

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  396075	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/29/2025
NAME OF PROVIDER OR SUPPLIER  Avalon Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  3410 W. Pittsburgh Rd New Castle, PA 16101	

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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 40832</p> <p>Based on review of clinical records and facility documents, and staff interviews, it was determined that the facility failed to follow physician's orders for medication administration for two of six residents reviewed (Residents R1 and R2).</p> <p>Findings include:</p> <p>Resident R1's clinical record revealed an admitted [DATE], with diagnoses that included broken right lower leg, stroke, dementia, and muscle wasting. A departmental progress note dated 4/07/25, revealed that Resident R1 was transported to the hospital for evaluation and treatment of rectal bleeding. Upon return to the facility a physician's order dated 4/07/25, identified to administer Azithromycin (antibiotic) 250 milligrams by mouth daily for four days for treatment of Respiratory Syncytial Virus (RSV- seasonal, highly contagious respiratory virus that often feels like a common cold).</p> <p>Review of Resident R1's April 2025 Medication Administration Record (MAR) revealed that he/she did not start receiving the ordered antibiotic until 4/10/25, (three days late).</p> <p>Resident R2's clinical record revealed an admitted [DATE], with diagnoses that included congestive heart failure (CHF- long-term condition that happens when your heart can't pump blood well enough to give your body a normal supply), kidney disease, heart disease, and respiratory failure.</p> <p>Review of a Complaint/Grievance Form provided by the facility on 4/24/25, and dated 3/31/25, revealed a concern that Resident R2 hadn't received a new medication on 3/28/25, through 3/31/25, (four days).</p> <p>Resident R2's departmental progress note dated 3/27/25, revealed that the facility was made aware that a medication as ordered by an outside provider and that the medication would be sent either tomorrow (3/28/25), or Saturday (3/29/25).</p> <p>Review of Resident R2's April 2025 MAR revealed that he/she did not receive the medication until 4/01/25, (four days late).</p> <p>During an interview on 4/24/25, at 1:20 p.m. the Director of Nursing confirmed that Resident R1 and Resident R2's medications were not administered according to physician's orders and were given late.</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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