

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396058	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/31/2025
NAME OF PROVIDER OR SUPPLIER Avalon Springs Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 745 Greenville Road Mercer, PA 16137	
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 - Some	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 review of facility policy and clinical records, and staff interview, it was determined that the facility failed to review and revise comprehensive care plans to reflect the current care and services for three of 17 residents reviewed (Residents R5, R49, and R2). Findings include: Review of facility policy entitled, Care Plans, Comprehensive Person-Centered dated 3/1/25, indicated that a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident; assessments of residents are ongoing and care plans are revised as information about the residents and the residents conditions change. Review of facility policy entitled, Advance Directives dated 3/1/25, indicated that, the resident has a right to formulate an advanced directive, including the right to accept or refuse medical or surgical treatment; the plan of care for each resident is consistent with his or her documented treatment preference and/or advance directive; changes are documented in the care plan and medical record. Resident R5's clinical record revealed an admission date of 2/18/25, with diagnoses that included Heart Failure (a chronic condition in which the heart doesn't pump blood as well as it should), Atrial Fibrillation (A-Fib &ndash; irregular and often rapid heartbeat that can lead to stroke, heart failure, and other complications), and Depression (characterized by persistent feeling of sadness loss of interest in activities once enjoyed). Resident R5's physician's orders dated 9/27/25, revealed an order for DNR / Do Not Attempt Resuscitation (allow natural death). Resident R5's clinical record revealed a Pennsylvania Orders for Life Sustaining Treatment (POLST- a legal document specifying the resident/responsible party choices regarding life-sustaining treatments) dated 6/5/25, that revealed Resident R5 requested Do Not Resuscitate (DNR), Limited Additional Interventions. Resident R5's comprehensive care plan dated 6/4/25 with revision date of 11/5/25, revealed Advance Directive: Full Code (CPR-emergency life-saving procedure that is done when breathing or a heartbeat has stopped and when performed immediately can double or triple chances of survival after cardiac arrest), indicating that the care plan was not reviewed and revised to reflect the current care and services regarding the code status. Resident R49's clinical record revealed an admission date of 7/1/24, with diagnoses that included (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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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	gastro-esophageal reflux disease (GERD - a condition where stomach acid flows back into the esophagus [tube that passes food from the mouth into the stomach]), hypothyroidism (a condition when the thyroid produces low amounts of thyroid hormones), and osteoporosis (a condition where bone strength weakens and is susceptible to breaking). Resident R49's physician's order dated 10/1/25, revealed an order for DNR / Do Not Attempt Resuscitation (allow natural death). Resident R49's clinical record revealed a POLST dated 10/6/25, that revealed Do Not Resuscitate (DNR), Comfort Measures Only. Resident R49's comprehensive care plan dated 8/13/25 with revision date of 10/21/25, revealed Advance Directive: Full Code, indicating that the care plan was not reviewed and revised to reflect the current care and services regarding the code status. During an interview on 12/30/25, at 11:10 a.m. the Director of Nursing (DON) confirmed that the care plans for Residents R5 and Resident R49 were not reviewed and revised to reflect current resident care and services regarding code status. Resident R2's clinical record revealed an admission date of 9/3/25, with diagnoses that included GERD, Diabetes (a health condition caused by the body's inability to produce enough insulin), and High Blood Pressure. Resident R2's clinical record revealed a POLST dated 7/22/25, that revealed DNR / Do Not Attempt Resuscitation (Allow Natural Death), Limited Additional Interventions. Resident R2's physician's order dated 9/16/25, revealed an order for DNR / Do Not Attempt Resuscitation (allow natural death). Resident R2's comprehensive care plan dated 9/5/25, with revision date of 10/1/25, revealed Advance Directive: Full Code. During an interview on 12/30/25, at 2:21 p.m. the DON confirmed that the care plan for Resident R2 was not reviewed and revised to reflect current resident care and services regarding code status. 28 Pa. Code 211.5(f)(i) Medical records 28 Pa. Code 211.10(c)(d) Resident care policies 28 Pa. Code 211.12(d)(1)(5) Nursing services		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records and Minimum Data Set (MDS - federally mandated standardized assessment conducted at specific intervals to plan resident care), and staff interview, it was determined that the facility failed to ensure that MDS assessments accurately reflected the status of two of 17 residents reviewed (Residents R2 and R4). Findings include: MDS instructions for section M Skin Conditions, Subsection M0300 Current number of unhealed pressure ulcers/injuries at each stage indicated For each pressure ulcer, determine the deepest anatomical stage and For each pressure ulcer/injury, determine if the pressure ulcer/injury was present at the time of admission / entry or reentry and not acquired while the resident was in the care of the nursing home. MDS instructions for section N Medications, Subsection N0415 High-Risk Drug Classes: Use and Indication indicated under the column Is Taking to check if the resident is taking any medication by pharmacological classification, not how it is used, during the last 7 days or since admission / entry or reentry if less than 7 days. Resident R2's clinical record revealed an admission date of 9/3/25, with diagnoses that included Gastroesophageal reflux disease (GERD - happens when stomach acid flows back up into the esophagus and causes heartburn), Diabetes (a health condition caused by the body's inability to produce enough insulin), and High Blood Pressure. Resident R2's significant change MDS with an Assessment Reference Date (ARD) of 9/26/25, revealed section M0300 G1 Number of Stage Unstageable - Deep Tissue Injury Pressure Ulcers (purple or [NAME] area of discolored intact skin due to damage of underlying soft tissue) was coded as 2. Section M0300 G2 Number of these unstageable pressure ulcers that were present upon admission / entry or reentry was coded as 0. Resident R2's clinical record revealed progress notes completed by wound care consultants on 9/4/25, 9/11/25, 9/18/25, and 9/25/25 indicating that Resident R2 was admitted with pressure ulcers to his/her right and left heel. During an interview on 12/30/25, at 1:47 p.m. Licensed Practical Nurse Assessment Coordinator (LPNAC) confirmed that Resident R2's 9/26/25, MDS was coded incorrectly and Resident R2's Section M0300 G2 should have been coded as a two. Resident R4's clinical record revealed an admission date of 7/21/25, with diagnoses that included Congestive Heart Failure (CHF - a long-term condition that happens when your heart can't pump blood well enough to give your body a normal supply causing blood and fluids collect in your lungs and legs over time), GERD, and fractured left femur (a break in the thigh bone). Resident R4's quarterly MDS with an ARD of 10/8/25, revealed section N Medications, Subsection N0415 High [NAME] Drug Classes E Anticoagulant (medication used to thin the blood) was coded as currently taking. Resident R4's clinical record revealed a physician's order dated 7/21/25, for Lovenox (anticoagulant medication) 30 milligrams (mg) subcutaneous (sq - injection into the fatty tissue just beneath the skin) daily for 21-days. Review of the October 2025 Medication Administration Record (MAR) revealed no evidence of Resident R4 receiving any anticoagulant during the seven-day look-back period for the 10/8/25 MDS. During an interview on 12/30/25, at 1:39 p.m. the LPNAC confirmed that Resident R4's 10/8/25, MDS was coded incorrectly and Resident R4's Section N0415E should not have been coded as receiving during the last seven days. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 211.5(f)(ix) Medical records		

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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. Based on review of facility policy and clinical records, observations, and staff interview, it was determined that the facility failed to develop a comprehensive care plan for one of 17 residents reviewed (Resident R3). Findings include: Review of facility policy entitled, Care Plans, Comprehensive Person-Centered dated 3/1/25, indicated that a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident; assessments of residents are ongoing and care plans are revised as information about the residents and the residents conditions change. Resident R3's clinical record revealed an admission date of 10/21/25, with diagnoses that included Atrial Fibrillation (A-Fib - irregular and often rapid heartbeat that can lead to stroke, heart failure, and other complications), Diabetes (a health condition caused by the body's inability to produce enough insulin), and Major Depressive Disorder (MDD-characterized by persistent feeling of sadness, loss of interest in activities once enjoyed). Resident R3's clinical record revealed a physician's order dated 10/21/25, for Apixaban (anticoagulant medication used to prevent blood clots) 5 milligrams (mg - metric unit of measure) two times a day; a physician's order dated 10/22/25, for Insulin Glargine (medication used to treat diabetes - a health condition caused by the body's inability to produce enough insulin) 20 units subcutaneously (sq - a short needle is used to inject a drug into the tissue layer between the skin and the muscle) at bedtime for diabetes; a physician's order dated 10/22/25, for Quetiapine Fumarate (an antipsychotic medication used as an adjunctive therapy of major depressive disorder) 25 mg at bedtime for major depressive disorder; a physician's order dated 11/6/25, for Sertraline (medication used to treat depression) 50 mg in the morning for depression. Resident R3's clinical record lacked evidence that a care plan had been developed to address his/her usage of an anticoagulant; diabetes and usage of insulin; and usage and monitoring of an antipsychotic and antidepressant medication. During an interview on 12/30/25, at 11:10 a.m. the Director of Nursing confirmed that a care plan had not been developed to address Resident R3's usage of an anticoagulant; diabetes and usage of insulin; and usage and monitoring of an antipsychotic and antidepressant medication. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 211.12(d)(3)(5) Nursing services		