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	05/08/2026

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 - Actual harm 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** Based on review of facility policy, clinical records, facility incident reports, facility documents, and staff interviews, it was determined that the facility failed to provide necessary precautionary measures to maintain resident safety and prevent injury during transport in a wheelchair resulting in harm of a fractured orbital bone (a bony cavity in the skull that houses and protects the eyeball) for one resident reviewed (Resident R1). Findings include: Review of facility policy entitled Abuse and Neglect dated 4/16/26, revealed Neglect.means the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. Review of the clinical record revealed that Resident R1 was admitted to the facility on [DATE], with diagnoses that included abnormalities of gait and mobility, weakness, difficulty in walking, hypertension (high blood pressure), dysphagia (difficulty swallowing), and lack in coordination. Review of the clinical record revealed that Resident R1 had a BIMS (brief interview for mental status) score of seven. The BIMS tool is used to assess cognitive function; a score of seven indicates a severe impairment. Nursing progress notes revealed that on 4/12/26, at 4:08 p.m. Resident R1's family member was pushing him/her outside in his/her wheelchair and staff educated at that time in relation to the importance of utilizing leg rests to prevent injury. Review of information dated 4/16/26, submitted by the facility to the Department of Health, revealed the following: Resident R1 was being pushed to the dining room, leaned forward, fell out of wheelchair and hit his/her head. sent to emergency department.occipital fracture . plan for therapy to add wheelchair leg rests at all times. Review of the initial facility incident report dated 4/16/26, revealed a staff description that Resident was being pushed up the ramp in a wheelchair when the resident fell face forward out of the wheelchair. Review of a facility document entitled NAs (Nursing Assistants) and Therapy Orientation Information indicated that equipment should be checked for safety and accuracy, i.e. leg rests in place. Review of facility orientation documents upon hire for NA Employee E1 revealed he/she received training related to safe transfers on the NA job competency orientation checklist 1/26/26, abuse/neglect 1/27/26, and acknowledgement to CNA duties on 1/27/26. Interview with the Registered Nurse Supervisor Employee E2 on 5/6/26, at 10:45 a.m. revealed that no matter what staff should always utilize leg rests during all transports when a resident utilizes a wheelchair. Interview conducted on 5/6/26, at 10:55 a.m. with the Director of Therapy revealed that it is the standard at the facility to utilize leg rests during all transport when a resident utilizes a wheelchair, and that staff are educated upon hire and throughout the year. Interview conducted on 5/6/26, at 12:01 p.m. with NA Employee E1, the staff member involved in the incident, revealed that Resident R1 had his/her leg rests on his/her wheelchair and that [the resident] was putting his/her right foot under the leg rests. Therefore, NA Employee E1 removed the leg rests and proceeded to push Resident R1 up the ramp to the dining area, when Resident R1 suddenly stiffened and fell forward out of the wheelchair. During an interview with the Director of Nursing (DON) on 5/6/26, at 2:29 p.m. he/she confirmed that during the transport on 4/16/26, Resident R1's wheelchair leg rests were not in place, causing Resident R1 to fall from his/her wheelchair and sustaining harm of a (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
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F 0689 Level of Harm - Actual harm Residents Affected - Few	fractured orbital bone. The DON also confirmed that leg rests should always be in place when transporting a resident in a wheelchair. 28 Pa. Code 211.12 (d)(3)(5) Nursing services 28 Pa. Code 211.10 (c) Resident care policies