

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 06/26/2025
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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>Based on review of facility policy and clinical records, observations, and interviews with residents, family members, and staff, it was determined that the facility failed to maintain a sanitary, orderly, and comfortable interior/homelike environment for two of 22 residents observed (Residents R9 and R32).</p> <p>Findings include:</p> <p>A facility policy entitled, Homelike Environment dated 1/20/25, revealed Residents are to be provided with a safe, clean, and comfortable environment and encouraged to use their personal belongings to the extent as possible.</p> <p>Resident R9's clinical record revealed an admission date of 11/04/24, with diagnoses that included fracture of left femur (large bone above the knee), post cholecystectomy syndrome (abdominal symptoms that persist after having the gallbladder removed), high blood pressure, and atrial fibrillation (an irregular, often rapid heart rate that causes poor blood flow).</p> <p>Resident R32's clinical record revealed an admission date of 4/20/25, with diagnoses that included cerebral infarction (when blood flow is interrupted and blocked in the brain causing tissue to die), high blood pressure, chronic obstructive pulmonary disease (a group of conditions that block airflow and make it difficult to breathe), and diabetes mellitus (a group of diseases that result in too much sugar in the blood).</p> <p>Observations on 6/23/25, at 4:15 p.m. of Resident R9's and R32's room revealed broken closet doors for both residents, peeled and chipped paint behind Resident R9's bed and chair, and an exposed soiled toilet plunger in their shared bathroom that was resting on a clear wet bag with a brown substance on bottom of plunger and bag.</p> <p>Interviews with Resident R9 and his/her family member, and Resident R32 on 6/23/25, at 4:15 p.m. revealed the closet doors have been broken for quite some time, the peeled-chipped paint has been a concern since Resident R9 was admitted, and the toilet plunger in the shared bathroom has always been there uncovered and exposed, due to the toilet has concerns with being plugged often.</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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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview on 6/24/25, at 3:00 p.m. with the Infection Control Nurse confirmed that Resident R9 and R32's closet doors were broken, the wall behind Resident R9's bed and chair was observed with peeled and chipped paint, and an exposed unsanitary toilet plunger was in Resident R9 and R32's shared bathroom. The Infection Control Nurse further confirmed that the facility failed to provide a sanitary and homelike environment for Residents R9 and R32.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 201.18 (b)(1)(3) Management</p>		

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<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.</p> <p>Based on review of facility policy and clinical records, and staff interview, it was determined that the facility failed to ensure that the necessary resident information was communicated to the receiving health care provider for two of three residents reviewed with facility-initiated transfers (Resident R12 and Closed Record Resident CR75).</p> <p>Findings include:</p> <p>A facility policy entitled Transfer or Discharge, Emergency dated 1/20/25, revealed should it become necessary to make an emergency transfer or discharge to a hospital or other related institution, our facility will implement the following procedures. Prepare a transfer form to send with the resident.</p> <p>Resident R12's clinical record revealed an admission date of 6/23/21, with diagnoses that included high blood pressure, diabetes (a health condition caused by the body's inability to produce enough insulin), and dementia (loss of cognitive functioning affecting a persons memory and behaviors). Resident R12 was transferred to the hospital on 2/6/25.</p> <p>Resident CR75's clinical record revealed an admission date of 3/19/25, with diagnoses that included muscle wasting and atrophy (wasting away of muscle tissue), muscle weakness, dysphagia (difficulty swallowing), and difficulty walking. Resident CR75 was transferred to the hospital on 3/25/25.</p> <p>Residents R12 and CR75's clinical records revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, to include the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility.</p> <p>An interview with the Corporate Compliance Registered Nurse on 6/26/25, at 1:30 p.m. confirmed Resident R12 and CR75's clinical record did not contain the required information prior to transferring to the hospital.</p> <p>28 Pa. Code 201.29 (a)(c.3)(2) Resident rights</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, job descriptions, resident council minutes and grievances, and resident, family, and staff interviews, it was determined that the facility failed to provide sufficient nursing staff and services to promote the physical and mental well-being and meet the needs for eight of eight residents interviewed (Residents R9, R32, R35, R37, R48, R49, R60, and R63).</p> <p>Findings include:</p> <p>Review of facility policy entitled, Answering the Call Light dated 1/20/25, indicated, The purpose of this procedure is to ensure timely responses to the resident's requests and needs. Steps in the Procedure - 1 Answer the resident call system immediately. When answering an auditory request for assistance, identify yourself and politely respond to the resident by his/her name (e.g., This is Mrs. [NAME]. Mr. [NAME], how may I help you?). If the resident needs assistance, indicate the approximate time it will take for you to respond. If the resident's request requires another staff member, notify the individual. If the resident's request is something you can fulfill, complete the task within five minutes if possible. If you are uncertain as to whether or not a request can be fulfilled, or if you cannot fulfill the resident's request, ask the nurse supervisor for assistance. 2 If assistance is needed when you enter the room, summon help by using the call signal. 3 When answering a visual request for assistance (light above the room door), knock on the room door. When the resident responds, address the resident by his/her name (e.g., How may I help you, Mr. [NAME]?).</p> <p>Review of facility job descriptions for a Certified Nursing Assistant (CNA) indicated, The purpose of Your Job Position - To provide each of your assigned residents with routine daily nursing care and services in accordance with the resident's assessment and care plan and as may be directed by your supervisor in accordance with the requirements of the policies and procedures of this facility in accordance with current federal, state, and local standards governing the facility. Customer Service & Resident Rights - Ensures that call lights are answered by all employees of the facility regardless of department. If you are not trained to assist with request/need then inform resident that you will seek appropriate personnel immediately, then do so.</p> <p>During an interview on 6/23/25, at 4:15 p.m. Resident R9's family member indicated that his/her family member's call bell can be on for an hour at a time, and when he/she visited on the weekend, he/she counted 13 call bells on down the hallway, and no staff were observed answering them or available to answer them.</p> <p>Interviews during the resident council meeting on 6/24/25, between 11:00 a.m. and 12:00 p.m., revealed resident concerns with staff not responding to their call bells timely. Eight of eight alert and oriented residents in attendance indicated that it takes 45 minutes to over an hour for call bell response, further indicating it is worse on the weekends. Resident R35 stated they answer his/her call bell and they say they will come back and they never do or they will tell him/her that they are not their aide and they will get his/her aide for them and they never do. Resident R49 stated when someone answers their call bell they must shut it off and not tell anyone because they say they will send an aide in and no one ever shows up. Resident R60 stated it is not uncommon to have to wait a hour to an hour and a half to get a response. The other residents in attendance agreed with statements made by Residents R35, R49, and R60.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of resident council minutes from April, May, and June of 2025, revealed the following:</p> <p>April 2025 resident council minutes revealed residents stated when they need assistance the aide stated that they are not their aide for the day and do not help them.</p> <p>May 2025 resident council minutes revealed aides are walking past resident rooms when being flagged down by the resident and when residents' need help, the aides will state they are not their aide.</p> <p>Review of the grievance logs from January, February, March, April, May, and June of 2025 revealed grievances related to call bell response time:</p> <p>January 2025-waiting 30 minutes for call bell response.</p> <p>February 2025-waiting two hours to have call bell answered and waiting a long period of time on the toilet for staff to respond.</p> <p>March 2025-waiting one hour for morning aide.</p> <p>April 2025-aides telling residents they are not their aide and call bells not being answered</p> <p>June 2025-waiting one and a half hours to be put to bed, staff answering call bell and stating they will be back and not returning</p> <p>During an interview with the Corporate Nursing Home Administrator, Corporate Registered Nurse, and Director of Nursing on June 26, 2025, at 2:30 p.m. they confirmed that the resident council minutes and grievance log revealed call bell concerns and had no further information to provide that addressed the above staffing related concerns.</p> <p>28 Pa. Code 201.18(b)(1) Management</p> <p>28 Pa. Code 211.12(d)(4)(5) Nursing services</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, observations, and staff interview, it was determined that the facility failed to ensure that food was stored in accordance with standards for food safety, failed to label food brought into the facility with the resident's name and use by date, and failed to maintain sanitary conditions in one of two resident refrigerators (Building 1).</p> <p>Findings include:</p> <p>Review of facility policy entitled Foods Brought by Family / Visitors, dated 1/20/25, revealed that Perishable foods are stored in re-sealable containers with tightly fitting lids in a refrigerator. Containers are labeled with the resident's name, the item, and the use by date, Nursing staff will discard perishable foods on or before the use by date, The nursing and/or food service staff will discard any foods prepared for the resident that show obvious signs of potential foodborne danger (for example, mold growth, foul odor, past due package expiration dates).</p> <p>Observation on 6/26/25, at 10:15 a.m. of resident freezer in Building 1 revealed the following: Stouffers Spaghetti with staff name and no date; [NAME] pie crust with no name and expiration date of 12/24/24; and bag of frozen carrots and peas, 20 ounce bottle of Pepsi, ice cream cake, salmon, and individual cheese and pepperoni pizza with no name and no date.</p> <p>Observation on 6/26/25, at 10:19 a.m. of resident refrigerator door in Building 1 revealed the following: Plastic cup tipped over that appeared to have a creamy white liquid that spilled in the door, with soaked paper towel noted under the cup, and dried sticky creamy white liquid on the shelf; container of grapefruit with no name and expiration date of 4/20/25; two individual containers of jello with no name and expiration dates of 2/25/25, and 6/3/25; and a container of yogurt with no name and expiration date of 6/7/25.</p> <p>Observation on 6/26/25, at 10:22 a.m. of resident refrigerator shelves in Building 1 revealed the following: three individual containers of jello with no name and expiration date of 5/30/25; a container of gelatin with no name and expiration date of 6/6/25; five individual containers of guacamole with no name and expiration date of 4/27/25; container of pineapple, container of cheesecake, container of a half piece of cheesecake with strawberries, four cartons of eggs, container of crackers and cheese, two packages of string cheese, and a half bag of shredded mozzarella cheese all with no name or date; container of fresh fruit, container of strawberries, container of watermelon, container of potato soup, container of pasta salad, container of mixed fruit, and a takeout container with steak, onions, and french fries all with no date.</p> <p>During an interview on 6/26/25, at 10:27 a.m. Medical Records / Admissions Coordinator confirmed resident freezer/refrigerator in Building 1 was dirty, contained numerous items that were not labeled as required, and/or items that were expired.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 201.18(e)(2.1) Management</p>		

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<p>F 0868</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Have the Quality Assessment and Assurance group have the required members and meet at least quarterly</p> <p>Based on review of facility policy and Quality Assurance meeting attendance records, and staff interviews, it was determined that the facility failed to conduct Quality Assurance and Performance Improvement (QAPI) meetings at least quarterly with all required committee members for two of four quarters (October 2024 and January 2025).</p> <p>Findings include:</p> <p>Review of facility policy entitled, Quality Assurance and Performance Improvement (QAPI) Program - Governance and Leadership dated 1/20/25, indicated the quality assurance and performance program is overseen and implemented by the QAPI committee, which reports its findings, actions, and results to the administrator and governing body. The following individuals serve on the committee: Administrator, or a designee who is in a leadership role, Director of Nursing Services, Medical Director, Infection Oventionist (nurse certified in Infection Control and Prevention), and Representatives of the following departments, as requested by the administrator: Pharmacy, Social Services, Activity Services, Human Resources, and Medical Records. The committee meets at least quarterly (or more often as necessary).</p> <p>Review of facility's QAPI Committee Meeting Attendance Records from July 2024, to June 2025, revealed the facility failed to have an Infection Preventionist in attendance for the October 2024, and the January 2025, meetings as required to attend at least quarterly.</p> <p>The Corporate Nursing Home Administrator confirmed on 6/27/25, at 2:41 p.m. that there was no evidence the Infection Preventionist attended the October 2024, and January 2025, QAPI meeting.</p> <p>The facility failed to have all the required QAPI committee members present at least quarterly as required.</p> <p>28 Pa. Code 201.18 (e)(1)(2) Management</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>Based on review of facility policy, observations, and staff interview, it was determined that the facility failed to ensure that all residents had access to a call bell for assistance from staff for one of 22 residents observed. (Resident R44)</p> <p>Findings include:</p> <p>Review of the facility policy entitled, Call system, Residents with a policy review date of 1/20/25 , revealed that residents are provided with a means to call staff directly for assistance from his/her bed, from toileting/bathing facilities and from the floor. Each resident is provided with a means to call staff directly for assistance from his/her bed, from toileting/bathing facilities and from the floor.</p> <p>Observation of building two during medication pass on 6/23/25, at approximately 5:30 p.m. revealed Resident R44 was sitting in a bedside chair with no call bell to alert staff for assistance if necessary. Upon checking the room for the call bell cord, it was observed that there was no call bell plugged into the wall for Resident R44's bed and no call bell observed in the room.</p> <p>During an interview with Licensed Practical Nurse Employee E1, at the time of the observation, it was confirmed that there was no call bell for Resident R1 and no way for Resident R1 to alert staff for assistance.</p> <p>28 Pa. Code 201.14 (a) Responsibility of licensee</p> <p>28 Pa. Code 201.18 (b)(1) Management</p>