STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396075	A. Building B. Wing	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avalon Care Center	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)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41309 Based on review of clinical records, facility policy and documentation, and staff and resident interviews, it was determined that the facility failed to implement sufficient monitoring interventions and supervision to prevent elopement (unauthorized leave from the facility). This failure placed residents at the facility in an Immediate Jeopardy situation for one of one residents reviewed who eloped from the facility (Resident R1). Findings include: Review of the facility policy entitled, Safety and supervision of residents, with a policy review date of 1/20/2025, revealed, Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. Our facility-oriented approach to safety address risks for groups of residents. Safety risks and environmental hazards are identified on an ongoing basis through a combination of employee training, employee monitoring and reporting process. Resident R1's clinical record revealed an admitted [DATE], with diagnoses that included traumatic subdural hemorrhage without loss of consciousness (Bleeding between the brain and its outermost covering), mild cognitive impairment (confusion), chronic obstructive pulmonary disease (a group of lung diseases that block air flow and make it difficult to breathe), type 2 diabetes (condition in which the body has difficulty controlling blood sugar and using it for energy), repeated falls, anxiety, depression, and nicotine dependence. A Minimum Data Set (MDS-a periodic assessment of resident care needs) dated 4/22/2025, identified Resident R1 with a Brief Interview for Mental Status (BIMS-a type of test to determine one's level of cognition) score of 14 and cognitively intact. During an initial interview on 4/29/2025, at 10:45 a.m. the Director of Nursing (DON) and the Nursing Home Administrator (NHA), confirmed that on Friday 4/25/2025 at approximately 7:30 p.m. Resident R1 exited the facility without staff awareness by unlocking the door and leaving the front porch and leaving the facility property. Resident R1 traveled down the street with assistance of a walker. The DON referenced that Resident R1 was alert and oriented and goes out on the front porch sitting area often. He/she was out of cigarettes and therefore left the facility to go to the store and buy a pack of cigarettes. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Upon request, the facility was unable to provide a smoking policy. It was then confirmed by the NHA and DON that the facility is a tobacco free and non-smoking facility. Review of progress notes revealed the following documentation: On 4/19/25, at 11:53 a.m. Activities came and made this nurse aware that she caught resident smoking in the hall by the back door. This nurse went in and made resident aware that he is not allowed to smoke in the facility due to the oxygen and this being a non-smoking facility. Resident verbalized understanding and stated, 'well if you guys would allow me outside to smoke, I'd just have one.' This writer made him aware that upon admission he had to sign a paper agreeing to this being a non-smoking facility. This writer was able to get lighter and cigarettes from resident. They are in med cart. Spouse made aware. She stated 'She will pick them up just don't know when' she was also made aware that this facility is a non-smoking facility and she is to not bring any tobacco products. She apologized and verbalized understanding. Resident is very upset in room, continuing to self-transfer. On 4/23/2025 at 1:10 a.m. Resident out at Nurses station C/o [complains of] not being able to smoke and was told it was facilities rule that it is a non-smoking building. He also stated that on 3-11 shift he had asked for Tylenol and had to wait a half an hour to receive it but refused when it was brought to him because it had taken too long. After explaining the smoking policy to him he said that the topic was not over yet and that he was told this a.m. that he could smoke a cigarette but then the nurse who gave it to him could not find a lighter and the cigarette was taken back from him for this reason. He also said that someone had told him that the administrator was coming to see him but did not show up. When I first informed him of the policy he said he was going to stand in front of it all night. To try and calm him down I offered him a cup of coffee and a CNA [certified nurse aide] got his w/c [wheelchair] from his room so he could have a seat and he sat and just generally conversed about all different things to get his mind off of what he was upset about and after awhile stated 'Well I am not going to take it out on you people just doing your job' and then went to bed. Review of Resident R1's MDS Section E Behaviors dated 4/22/2025, revealed under section E0900 wandering presence and frequency- Has the resident wandered? with response of 0-Behavior not exhibited. An interview was conducted with Resident R1 on 4/29/2025, at 11:25 a.m. Resident R1 was in the lobby sitting in a wheelchair with a pack of cigarettes and a lighter on his lap, waiting to go outside on the front porch. During the interview, Resident R1 identified that he did leave the building on April 25, 2025, at approximately 7:30 p.m. Resident R1 stated that he was out of cigarettes, and needed to smoke, he could not get a cigarette from anybody. He knew where the door button was under the nurse's station desk, he leaned over the desk, pushed the button to open the door and went outside with his walker opened the gate on the front porch and went down the street to find a store to buy cigarettes. He stated that an employee noticed him standing by the side of the road who gave him a ride back to the facility. He stated that the facility lets him outside to smoke and keeps his cigarettes and lighter locked in the medication cart. When he needs a cigarette he asks, they give him his lighter and cigarettes and let him out to smoke on the porch. He stated he knew where the button to unlock the door was because he had seen it done before. Resident R1 stated he had never tried to leave the facility property without somebody knowing before. He stated that the DON did speak with him about not leaving the facility, and safety issues and the facility non-smoking policy. When asked if he would try to leave again, Resident R1 stated, If I need a cigarette I will. I am an adult, they cannot hold me here against my will. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	There was no evidence that Resident R1 had any safety interventions in place regarding smoking habits until after the elopement had occurred on 4/25/2025. There was no evidence that the facility completed a safe smoking assessment to provide safety and prevent injury to Resident R1. Review of progress notes lacked any documentation on 4/25/2025, regarding the elopement until the investigation on 4/29/2025. Review of care plans revealed no updates to care plans regarding elopement risk or smoking safety from the date of the elopement on 4/25/2025, to investigation on 4/29/2025. At the time of investigation on 4/29/2025, there were no elopement prevention interventions in place for Resident R1 An interview with Licensed Practical Nurse (LPN) Employee E1 on 4/29/2025, at 11:35 a.m. revealed that Resident R1's lighter and cigarettes were kept in the medication cart in the locked drawer. When he wants a cigarette, he asks and was given his cigarettes to go out and smoke. A telephone interview on 4/29/2025, at approximately 11:50 a.m. with the Registered Nurse (RN) Supervisor who had been on duty the evening of the elopement on 4/25/2025, revealed that Resident R1 was in the lobby and upset that he had no cigarettes. There was nobody at the desk at the time the resident left due to performing resident care in another area of the facility. It was unknown that Resident R1 left the building and went down the street until they were informed by one of the staff that had left after their shift was done and recognized him standing by the road with his walker. He was then brought back to the facility. An Immediate Jeopardy (IJ) situation was identified to the NHA and DON on 4/29/2025, at 2:03 p.m. and the IJ template was provided to the NHA, related to Resident R1's elopement from the facility and smoking safety. The NHA and DON were made aware that Immediate Jeopardy existed for the facility's failure to ensure implementation of all supervision and safety measures to prevent elopement for residents in the facility and an immediate action plan was requested. On 4/29/2025, at 6:15 p.m. an acceptable immediate action plan was approved which included the following interventions: 1. Resident will have a smoking assessment completed 4/29/2025. Resident will have supervised smoking three times per day until discharged to a smoking facility, or until discharged to his residence. 2. All residents will be assessed for elopement risk by the director of nursing or designee by the end of the day on 4/29/2025. 3. All care plans for residents identified with elopement risks will be reviewed and updated if needed with interventions to prevent elopement by the end of the day on 4/29/2025, by the Director of Nursing or designee. 4. Facility is a non-smoking facility and currently all other residents are compliant. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	5. A facility care feed message will be sent to families reminding them that the facility is a non-smoking facility and resident smoking is prohibited. 6. Education will be completed by all staff on elopement risks, assessments, and supervision of residents by the director of nursing or designee. 7. Education will be provided to all staff on facility smoking policy. Facility is a non-smoking facility for residents. 8. Elopement books with identified resident photos will be placed on all nurses stations in addition to the current one at the receptionist's desk by the Administrator or designee by 4/29/2025 9. A protective device will be placed over the exit door button to prevent residents from access. 10. Audits will be implemented to ensure residents are adhering to the facility smoking policy daily for two weeks, weekly for two weeks, and monthly for two months by the Director of nursing or designee. 11. New admissions will be audited for elopement and smoking risks at morning stand up meeting by the director of nursing or designee to ensure appropriate interventions are in place as needed. 12. An Ad Hoc Quality Assurance and Process Improvement Meeting will be held by the Administrator or designee on 4/29/2025. 13. This part of correction will be monitored at the Quality Assurance and Process Improvement meeting until such time consistent substantial compliance has been met. After review of facility documentation, observations, and staff interviews, the implementation of the above stated action plan was confirmed on 4/30/2025, at 1:44 p.m. and the NHA was informed that the Immediate Jeopardy situation was removed. 28 Pa. Code 201.14(a) Responsibility of Licensee 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 211.10(d) Resident care policies 28 Pa. Code 211.12(d)(5) Nursing Services

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 41309 Based on review of facility records and job descriptions, and staff interviews, it was determined that the Nursing Home Administrator (NHA) and the Director of Nursing (DON) failed to effectively manage the facility to make certain that proper supervision and elopement prevention and safe smoking interventions were effectively implemented in the facility. Findings include: The job description for the NHA revealed that the primary purpose of the job position is to manage the Facility in accordance with current applicable federal, state, and local standards, guidelines, and regulations that govern long-term care facilities. To follow all facility policies and apply them uniformly to all employees. To ensure the highest degree of quality care is provided to our residents at all times. The job description for the DON specified to plan, organize, develop and direct the overall operation of the Nursing Service Department in accordance with current federal, state, and local standards, guidelines, and regulations that govern the facility, and as may be directed by the Administrator and the Medical Director, to ensure that the highest degree of quality care is maintained at all times. Based on the findings in this report that identified the facility failed to consistently supervise and maintain all safety interventions to prevent elopement for their residents, the NHA and the DON failed to fulfill their essential job duties to ensure that the Federal and State guidelines and Regulations were followed. Refer to F689 28 Pa. Code 201.14(a) Responsibility of Licensee 28 Pa. Code 201.18(b)(1)(3) Management 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 211.10(d) Resident care policies 28 Pa. Code 211.12(c) Nursing Services 28 Pa. Code 211.12(d)(1)(5) Nursing Services