m., 4/11/2025 at 2:50 p.m., 4/11/2025 at 4:42 p.m., and 4/12/2025 at 2:14 p.m.</p> <p>Resident 1's heart rates were taken on 4/10/2025 at 6:22 p.m., 4/11/2025 at 2:50 p.m. and 4/11/2025 at 7:55 p.m.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident 1's Respiration rates were taken on 10/10/2025 at 6:22 p.m. and 4/11/2025 at 7:28 p.m.</p> <p>During a review of Resident 1's Change of Condition (COC) Evaluation, dated 4/11/2025 at 2:00 p.m., the COC indicated Resident 1 had chest pain localized to the left side of the chest which started on 4/11/2025 at 2:50 p.m. The COC indicated nitroglycerin 0.4 mg. was administered to Resident 1 as ordered and after five minutes, the resident continued to report chest pain. The COC indicated a second dose of nitroglycerin 0.4 mg. was administered with verbalized relief of chest pain. The COC indicated most recent blood pressure was 129/78 on 4/11/2025 at 2:50 p.m., heart rate was 78 on 4/11/2025 at 2:50 p.m., and respiration was 18 on 4/10/2025 at 6:22 p.m. the doctor was notified on 4/11/2025 at 2:30 p.m.</p> <p>During a concurrent interview and record review on 4/16/2025 at 2:07 p.m. with the Director of Nursing (DON), Resident 1's COC, dated 4/11/2025, was reviewed. The DON stated Resident 1's chest pain started on 4/11/2025 at 2:50 p.m. and the doctor was called on 4/11/2025 at 2:30 p.m. The DON stated the vital signs were taken on 4/11/2025 at 2:50 p.m. and the vital signs were normal. The DON stated there were no vital signs documented during the change of condition. The DON stated the documentation was off and accurate documentation was important to give a timeline of the events.</p> <p>During an interview with Quality Assurance Nurse (QA) 1, QA 1 stated, Resident 1's change of condition (chest pain) started on 4/11/2025 at 2:00 p.m. QA 1 stated, he administered nitroglycerin and checked Resident 1's vital signs on 4/11/2025 at around 2:05 p.m. QA 1 stated the COC and vital signs documented as 4/11/2025 at 2:50 p.m. does not reflect the actual time when the COC occurred and when the vital signs were obtained.</p> <p>During a review of the facility's policy and procedure (P&P) titled Charting and Documentation, dated 7/2017, the P&P indicated documentation in the medical record would be objective, complete, and accurate. The P&P indicated the documentation of procedures and treatments would include care-specific details including the assessment data and/or any unusual findings obtained during the treatment.</p>		