STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396058	A. BLDG: __--_____ B. WING: _____	01/09/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
AVALON SPRINGS CARE CENTER STATE LICENSE NUMBER: **132402**	**745 GREENVILLE ROAD MERCER, PA 16137**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
E 0000	INITIAL COMMENT Based on an Onsite Revisit to an Emergency Preparedness Survey completed on November 14, 2024, at Avalon Springs Place, it was determined there were no deficiencies identified with the requirements of 42 CFR 483.73.	E 0000		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

Certified End Page

AVALON SPRINGS CARE CENTER

STATE LICENSE NUMBER: 132402

SURVEY EXIT DATE: 01/09/2025

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeanne Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen MD
Debra L. Bogen, MD, FAAP
Secretary of Health

Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396058	A. BLDG: __01_____ B. WING: _____	01/09/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
AVALON SPRINGS CARE CENTER STATE LICENSE NUMBER: 132402	745 GREENVILLE ROAD MERCER, PA 16137

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
K 0000	INITIAL COMMENT	K 0000		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396058	A. BLDG: __01_____ B. WING: _____	01/09/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
AVALON SPRINGS CARE CENTER STATE LICENSE NUMBER: 132402	745 GREENVILLE ROAD MERCER, PA 16137

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
K 0000	Continued from page 1 Facility ID #132402 Component 01 Main Building Based on an Onsite Revisit to a Medicare/Medicaid Recertification Survey completed on November 14, 2024, it was determined that Avalon Springs Place was not in compliance with the following requirements of the Life Safety Code for an existing health care occupancy. Compliance with the National Fire Protection Association's Life Safety Code is required by 42 CFR 483.90(a). This is a two-story, Type II (000), unprotected, non-combustible building, with a ground floor, that is fully sprinklered.	K 0000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396058	A. BLDG: __01_____ B. WING: _____	01/09/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
AVALON SPRINGS CARE CENTER STATE LICENSE NUMBER: **132402**	**745 GREENVILLE ROAD MERCER, PA 16137**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
K 0100 SS=E	NFPA 101 General Requirements - Other General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. This REQUIREMENT is not met as evidenced by:	K 0100	The facility will not occupy the flooded areas. Cleanup and sanitation completed. Plans for rebuild on hold due to the pending change of facility ownership scheduled for 3/1/2025. A narrative and plans will be submitted for plan review prior to any work being conducted in the flooded areas. The facility is using designated storage areas for facility storage. Facility maintenance staff or designee will round daily to ensure the space remains safe and secure until rebuild is completed.	Completion Date: **01/24/2025** Status: **APPROVED** Date: **01/21/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396058	A. BLDG: __01_____ B. WING: _____	01/09/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
AVALON SPRINGS CARE CENTER STATE LICENSE NUMBER: **132402**	**745 GREENVILLE ROAD MERCER, PA 16137**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
K 0100 SS=E	Continued from page 3 Based on observation and interview, the facility failed to maintain general requirements not addressed by the provided K-tags, but they are deficient, affecting two of three building levels. Findings include: Observation on November 14, 2024, between 11:55 a.m. and 12:04 p.m., revealed the facility failed to obtain required approval from the Department of Health State Plan Review and a granted occupancy from the Life Safety Division for the following projects: A. (11:55 p.m.) First floor, north hall, had recent flood damage. There was remediation work being completed from the floor level up approximately three feet of the corridor walls. The residents were evacuated from this area and relocated as a result of the event; B. (12:04 p.m.) Ground floor, north hall, dementia unit, had recent flood damage, resulting in total remediation of the partitioning studs; C. (12:04 p.m.) The facility is currently using various rooms throughout the facility to provide item	K 0100		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396058	A. BLDG: __01_____ B. WING: _____	01/09/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
AVALON SPRINGS CARE CENTER STATE LICENSE NUMBER: 132402	745 GREENVILLE ROAD MERCER, PA 16137

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
K 0100 SS=E	Continued from page 4 storage due to the recent flood event. Interview with the maintenance supervisor on November 14, 2024, at 12:04 p.m., confirmed the deficiencies. ********** Based on an interview during an Onsite Revisit Survey conducted on January 9, 2025, at 11:15 a.m., the facility failed to obtain required approval for items A, B, and C from the Department of Health State Plan Review and receive a granted occupancy from the Life Safety Division. The facility was preparing the drawings and applications for submission at the time of the Revisit Survey. Interview with the maintenance supervior on January 9, 2025, at 11:15 a.m., confirmed the deficiency.	K 0100		

Certified End Page

AVALON SPRINGS CARE CENTER

STATE LICENSE NUMBER: 132402

SURVEY EXIT DATE: 01/09/2025

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeanne Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen MD
Debra L. Bogen, MD, FAAP
Secretary of Health

Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY