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	12/12/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (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
	056023	A. Building B. Wing	12/12/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents received timely incontinence care (providing support, management, and treatment for people who can't control their bladder or bowel) for three of four sampled residents (Residents 1, 2, and 4).This deficient practice had the potential to negatively affect Resident 1, 2, and 4's comfort, dignity, and safety, and had the potential to lead to pressure-related skin injuries (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence). Findings: 1. During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was initially admitted to the facility on [DATE]. Resident 1's diagnoses included muscle weakness, ESRD (End Stage Renal Disease- irreversible kidney failure), abnormalities of gait and mobility, cataracts (cloudy area in the lens of the eye that leads to a decrease in vision of the eye), and hypertension (high blood pressure). During a review of Resident 1's Minimum Data Set ([MDS], a resident assessment tool), dated 9/28/2025, the MDS indicated Resident 1's cognitive skills (ability to think and reason) for daily decision making were moderately impaired. The MDS indicated Resident 1 was entirely dependent on staff for toileting hygiene and sitting to standing. The MDS indicated Resident 1 required substantial or maximal assistance (helper does more than half the effort) for bed mobility, performing a bed-to-chair and toileting transfer, lower body dressing, and showering. During a review of Resident 1's History and Physical (H&P), dated 9/18/2025, the H&P indicated Resident 1 had fluctuating capacity to understand and make decisions. During a review of Resident 1's Braden Scale for Predicting Pressure Sore Risk, dated 11/6/2025, the Braden Scale indicated Resident 1's was at risk for the development of a pressure sores (pressure ulcer-localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence). During a review of Resident 1's At Risk for Falls Care plan, dated 9/18/2025, the Care Plan indicated Resident 1 was at risk for falls due to issues with balance, transfers, bowel and bladder incontinence, and generalized weakness. The Care Plan indicated Resident 1 required a prompt response to all requests for assistance. The Care Plan interventions were to anticipate and meet Resident 1's needs and reinforce the use of the call light. During an interview on 12/11/2025 at 9:00 a.m. with Resident 1, in Resident 1's room, Resident 1 stated, They [facility staff] treat these patients like animals. They stick you in the bed, put the cover over you, walk out the room, and never come back. Resident 1 stated he recently had an encounter with a rude male certified nursing assistant (CNA) that ignored his request to be cleaned after he had a bowel movement while he sat in his wheelchair around 4:00 p.m. Resident 1 stated the male CNA answered his call light, looked me and left. Resident 1 stated he was left to sit on his bowel movement from 4:30 p.m. through 10:30 p.m. Resident 1 stated, It was a ghost town out there and had to repeatedly call for help after his call light was left unanswered for hours. Resident 1 stated his legs started to hurt, so he attempted to transfer himself from his wheelchair to his bed and got stuck in between the wheelchair and the bed in the process. Resident 1 stated, around 10:30 p.m. the male CNA finally came back and cleaned him. During an interview on 12/11/2025 at 2:27 p.m. with CNA 1, CNA 1 stated he was Resident 1's assigned nurse during the 3 p.m. to 11 p.m. shift on 12/8/2025. CNA 1 stated when he entered Resident 1's room at approximately 4:00 p.m., Resident 1 was sitting on his wheelchair and immediately refused care from him, telling him to get the f*ck out of [his] room. CNA 1 stated he informed the charge nurse of the refusal, and the charge nurse instructed him to find another CNA to switch assignments. CNA 1 stated he attempted to locate another CNA to assume care for Resident 1 but was unsuccessful. CNA 1 stated he did not inform the charge nurse that CNA 1 was unable to secure an alternative CNA assignment. CNA 1 stated he assumed Resident 1 would eventually agree to receive care and did not pursue further intervention. CNA 1 stated he ultimately provided incontinence care to Resident 1 at approximately 10:30 p.m., prior to the end of his shift. CNA 1 stated that upon providing care, Resident 1 had a large amount of bowel movement which appeared dried and crusted, which may have indicated Resident 1 was soiled for an extended amount of time. CNA 1 stated he should have informed the charge nurse when he was unable to arrange alternative coverage so that another solution could have been implemented to ensure Resident 1's needs were met in a timely manner. CNA 1 stated Resident 1 had the right to refuse care from CNA 1 and request reassignment. CNA 1 stated due to the lack of communication with his charge nurse, an alternative work assignment was not arranged. CNA 1 stated this delay resulted in Resident 1 sitting on a soiled incontinence pad for an extended amount of time, from approximately 4:30 p.m. through 10:30 p.m. During an interview on 12/12/2025 at 1:51 p.m. with the

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	12/12/2025

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 develop a comprehensive care plan in a timely manner for one of three residents (Resident 2) who was at risk for skin breakdown. This deficient practice had the potential for the resident to not receive appropriate care and treatment and to develop or have worsening skin issues. Findings:During a review of Resident 2's admission Record (Face sheet), the admission record indicated the facility admitted the resident on 11/18/2025 with diagnoses including right hemiplegia (the loss of ability to move the arm, leg, and trunk on the same side of the body), hemiparesis (weakness on one side of the body, affecting the arm, leg, or face), and muscle weakness.During a review of Resident 2's History and Physical (H&P) dated 11/19/2025, the H&P indicated the resident was alert, oriented, but had fluctuating capacity to understand and make decisions.During a review of Resident 2's MDS Minimum Data Set (MDS - a resident assessment tool) dated 11/24/2025, indicated Resident 99's cognitive function was intact (alert, oriented and able to recall information). During a review of Resident 2's Braden Scale dated 11/18/2025, with a score of 15 (scoring of 15-18) indicating resident was at risk for skin breakdown. During a record review with Record Review of Resident 2's Care Plan Report, initiated on 12/11/2025, the Care Plan Report indicated the Resident 2 had the potential for skin breakdown related due to bowel and bladder incontinence requiring repositioning assistance. During an interview and record review on 12/5/2025 at 1:10 p.m. with Registered Nurse (RN) 1, RN 1 stated interventions to prevent skin breakdown included repositioning every two hours, providing proper nutrition, performing daily wound care, maintaining residents' dryness and cleanliness, and conducting frequent rounds. RN 1 stated the care plan should be completed upon admission and updated with any changes in residents' conditions, and if a resident was identified as at risk on the Braden Scale (a tool for assessing skin breakdown risk), a new assessment and care plan should be created immediately following the Braden Scale assessment. RN 1 stated Resident 2 was admitted on [DATE] and identified as at risk for skin breakdown, but the care plan for skin breakdown was initiated on 12/11/2025, one month later. RN 1 stated the care plan for Resident 2's risk of skin breakdown was important to establish preventative measures, interventions, and goals. RN 1 stated because Resident 2's care plan was initiated a month later, necessary preventions were not monitored, and tracking the start or progress of interventions and goals was not possible. During a review of the facility's Policy and Procedure (P&P), titled, Care Plans, Comprehensive Person-Centered, revised December 2016, the P&P indicated 12. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required comprehensive assessment.

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	12/12/2025

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on interview and record review, the facility failed to update care plan for one of three sampled residents (Resident 3) to include the resident's noncompliance with non-weight bearing on right foot due to diabetic ulcer (an open wound due to nerve damage and poor circulation) of the right heel.This deficient practice had the potential to place the resident at risk for complications including delayed wound healing and infection. Findings:During a review of Resident 3's admission Record (Face sheet), the admission Record indicated the facility admitted the resident on 10/2/2025 with diagnoses including osteomyelitis (inflammation of bone or bone marrow, usually due to infection), type-2 diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing) and hypertension (HTN- high blood pressure). During a review of Resident 3's Minimum Data Set (MDS- a resident assessment tool), dated 10/8/2025, the MDS indicated Resident 3 had moderately impaired cognition (ability to think and understand). The MDS indicated Resident 3 required maximal assistance from staff for toileting, bathing and dressing and required supervision for eating. The MDS indicated Resident 3 had diabetic foot ulcers.During a review of Resident 3's Non-Pressure Injury Skin Problem Report [document completed by treatment nurse (nurse providing specialized nursing care such as wound care) includes assessment, measurements and treatments of skin breakdown not caused by direct pressure], dated 11/14/2025, indicated Resident (was) advised non-weight bearing and continues to be seen several times walking on her feet.During a concurrent interview and record review on 12/12/2025 at 11:32 a.m. with the Treatment Nurse (TXN) 1, Resident 3's Skin/Wound Note, dated 11/19/2025 was reviewed. Resident 3's Skin/Wound Note indicated, Resident 3 seen transferring self-bearing weight on both legs despite wound care specialist recommendations of non-weight bearing. TXN 1 stated she wrote a Skin/Wound Note after observing Resident 3 walk despite education from TXN 1 and Wound Care Specialist regarding importance of non-weight bearing status. Resident 3's Care Plan, dated 10/3/2025, indicated Resident 3 has diabetic ulcer of the right heel related to diabetes. TXN 1 stated Resident 3's care plan did not have any revisions to include Resident 3's noncompliance with non-weight bearing order. TXN 1 stated there should be interventions that addressed Resident 3's noncompliance and failure to update care plans places the resident at risk for complications such as delayed wound healing and infection.During a concurrent interview and record review on 12/12/2025 at 1:49 p.m. with Registered Nurse (RN) 1, Resident 3's Care Plan Report titled The resident has diabetic ulcer of the right heel related to Diabetes dated 10/3/2025 was reviewed. RN 1 stated Resident 3's care plan did not have any revisions to include Resident 3's noncompliance with non-weight bearing order. RN 1 stated care plans should be revised any time the residents' conditions change, and facility should implement interventions to address these changes. RN 1 stated all licensed nurses involved in residents care were responsible for revising care plans. RN 1 stated failure to update Resident 3's care plan to include interventions to address noncompliance can place the resident at risk for complications such as delayed wound healing and infection. During a concurrent interview and record review on 12/12/2025 at 3:33 p.m. with the Director of Nursing (DON), Resident 3's Care Plan dated 10/3/2025 was reviewed. The DON stated Resident 3's care plan did not have any revisions to include Resident 3's noncompliance with non-weight bearing order. The DON stated updating care plans for behaviors such as noncompliance was important to ensure care team was aware of residents' behaviors and to implement interventions to address noncompliance. The DON stated failure to update Resident 3's care plan can result in complications such as delayed wound healing and infection.During a review of facility's policy and procedure (P&P), titled Care Plans, Comprehensive Person-Centered dated 12/2016, indicated, Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' conditions change.

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	12/12/2025

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on interview and record review, the facility failed to ensure an order for non-weight bearing for the right foot was transcribed from a doctor's order for one of three sampled residents (Resident 3) into Resident 3's electronic health record . This deficient practice placed Resident 3 at risk of non-weight bearing order not being followed and delayed wound healing. Findings:During a review of Resident 3's admission Record (Face sheet), the admission Record indicated the facility admitted the resident on 10/2/2025 with diagnoses including osteomyelitis (inflammation of bone or bone marrow, usually due to infection), type-2 diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing) and hypertension (HTN- high blood pressure). During a review of Resident 3's Minimum Data Set (MDS- a resident assessment tool), dated 10/8/2025, the MDS indicated Resident 3 had moderately impaired cognition (ability to think and understand). The MDS indicated Resident 3 required maximal assistance from staff for toileting, bathing and dressing and required supervision for eating. The MDS indicated Resident 3 had diabetic foot ulcers (an open wound that develops in people with diabetes due to nerve damage and poor circulation) and required application of wound dressings to feet. During a concurrent interview and record review on 12/12/2025 at 4:04 p.m. with Registered Nurse (RN) 1, Resident 3's Wound Care Specialist visit note dated 11/7/2025 was reviewed. The Wound Care Specialist visit note indicated Resident 3 had right heel diabetic and surgical wound and order for non-weight bearing on the right foot. RN 1 stated the wound doctor provides the treatment nurse (nurse providing specialized nursing care such as wound care) with a paper and verbally communicates new orders after each wound care visit, and the treatment nurse is responsible for placing wound doctor's orders. During a review of Resident 3's orders, RN 1 stated there were no orders indicating Resident 3 was non-weight bearing on the right foot. RN 1 stated failure to ensure non-weight bearing order was transcribed had the potential to result in non-weight bearing order not being followed and complications including impaired wound healing, injury and infection.During a concurrent interview and record review on 12/12/2025 at 3:33 p.m. with the Director of Nursing (DON), Resident 3's Wound Care Specialist visit note dated 11/7/2025 was reviewed. The DON stated the Wound Care Specialist visit note indicated an order of non-weight bearing on the right foot. The DON stated there were no orders indicating Resident 3 was non-weight bearing on the right foot. The DON stated Medical Records and Quality Assurance (QA) nurse also reads the wound doctor's notes after each wound care visit and was responsible for notifying the RN or DON of new orders needing to be placed. The DON stated failure to ensure non-weight bearing order was transcribed placed the resident at risk of non-weight bearing order not being followed and impaired wound healing. During a review of the facility's policy and procedure (P&P) titled Verbal Orders dated 2/2014, the P&P indicated, Verbal orders are those given by an authorized practitioner directly to a person authorized to receive and transcribe orders on his or her behalf .

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	12/12/2025

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 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. (continued on next page)

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	12/12/2025

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 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a licensed nurse notified the physician and received clarification of orders of a scheduled medication for one of four sampled residents (Resident 1). This deficient practice led to an unapproved alteration of Resident 1's ordered medication regimen and had the potential to result in untreated pain caused by muscle spasms. Cross reference F842.Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was initially admitted to the facility on [DATE]. Resident 1's diagnoses included muscle weakness, ESRD (End Stage Renal Disease-irreversible kidney failure), abnormalities of gait and mobility, cataracts (cloudy area in the lens of the eye that leads to a decrease in vision of the eye), and hypertension (high blood pressure). During a review of Resident 1's Minimum Data Set ([MDS], a resident assessment tool), dated 9/28/2025, the MDS indicated Resident 1's cognitive skills (ability to think and reason) for daily decision making were moderately impaired. The MDS indicated Resident 1 was entirely dependent on staff for toileting hygiene and sitting to standing. The MDS indicated Resident 1 required substantial or maximal assistance (helper does more than half the effort) for bed mobility, performing a bed-to-chair and toileting transfer, lower body dressing, and showering. During a review of Resident 1's History and Physical (H&P), dated 9/18/2025, the H&P indicated Resident 1 had fluctuating capacity to understand and make decisions. During a review of Resident 1's Order Summary Report, dated 12/12/2025, the Order Summary Report indicated the following:1. Midodrine hydrochloride (HCL) oral tablet (a medication used to treat low blood pressure) 10 milligrams (mg - a unit of measurement) give one tablet by mouth every six hours for hypotension (low blood pressure). Hold for a systolic blood pressure (SBP - the top number in a blood pressure reading, indicated the amount of pressure on the blood vessels) greater than 110.2. Methocarbamol oral tablet 1000 mg one tablet by mouth every eight hours for muscle spasms (sudden, painful, involuntary tightening of a muscle).3. Norco tablet (Hydrocodone-Acetaminophen, a medication used to treat pain) 5-325 mg one tablet every six hours as needed for severe pain. During a concurrent interview and record review on 12/11/2025 at 8:42 a.m. with Licensed Vocational Nurse (LVN) 4, Resident 1's Medication Administration Record (MAR) and Nursing Progress Notes, dated 12/2025, were reviewed. The MAR indicated Resident 1's 6 a.m. dose of methocarbamol was held on 12/10/2025. The MAR also indicated Resident 1 was administered a Norco tablet 5-325 mg (Hydrocodone-Acetaminophen) at 5:37 a.m. on 12/11/2025. The MAR and the Nursing Progress Notes indicated no reason for holding Resident 1's dose of methocarbamol. LVN 4 stated the normal process for holding a medication included documenting the reason the medication was held. During an interview on 12/11/2025 at 3:02 p.m. with LVN 3, LVN 3 stated LVN 3 was Resident 1's nurse on the 11 p. m. to 7 a.m. shift on 12/9/2025 to 12/10/2025. LVN 3 stated he held Resident 1's 6 a.m. dose of methocarbamol on 12/10/2025 because LVN 3 administered one tablet of Norco Tablet 5-325 mg (Hydrocodone- Acetaminophen [a pain medication]) during that same time frame (6 a.m.). LVN 3 stated he believed muscle relaxants should not be administered concurrently with narcotics (substances used to treat moderate to severe pain) due to the risk of respiratory compromise. LVN 3 stated he should have notified the physician and obtained a clarifying order to hold methocarbamol. During an interview with the Director of Nursing (DON) on 12/12/2025 at 1:51 p.m., the DON stated when muscle relaxants were co-administered with narcotics, the licensed nurses were expected to assess the resident and administer the medications as ordered if deemed safe, unless the physician's order specified otherwise. The DON stated if LVN 3 determined it was necessary to hold a medication, LVN 3 was required to notify the physician and obtain an order to clarify the administration of the medications. The DON stated that holding a scheduled medication without provider notification and order clarification did not meet facility expectations. The DON stated this led to the holding of a medication without a physician's order and placed Resident 1 at risk for continued pain related to untreated muscles spasms. During a review of the facility's Policy and Procedure (P&P) titled, Administering Medications, revised 12/2012, the P&P indicated medications would be administered in a safe and timely manner, and as prescribed. The P&P indicated if a dosage was believed to be inappropriate or excessive for a resident, or a medication has been identified as having potential adverse consequences for the resident or is suspected of being associated with adverse consequences, the person preparing or administering the medication should contact the resident's Attending Physician or the facility's Medical Director to discuss the concerns. During a review of the facility's P&P titled, Physician Services, revised

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	12/12/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

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	12/12/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure accurate and reliable medication administration documentation when the following occurred for one of four sampled residents (Resident 1):1. Licensed nurses failed to accurately document the medication administration of Resident 1's ordered doses of midodrine (a medication used to treat low blood pressure) in December 2025.2. Licensed Vocational Nurse (LVN) 3 failed to ensure Resident 1's blood pressure was documented accurately on 12/10/2025.3. LVN 3 failed to document the reason why Resident 1's methocarbamol (a muscle relaxant medication) was held on 12/11/2025. These deficiencies resulted in inaccurate medication administration documentation, which had the potential to place Resident 1 at risk for inappropriate medication administration, untreated conditions, and adverse medication effects.Findings: 1a. During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was initially admitted to the facility on [DATE]. Resident 1's diagnoses included muscle weakness, ESRD (End Stage Renal Disease-irreversible kidney failure), abnormalities of gait and mobility, cataracts (cloudy area in the lens of the eye that leads to a decrease in vision of the eye), and hypertension (high blood pressure). During a review of Resident 1's Minimum Data Set ([MDS], a resident assessment tool), dated 9/28/2025, the MDS indicated Resident 1's cognitive skills (ability to think and reason) for daily decision making were moderately impaired. The MDS indicated Resident 1 was entirely dependent on staff for toileting hygiene and sitting to standing. The MDS indicated Resident 1 required substantial or maximal assistance (helper does more than half the effort) for bed mobility, performing a bed-to-chair and toileting transfer, lower body dressing, and showering. During a review of Resident 1's History and Physical (H&P), dated 9/18/2025, the H&P indicated Resident 1 had fluctuating capacity to understand and make decisions. During a review of Resident 1's Order Summary Report, dated 12/12/2025, the Order Summary Report indicated the following:1. Midodrine hydrochloride (HCL) oral tablet (a medication used to treat low blood pressure) 10 milligrams (mg - a unit of measurement) give one tablet by mouth every six hours for hypotension (low blood pressure) and to hold for a systolic blood pressure (SBP - the top number in a blood pressure reading, indicated the amount of pressure on the blood vessels) greater than 110.2. Methocarbamol oral tablet 1000 mg one tablet by mouth every eight hours for muscle spasms (sudden, painful, involuntary tightening of a muscle).3. Norco tablet (Hydrocodone-Acetaminophen, a medication used to treat pain) 5-325 mg one tablet every six hours as needed for severe pain. During a review of Resident 1's Medication Administration Record (MAR), dated 12/2025, the MAR indicated Resident 1 was administered midodrine oral tablet 10 mg five times on the following dates and times for the corresponding blood pressures (normal blood pressure: systolic number less than 120 millimeters of mercury [mm Hg- a unit to measure blood pressure] and a diastolic number [pressure during the resting phase between heartbeats] less than 80 mm Hg):1. 12/4/2025 at 12:00 a.m. for a blood pressure of 122/57 mm Hg. 2. 12/4/2025 at 12:00 p.m. for a blood pressure of 123/68 mm Hg.3. 12/6/2025 at 6:00 p.m. for a blood pressure of 129/78 mm Hg.4. 12/8/2025 at 12:00 p.m. for a blood pressure of 112/70 mm Hg.5. 12/10/2025 6:00 a.m. for a blood pressure of 116/78 mm Hg. During a concurrent interview and record review on 12/11/2025 at 9:52 a.m. with Registered Nurse (RN) 2, Resident 1's MAR, dated 12/2025, was reviewed. RN 2 stated Resident 1's order for midodrine was not administered per the physician's ordered parameters five times in the month of December 2025. RN 2 stated this placed Resident 1 at risk for increased blood pressure and cardiovascular issues. During a concurrent interview and record review on 12/11/2025 at 11:29 a.m. with Treatment Nurse (TXN) 1, Resident 1's MAR, dated 12/2025, was reviewed. TXN 1 stated she was Resident 1's assigned nurse during the 7:00 a.m. to 3:00 p.m. shift on 12/4/2025. TXN 1 stated, on 12/4/2025, she held Resident 1's dose of midodrine but accidentally documented it as administered. TXN 1 stated she documented in error because she recalled feeling overwhelmed during the shift due to being assigned medication administration on short notice. TXN 1 stated inaccurate medication administration documentation had the potential to lead to medication errors, documentation discrepancies, or double dosing. 1b. During an interview on 12/11/2025 at 3:02 p.m. with Licensed Vocational Nurse (LVN) 3, LVN 3 stated he was Resident 1's assigned nurse on the 11 p.m. through 7 a.m. shift on 12/9/2025. LVN 3 stated he held Resident 1's ordered dose of midodrine but mistakenly documented it as administered. LVN 3 stated he incorrectly documented Resident 1's SBP as 116, and the actual SBP 106. LVN 3 stated it was important to accurately document Resident 1's medication administration and blood pressure as accurately as possible