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	06/12/2026

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. Based on review of facility policy and clinical records, observations, and staff and resident interviews, it was determined that the facility failed to administer supplemental oxygen as ordered for one resident and promote cleanliness and prevent the spread of infection regarding respiratory care equipment for three of 25 residents reviewed (Residents R32, R53, and R72).Findings include:Review of facility policy entitled Oxygen Administration, dated 4/16/26, revealed Set the flow rate as ordered by physician; Oxygen shall be humidified as indicated by physician; Humidifier bottle shall be connected to the oxygen concentrator prior to setting flow rate.Review of facility policy entitled Continuous Positive Airway Pressure/ Bilevel Positive Airway Pressure [CPAP (therapy that keeps your airways open during sleep to treat sleep apnea and other breathing disorders) BiPAP (noninvasive device that helps people breathe by providing two levels of air pressure: higher when inhaling and lower when exhaling)] Support dated 4/16/26, revealed: Mask, nasal pillows, and tubing; clean daily by placing in warm, soapy water and soaking/agitating for five minutes, rinse with warm water and allow it to air dray between uses. Headgear; was with warm water and mild detergent as needed and allow to air dry. Resident R53's clinical record revealed an admission date of 9/20/24, with diagnoses that included sleep apnea, irregular heartbeat, muscle wasting, and lack of coordination. The clinical record revealed a physician's order dated 11/20/24, revealed to clean Resident R53's CPAP corrugated tubing and mask weekly by placing in warm soapy water, rinse with water and allow to air-dry on a towel. Clean mask by wiping, using a damp cloth with warm soapy water on it, rinse and allow the mask to air dry every Sunday on the night shift; and a physician's order dated 6/21/25, to change the distilled water daily.Resident R53's clinical record lacked physician's orders related to the care of his/her nebulizer equipment.Observation on 6/09/26, at 12:40 p.m. revealed Resident R53's CPAP mask contained dried substance inside the mask and was found inside of an opaque white shopping bag lying on the floor. The interior of the bag was noted to contain numerous moist black flecks of unknown substance scattered through the interior of the bag and on the CPAP mask. The humidifier chamber of the CPAP machine was observed to be discolored with a yellowish hue and was approximately 1/4 full of water. Resident R53's nebulizer mask was lying on his/her bed with the elastic strap wrapped around nebulizer motor. During an interview at that time Resident R53 shared that he/she has been in the facility for two years, has never received a new mask, staff don't clean his/her CPAP mask, and that he/she keeps it in that bag so it doesn't get broken because he/she can't afford a new one. Resident R53 also confirmed that he/she fills the humidifier chamber of the CPAP machine himself/herself, and staff do not clean it. Resident R32's clinical record revealed an original admission date of 6/05/23, with diagnoses that included respiratory failure, asthma, irregular heartbeat, and pleural effusion (fluid builds up between the thin membranes that line the lungs and the inside of the chest cavity).Resident R32's clinical record revealed the following physician's orders:Change the oxygen bag weekly and label with the date, dated 7/13/25Change the oxygen tubing weekly and label with the date dated 6/21/25.Change the nebulizer tubing and place clean tubing in a plastic bag, label and date the tubing and the bag, wipe down the nebulizer machine once a week, dated 6/24/25.Clean filter in oxygen concentrator weekly and replace every Sunday on night shift, dated 6/21/25.Clean the CPAP corrugated tubing and mask (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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	weekly by placing in warm soapy water, rinse with water and allow to air-dry on a towel. Clean mask by wiping, using a damp cloth with warm soapy water on it, rinse and allow the mask to air dry every Sunday on the night shift,Change the distilled water daily, 4/12/26Observation on 6/09/26, 1:50 pm revealed Resident R32's oxygen tubing to CPAP dated 5/17/26, the corrugated CPAP tubing was dated 4/06/26, and laying on top of the tray table and connected to the CPAP mask, his/her nebulizer mask lying on top of tray table and not in a bag. There was no filter in oxygen concentrator, and the air inlet was covered in a thick layer of gray fluffy substance, that blocked the pathway of air intake. During an interview at that time, Licensed Practical Nurse Employee E1 confirmed the above stated conditions and locations of Resident R32's CPAP and nebulizer equipment, that the oxygen concentrator lacked a filter, and the air inlet was covered in a thick layer of gray fluffy substance, that blocked the pathway of air intake. Resident R72's clinical record revealed an admission date of 6/23/25, with diagnosis that included Chronic obstructive pulmonary disease (COPD - when your lungs do not have adequate air flow), gastro-esophageal reflux disease (GERD-a condition where stomach acid flows back into the esophagus [tube that passes food from the mouth into the stomach]), and hyperlipidemia (high cholesterol). Resident R72's clinical record revealed a physician's order dated 7/2/25, for oxygen at 2-3 liters per minute (lpm) to maintain O2 sat (oxygen level) greater than 90% via nasal cannula (a thin tube with two prongs that fit into the resident's nostrils to deliver oxygen) or mask; a physician's order dated 6/29/25, to clean filter in oxygen concentrator weekly and replace; a physician's order dated 6/29/25, to replace oxygen humidification bottle weekly and date.Observation on 6/9/26, at 2:35 p.m. revealed Resident R72 sitting on his/her bed with supplemental oxygen in place via nasal cannula and the oxygen concentrator liter flow set at 4 lpm. Further observation of the concentrator filter on the right side of the oxygen concentrator revealed a large amount of a gray fluffy substance covering the filter and the concentrator was running without a humidification bottle attached. During an interview on 6/09/26, at 2:00 p.m. the Director of Nursing (DON) confirmed the above stated conditions and locations of Resident R53's CPAP and nebulizer equipment, and that the nebulizer mask should be kept in a bag, and that the CPAP mask needed replaced. During an interview on 6/09/26, at 2:00 p.m. the DON confirmed the above stated conditions and locations of Resident R32's CPAP and nebulizer equipment, that the nebulizer mask should be kept in a bag, and that the oxygen concentrator needed replaced. During an interview on 6/9/26, at 2:35 p.m. DON confirmed that Resident R72's oxygen concentrator was on and set at 4 lpm and was not in accordance with the physician's order dated 7/2/25, for oxygen at 2-3 lpm. The DON further confirmed that Resident R72's oxygen concentrator's filter was dirty and should be cleaned and there was no humidification bottle on the concentrator.During an interview on 6/11/26, at 10:24 a.m. DON confirmed the facility didn't have a policy for cleaning and/or storage of oxygen and nebulizer equipment and followed the physician's orders for maintenance of the equipment. 28 Pa. Code 211.5(f)(viii) Medical records28 Pa. Code 211.10(c) Resident care policies28 Pa. Code 211.12(d)(1)(5) Nursing services

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on review of facility policy, clinical records, and staff and resident interviews it was determined that the facility failed to have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care for four of 21 residents reviewed for showers/bathing (residents R2, R43, R53, and R77), and eight of 21 residents reviewed for call bell response times (Residents R21, R23, R29, R32, R42, R44, R65, and R66) Findings include:A Facility policy entitled Activities of Daily Living (ADL), Supporting dated 4/16/26, indicated that: residents who are unable to carry out ADLs independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene; appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with hygiene (bathing, dressing, grooming, and oral care).Resident R53's clinical record revealed an admission date of 9/20/24, with diagnoses including sleep apnea, irregular heartbeat, muscle wasting, and lack of coordination Resident R53's was scheduled to receive his/her shower/bath on Monday and Thursday evenings. Further review of Resident R53's clinical record revealed that he/she received two of nine scheduled showers/baths in the last 30 days.During an interview on 6/09/26, at 12:40 p.m. Resident R53 shared that he/she does not receive showers/baths routinely, and that staff will state they are going to come get him/her for a shower but never do. Resident R2's clinical record revealed an initial admission date of 8/29/24, with diagnoses including Parkinson's Disease (disorder of the nervous system that causes nerve cells in parts of the brain to weaken, become damaged, and die, and can lead to difficulty walking, talking, or completing everyday tasks), high blood pressure, muscle wasting, and lack of coordination Resident R2 was scheduled to receive his/her shower/bath Tuesday and Friday afternoons. Further review of Resident R2's clinical record revealed that he/she received two of nine scheduled showers/baths in the last 30 days. During an interview on 6/09/26, at 12:47 p.m. Resident R2 shared that he/she does not receive showers/baths routinely, and that staff will state they are going to come get him/her for a shower but never do. Resident R43's clinical record revealed an admission date of 5/16/26, with diagnoses including respiratory failure, embolism (obstruction or blockage in a blood vessel] and thrombosis (blood clots block your blood vessels) of the lower extremity, heart failure, and Type 2 Diabetes (condition when the body cannot use insulin correctly and sugar builds up in the blood) Resident R43 was scheduled to receive his/her shower/bath on Wednesday and Saturday on the day shift. Further review of Resident R43's clinical record revealed that he/she received one shower/bath and one bed bath since admission. During an interview on 6/10/26, at 11:00 a.m. Resident R43 confirmed that he/she has only had one shower/bath since coming here and was washed up in bed once, and that he/she doesn't know why they can't take ten minutes to give him/her a shower. Resident R77's clinical record revealed an admission date of 6/25/25, with diagnoses including bacterial infection in the right ankle/foot bone, amputation of the right leg below the knee, Type 2 Diabetes, Parkinson's and Alzheimer's diseases Resident R77 was scheduled to receive his/her shower/bath on Wednesday and Saturday nights. Further review of Resident R77's clinical record revealed he/she had received two bed baths in the last 30 days. During an interview on 6/10/26, at 11:23 a.m. Resident R77 confirmed that he/she has not been taken to the shower/bath area recently and has only been washed up in his/her room. During an interview on 6/12/26, at 9:50 a.m. the Director of Nursing confirmed the facility could not provide additional documentation to support Residents R2, R43, R53, and R77 had received more showers/baths. During an interview on 6/09/26, at 12:55 p.m. Resident R65 reported that he/she has waited up to three hours in the evening and on weekends for his/her call bell to be answered and that (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	he/she has wheeled themselves out to the hallway to seek assistance. Resident R65 also reported that he/she has waited as long as two hours to get put to bed. During an interview on 6/09/26, at 1:07 p.m. Resident R29 reported that he/she has waited two-three hours to have their call bell answered and that it mostly happens on the afternoon shift, and that he/she soiled the bed while waiting for the staff to answer his/her call bell. During an interview on 6/10/26, at 10:34 a.m. Resident R42 reported that his/she waits way too long for the call bell to be answered, and that it is frustrating when you have been waiting at least an hour and when staff finally do come in you are told that you now have to wait until someone goes to break. He/she confirmed this most often happens on the second shift. During a resident council meeting n 6/10/26, from 11:00 a.m. to 11:45 a.m., it was confirmed by all resident's in attendance (Resident R21, Resident R23, Resident R32, Resident R44, and Resident R66) that call bell wait times are excessive and the average wait time is over 30 minutes on a consistent basis. All residents also identified that morning and evenings before bed are the longest call bell waits.Resident R44 stated that he/she has waited over 2 hours. Resident R23 stated that employees come in the room and turn the call bell off after waiting over 30 minutes and then residents have to ring again and wait for assistance. Resident R23 also stated that if they don't answer call bell, he/she has to blow a whistle to get attention. Resident R23 also has called the front desk to get someone to please answer call bell and assist self or roommate R21. Resident R32 stated that he/she waited until after noon to get assistance out of bed in the morning. Resident R32 called for assistance and did not get help all morning. 28 Pa. Code 201.14(a) Responsibility of licensee28 Pa. Code 201.18(b)(1)(3) Management28 Pa. Code 211.12(d)(1)(4)(5) Nursing services

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policies, observations, and staff interviews, it was determined that the facility failed to discard outdated insulin on two of four medication carts and failed to prevent the opportunity for unauthorized access of medications on one of four medication carts. Findings include: A facility policy entitled Storage of Medications dated [DATE], indicated discontinued, outdated, or deteriorated drugs or biologics are returned to the dispensing pharmacy or destroyed; and compartments (including drawers, carts) containing drugs and biologics are locked when not in use, and unlocked medication carts are not left unattended. A facility policy entitled Insulin Pen Storage Policy dated [DATE], indicated that a beyond-use dating label will be assigned to the cartridge (28 days or manufacturer's expiry, whichever is first), check the cartridge's insulin type and expiry before each use. Observation on [DATE], at 3:11 p.m. revealed that Building One Back Hall medication cart was located in the hallway and was unlocked and left unattended. During an interview on [DATE], at 3:19 p.m. Registered Nurse Employee E2 confirmed that the Building One Back Hall medication cart should have been locked when it was left unattended. Observation on [DATE], at 4:02 p.m. revealed Building Two [NAME] medication cart contained a multi-dose injection pen of Lantus (long-acting insulin used to control high blood sugar in adults and children with diabetes mellitus) labeled for discard date of [DATE]. During an interview at that time Licensed Practical Nurse (LPN) Employee E4 confirmed that the multi-dose injection pen was expired. Observation on [DATE], at 4:10 p.m. revealed Building One Front Hall medication cart contained a multi-dose injection pen of Humalog (man-made analog of natural insulin, designed to act quickly in the body) label with an open date of [DATE], and discard date of [DATE]. During an interview at that time LPN Employee E3 confirmed that the multi-dose injection pen was expired. 28 Pa. Code 201.18(b)(1)(3) Management 28 Pa. Code 211.10(c) Resident care policies 28 Pa. Code 211.9(a)(1) Pharmacy services 28 Pa. Code 211.12(d)(1)(5) Nursing services

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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 the hospice/facility agreement and clinical records, and staff interview, it was determined that the facility failed to maintain current information related to hospice services for one of four hospice residents reviewed (Resident R13). Findings include: Review of a hospice facility agreement dated 5/23/26, revealed the following:The Interdisciplinary Team with Nursing Facility representatives and the Nursing Facility Attending Physician shall review and revise the individualized Plan of Care as frequently as the resident/patient's condition requires, but no less frequently than every 15 calendar days.Hospice shall provide the Nursing Facility Designee with a copy of the most recent Plan of Care specific to each resident/patient.Nursing Facility and Hospice shall each prepare and maintain complete, accurate, and detailed clinical records concerning each resident/patient.All entries made for services provided hereunder are to be legible, clear, complete, and appropriately authenticated and dated in accordance with applicable policy and currently accepted standards of practice. Resident R13's clinical record revealed an initial admission date of 11/11/25, with diagnoses that included Parkinson's Disease (disorder of the nervous system that causes nerve cells in parts of the brain to weaken, become damaged, and die, and can lead to difficulty walking, talking, or completing everyday tasks), dementia, depression, and high blood pressure. The clinical record revealed a physician's order dated 1/07/26, that indicated Resident R13 was admitted to hospice services. Further review of Resident R13's clinical record revealed the most recent plan of care included an end date of 5/06/26 and wasn't updated; and the most recent hospice visit notes (communication sheets) were dated 5/12/26 and no more current visit notes. During an interview on 6/11/26, at 10:50 a.m. the Director of Nursing confirmed Resident R13's clinical record lacked evidence that the hospice care plan was current/updated and that hospice visit notes/communication sheets were current. 28 Pa. Code 201.14(a) Responsibility of licensee28 Pa. Code 201.18(b)(1)(3) Management28 Pa. Code 211.5(f) Medical records28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on review of facility policy, observation, and staff interview, it was determined that the facility failed to ensure that food was stored in accordance with standards for food safety and failed to maintain sanitary conditions in one of two resident refrigerators (Building One). Findings include: Review of facility policy entitled Use and Storage of Food Brought to Residents By Visitors, dated 4/16/26, revealed that Visitors may bring food to our residents upon their request; Any food brought into the facility for onsite consumption must be in ready-to-eat form; Food or beverage in the original containers that is beyond the manufacturer's expiration date will be discarded by nursing staff. Observation on 6/10/26, at 10:50 a.m. of the building one refrigerator used for residents revealed two individual containers of yogurt with manufacturer's expiration dates of 5/28/26 and 5/31/26, and a brown sticky substance covering the shelf of the refrigerator. During an interview on 6/10/26, at the time of observation Registered Nurse Employee E5 confirmed the resident refrigerator in building one was not clean and contained two single serve yogurt containers that were expired and should be discarded. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(e)(2.1) Management

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F 0848 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide a neutral and fair arbitration process and agree to arbitrator and venue. Based on review of the facility's arbitration agreement and staff interview, it was determined that the facility failed to ensure a neutral and fair arbitration process by ensuring both the resident and/or resident representative and facility agree on the selection of an arbitrator and venue. Findings include: Upon review of the facility's arbitration agreement for who will conduct the arbitration, the arbitration agreement lacked evidence addressing that the selected venue would be convenient to both the resident and/or resident representative and the facility. During an interview on 6/12/26, at 11:20 a.m. Nursing Home Administrator confirmed the language of the arbitration agreement does not provide for the selection of a neutral arbitrator agreed upon by both parties and for the selection of a venue that is convenient to both parties. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 201.29(a) Resident rights

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on review of clinical records and facility policy, observations, and staff interview, it was determined that the facility failed to prevent the potential for cross contamination (the spreading of germs/microorganisms from one surface to another) during the administration of medications through a gastrostomy tube [G-tube (a surgically placed tube that delivers nutrition, fluids, and medications directly into the stomach for individuals who cannot eat enough by mouth)] for one of five residents observed during medication administration (Resident R38).Findings include:A facility policy entitled Enhanced Barrier Precautions (EBP (infection control measures using gowns and gloves during high-contact care to prevent the spread of multidrug-resistant organisms [MDROs] in healthcare settings) dated 4/16/26, indicated that EBPs employ targeted gown and glove use during high-contact resident care activities when contact precautions do not otherwise apply; and examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include device care or use (feeding tube [g-tube/peg tube]).Resident R38's clinical record revealed an admission date of 9/09/24, with diagnoses that included stroke with left-sided weakness, mild cognitive impairment, aphasia (language disorder that affects your ability to speak and understand what others say), and muscle wasting. The clinical record also revealed a physician's order dated 4/24/25, for EBPs for peg tube every shift. Observation on 6/10/26, at 8:20 a.m. revealed that Licensed Practical Nurse (LPN) Employee E3 administered Resident R38's medications through his/her g-tube and failed to don a gown prior to administering the medications.During an interview on 6/10/26, at 8:25 a.m. LPN Employee E3 confirmed he/she didn't believe they had to wear a gown to administer medication through a g-tube.During an interview on 6/11/26, at 10:55 a.m. the Director of Nursing confirmed that LPN Employee E3 should have worn a gown to administer medications through a g-tube. 28 Pa. Code 211.10(c)(d) Resident care policies 28 Pa. Code 211.12(d)(1)(5) Nursing services