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	12/17/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on review of facility policy, clinical records, and staff interview it was determined that the facility failed to implement resident-directed care and treatment consistent with professional standards of practice, for one of six residents reviewed (Resident R1).Findings include: Review of a current facility policy entitled Verbal Orders indicated a verbal order will not be written that is not based on a conversation with the practitioner. Resident R1's clinical record revealed an admission date of 9/23/25, with diagnoses including respiratory failure, pneumonia (viral or bacterial infection of the lung), difficulty swallowing, artificial right knee, and altered mental status. The clinical record also revealed a verbal physician's order dated 10/30/25, and signed by the physician on 10/31/25, for staff member present with resident during meals. Small bites & small sips. Review of Resident R1's hospital discharge orders dated 10/30/25, lacked evidence of orders to include for staff member present with resident during meals, small bites and sips. Review of Resident R1's clinical record indicated that he/she was evaluated and treated by Speech Therapy from 10/31/25, to 11/26/25, There was no evidence of a Speech Therapy recommendation and/or a conversation with the provider prior to the order dated 10/30/25, to have staff member present during meals, small bites and sips. Observation on 12/17/25, at 12:29 p.m. revealed staff placed Resident R1's lunch meal on his/her tray table and left the room, at 12:33 p.m. Resident R1 was observed using a fork to feed himself/herself without difficulty and without a staff member present. Observation and confirmation on 12/17/25, at 12:43 p.m. with the Director of Nursing (DON) confirmed that Resident R1 was sitting up in bed feeding himself/herself alone. During an interview on 12/17/25, at 2:30 p.m. the DON confirmed that Resident R1's order for staff member present with resident during meals, small bites and sips was not based on Speech Therapy recommendations, and that there was no evidence that staff consulted the medical provider prior to writing the verbal order, and that the order was entered in the clinical record in error. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1)(3) Management 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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