

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395893	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/10/2025
NAME OF PROVIDER OR SUPPLIER Care Pavilion Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 6212 Walnut Street Philadelphia, PA 19139	

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 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>43923</p> <p>Based on observations, resident and staff interviews, it was determined that the facility failed to provide food and drink that were served at palatable temperatures for one out of the five residents reviewed. (Resident R1)</p> <p>Findings include:</p> <p>Review of facility policy titled, Accurate and Quality of Tray Line Service, dated January 17, 2019, revealed, Hot food will be kept hot (> 135 F) and cold foods will be kept cold (<41 F).</p> <p>Interview with Resident R1 on April 10, 2025, at 10:54 a.m. revealed food is cold, drink is too warm.</p> <p>Observations during a test tray conducted with the Food Service Director, Employee E8, on April 10, 2025, at 11:37 p.m. revealed Corned Beef 120 degrees Fahrenheit (F); New Potatoes registered 125 degrees F; and cold Lemon Meringue Pie registered 80 degrees F, Cranberry juice registered 62 degrees.</p> <p>Follow-up interview with the FSD, at 11:45 a.m. revealed that hot foods should be at at least 135 degrees F and confirmed that these food items were outside the acceptable temperature range and therefore not palatable.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 201.18(b)(3) Management</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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>43923</p> <p>Based on observations, resident and staff interview and review of facility policy, it was determined facility failed to maintain standards of an infection control practices by reusing resident's bedpan for three out of five residents reviewed. (R1, R2, R3).</p> <p>Findings include:</p> <p>Review of the facility policy titled Non-critical Resident Care Equipment -Cleaning, dated April 1, 2022, revealed Reusable resident care equipment/instruments/devices will be maintained and decontaminated according to manufacturer's instructions to prevent resident-to-resident transmission of infections (cross contamination). It further under Responsibility states The responsibility for cleaning non-critical resident care equipment is divided between housekeeping and clinical staff. The housekeeping items are addressed in a department specific policy.</p> <p>Interview with Resident R1 on April 10, 2025, at 10:42 a.m. revealed they reuse my bedpan with my roommate and it's unsanitary. An observation revealed one bedpan located in the Resident's R1 and R2 restroom laying on the top of the toilet not being labeled and having unsanitary yellow residue.</p> <p>Interview with nursing assistance, Employee E6 on April 10, 2025, at 10:46 a.m. during the interview, when asked about the use of bedpans, Employee E6 initially presented a washing basin. Upon clarification that a bedpan is used for toileting in bed, Employee E5 reported that bedpans are stored in the medication room. When any resident needs to use a bed panstaff can access them in medication rooms.</p> <p>Interview with the license nurse, Employee E7 on April 10, 2025, at 10:47 a.m. Employee E7 confirmed that each resident should have a personal bedpan stored in their drawers Residents R1 and R2, labeled with their names. It was further confirmed that one bedpan was found in the shared restroom of Residents R1 and R2, placed on top of the toilet and noted to have yellow residue.</p> <p>When asked who else uses a bedpan on the nursing unit, Employee E7 identified Resident R3. Observation confirmed that Resident R3's bedpan was located on top of her tray table and was not labeled.</p> <p>When asked where bedpans are stored and how nursing aides access them, Employee E7 stated they are kept in the medication room. However, upon observation of the medication room, no bedpans were found.</p> <p>Interview with the unit manager, Employee E4 on April 10, 2025, at 12 : 10 p.m. Employee E4 confirmed that each resident should have a personal bedpan stored in their drawers and labeled. Resident R1 still did not have her bedpan, and that the unsanitary bedpan remained in Resident R1's restroom.</p> <p>On April 10, 2025, at 12:19 p.m. an observation with Central Supply Employee E9 confirmed that facility does have 50+ bed pans in the central supply room in the basement; E9 did not received any request to form nursing staff that 1 east nursing unit had no bed pans in the medication room.</p> <p>(continued on next page)</p>		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On April 10, 2025, at 2:45 p.m. it was confirmed that by the Administrator, Employee E1 and Assistant Director of Nursing, Employee E3 the facility did not ensure that each resident had their own bedpan, which should have been labeled, appropriately sanitized, and assigned to each resident with proper name labeling. 28 Pa Code 211.12 (d)(1)(5) Nursing services		