

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 08/19/2025
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)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (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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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure routine drugs and biologicals were provided to residents by allowing an unlicensed nurse (Staff 1) to administer medications to four of six sampled residents (Residents 1, 2, 3, and 4) for over one and a half years. This deficient practice caused an increased risk in unsafe and inappropriate care of the residents, medication errors, and adverse outcomes to the residents. 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 readmitted on [DATE] with diagnoses including right ankle and foot osteomyelitis (an infection in the bone). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 7/2025, the MDS indicated Resident 1 had the ability to make self-understood and to understand others. The MDS indicated Resident 1 received an opioid (a drug used for pain) medication. During a review of the Medication Administration Records (MAR) dated 6/1/2025 through 8/15/2025, the MAR indicated Resident 1 received Norco 5-325 mg (a controlled substance used to relieve moderate to severe pain) on seven separate occasions administered by Staff 1. During a concurrent interview and record review on 8/18/2025 at 10:45 a.m., with Director of Staff Development (DSD), Staff 1's personnel file was reviewed. The personnel file indicated Staff 1 was hired to work in the facility as a Licensed Vocational Nurse (LVN, an entry level healthcare provider who must complete a state approved educational program and pass a licensing exam to practice) on 1/8/2024, and did not have proper documentation of a valid professional LVN license. The DSD stated Staff 1's personnel file contained a California Identification Card (ID) and Social Security (SS) card but did not contain evidence of a valid LVN license verification through the California Board of Vocational Nursing and Psychiatric Technicians (BVNPT) system. The DSD stated Staff 1's employee file contained a copy of a LVN license of an unidentified individual which did not match Staff 1's ID and SS card. The DSD stated the facility hired Staff 1 by using the unidentified individual's professional LVN license. The DSD stated by allowing unlicensed Staff 1 to function as an LVN for over a year and a half placed all residents at risk for unsafe care and potential harm. b. During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was admitted to the facility on [DATE] with diagnoses including pelvis (bony structure inside hips) fracture (a break in a bone) and lumbar vertebra (bone in the lower back) fracture. During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2 had the ability to make self-understood and to understand others. The MDS indicated Resident 2 received an opioid medication. During a review of the Medication Administration Records (MAR) dated 6/1/2025 through 8/15/2025, the MAR indicated Resident 2 received Oxycodone (an opioid, controlled substance used to relieve severe pain, by prescription only with a high potential for addiction, abuse and misuse) 10 mg on 31 separate occasions and the medication was administered by Staff 1. During an interview on 8/18/2025 at 1:45 p.m., the Director of Nursing (DON) stated that on 8/13/2025, it was brought to her attention that Staff 1 had been working in the facility as an LVN without a professional LVN license for over a year and a half. The DON stated this posed a significant risk, including improper medication administration, inaccurate documentation, and the potential for residents to receive unnecessary or inappropriate medications. The DON stated by hiring unlicensed staff to function as an LVN without proper credentials or clinical competency created significant risks, including medication errors and improper treatments, which placed residents at risk for infection and misrepresented residents' condition, leading to unsafe care and adverse outcomes. Further review of the MARs dated 6/1/2025 through 8/15/2025 indicated Resident 3, who was diagnosed with left femur (thigh bone) fracture, received Percocet 5-325 mg (a narcotic, controlled substance medication used to treat moderate to severe pain) on 34 different occasions administered by Staff 1. The MARs indicated Resident 4, who was diagnosed with paraplegia (loss of movement and/or sensation, to some degree, of the legs), and back pain, received Norco tablet 5-325 mg, on 33 separate occasions administered by Staff 1. The MARs indicated Staff 1 also administered Tramadol (an opioid, controlled substance used to relieve moderate to severe pain), and other controlled substances to six different residents during this time. During a review of the facility's policy and procedure (P&P) titled, Administering Medications, revised 4/2019, the P&P indicated Only persons licensed or permitted by this state to prepare, administer and document the administration of medications may do so. During a review of the facility's P&P titled, Controlled Substances, revised 11/2022, the P&P indicated the facility would comply with all laws and regulations relating to handling and documentation of controlled medications. The P&P</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>Based on interview and record review, the facility failed to ensure services were administered effectively and efficiently, as the facility Administrator did not confirm the credentialing process was completed prior to hiring one of five sampled staff (Staff 1), who worked in the facility as a Licensed Vocational Nurse (LVN) for over a year and a half without a nursing license. This deficient practice resulted in the hiring of unlicensed Staff 1 who was permitted to function as a LVN and placed all residents at risk for unsafe and inappropriate care. Findings: During a review of the Medication Administration Records (MAR) dated 6/1/2025 through 8/15/2025, the MAR indicated Resident 1, who had diagnoses including right ankle and foot osteomyelitis (an infection in the bone), received Norco 5-325 mg (a controlled substance used to relieve moderate to severe pain) on seven separate occasions administered by Staff 1. Further review of the MAR indicated Staff 1 also administered Tramadol (an opioid, controlled substance used to relieve moderate to severe pain), and Oxycodone (an opioid, controlled substance used to relieve severe pain, by prescription only with a high potential for addiction, abuse and misuse) to six different residents during this time. During a concurrent interview and record review on 8/18/2025 at 10:45 a.m., with Director of Staff Development (DSD), Staff 1's personnel file was reviewed. The personnel file indicated Staff 1 was hired to work in the facility as a LVN on 1/8/2024, and did not have proper documentation of a valid professional LVN license. The DSD stated Staff 1's personnel file contained a California Identification Card (ID) and Social Security (SS) card but did not contain evidence of a valid LVN license verification through the California Board of Vocational Nursing and Psychiatric Technicians (BVNPT) system. The DSD stated she did not conduct a license verification for Staff 1 upon hire on 1/8/2024. Upon request, the DSD conducted a license verification on 8/18/2025, through the California BVNPT system and the search revealed no record of an LVN license for Staff 1. The DSD stated the facility hired unlicensed staff to work with the residents. The DSD stated that by allowing unlicensed Staff 1 to function as a LVN, all residents were placed at risk for unsafe care and harm. During an interview on 8/18/2025 at 1:45 p.m., the Director of Nursing (DON) stated that on 8/13/2025, it was brought to her attention that Staff 1 had been working in the facility as an LVN without a professional LVN license. The DON stated this posed a significant risk, including improper medication administration, inaccurate documentation, and the potential for residents to receive unnecessary or inappropriate medications. The DON stated by hiring unlicensed staff to function as an LVN without proper credentials or clinical competency created significant risks, including medication errors and improper treatments, which placed residents at risk for infection and misrepresented residents' condition, leading to unsafe care and adverse outcomes. During a review of the facility's policy and procedure (P&P) titled, Licensure, certification, and Registration of Personnel, revised 4/2007, the P&P indicated the facility would conduct employment background screening and license verification and should the background reveal that the employee / applicant did not hold a current valid license, the employee would not be employed. During an interview on 8/19/2025 at 1:18 p.m., the Administrator (ADM) stated the facility should have followed the P&P but did not. The ADM stated Staff 1 should not have been hired without license verification and that not following the policy, the facility ended up hiring Staff 1 who was unlicensed and unqualified, and this placed all residents at high risk of harm. During a review of the facility's Job Description- Administrator, dated 2023, the Job Description indicated the ADM was responsible for ensuring the credentialing process was completed for all licensed staff providing services in the facility.</p>		

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<p>F 0839</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Employ staff that are licensed, certified, or registered in accordance with state laws.</p> <p>Based on interview and record review, the facility failed to ensure Staff 1 met the qualifications of a Licensed Vocational Nurse (LVN, an entry level healthcare provider who must complete a state approved educational program and pass a licensing exam to practice) to provide administration of narcotic medications (controlled substance used to relieve severe pain, by prescription only with a high potential for addiction, abuse and misuse) to the residents. Staff 1 was working in the facility as a LVN, since the hire date of 1/8/2024, without a professional LVN license. This deficient practice caused an increased risk for medication errors, unsafe care, adverse outcomes, and potential death to the residents. Findings: During a review of the Medication Administration Records (MAR) dated 6/1/2025 through 8/15/2025, the MAR indicated Resident 1, with diagnoses including right ankle and foot osteomyelitis (an infection in the bone) received Norco 5-325 mg (a controlled substance used to relieve moderate to severe pain) on seven separate occasions administered by Staff 1 and Resident 2, with diagnoses including pelvis (bony structure inside hips) fracture (a break in a bone) and lumbar vertebra (bone in the lower back) fracture, received Oxycodone (an opioid, controlled substance used to relieve severe pain, by prescription only with a high potential for addiction, abuse and misuse) 10 mg on 31 separate occasions administered by Staff 1. Further review of the MARs dated 6/1/2025 through 8/15/2025 indicated Resident 3, who was diagnosed with left femur (thigh bone) fracture, received Percocet 5-325 mg (a narcotic, controlled substance medication used to treat moderate to severe pain) on 34 different occasions administered by Staff 1. The MARs indicated Resident 4, who was diagnosed with paraplegia (loss of movement and/or sensation, to some degree, of the legs), and back pain, received Norco tablet 5-325 mg, on 33 separate occasions administered by Staff 1. The MARs indicated Staff 1 also administered Tramadol (an opioid, controlled substance used to relieve moderate to severe pain), and other controlled substances to six different residents during this time. During a concurrent interview and record review on 8/18/2025 at 10:45 a.m., with Director of Staff Development (DSD), Staff 1's personnel file was reviewed. The personnel file indicated Staff 1 was hired to work in the facility as a Licensed Vocational Nurse (LVN, an entry level healthcare provider who must complete a state approved educational program and pass a licensing exam to practice) on 1/8/2024, and did not have proper documentation of a valid professional LVN license. The DSD stated Staff 1's personnel file contained a California Identification Card (ID) and Social Security (SS) card but did not contain evidence of a valid LVN license verification through the California Board of Vocational Nursing and Psychiatric Technicians (BVNPT) system. The DSD stated Staff 1's employee file contained a copy of a LVN license of an unidentified individual which did not match Staff 1's ID and SS card. The DSD stated the facility hired Staff 1 by using the unidentified individual's professional LVN license. The DSD stated by allowing unlicensed Staff 1 to function as an LVN for over a year and a half placed all residents at risk of unsafe care and potential harm. During a concurrent interview and record review on 8/19/2025 at 1:18 p.m., with the Administrator (ADM), the facility's policy and procedure (P&P) titled, Licensure, Certification, and Registration of Personnel, revised 4/2007 was reviewed. The P&P indicated the facility would conduct employment background screening and license verification, and should the background reveal that the employee / applicant did not hold a current valid license, the employee would not be employed. The ADM stated the facility should have followed the P&P but did not. The ADM stated Staff 1 should not have been hired without license verification. The ADM stated not following the policy, the facility ended up hiring Staff 1 who was unlicensed and unqualified, and this placed all residents at high risk of harm.</p>		