

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 05/29/2025
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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based on review of clinical record and interview with staff, it was determined that facility did not ensure that residents received treatment and care in accordance with professional standards practice related to physician orders for blood sugar levels for one of three residents reviewed (Resident R3)</p> <p>Findings include:</p> <p>Review of facility's policy 'Insulin Administration,' revised April 1, 2022, indicates that blood glucose is to be checked per physician's order or facility protocol.</p> <p>Review of facility policy 'Administering Medications,' reviewed December 11, 2024, indicates that the following information must be checked/verified for each resident prior to administering medications: blood sugar, if necessary, per physician order.</p> <p>Review of Resident R3's clinical record revealed that resident had the diagnoses of end stage renal disease, type 2 diabetes mellitus (failure of the body to produce insulin), mild protein-calorie malnutrition, and dependence on renal dialysis.</p> <p>Review of Resident R3's May 2025 physician order for Novolog (insulin Aspart) to be injected per sliding scale before meals and at bedtime; at 7:30 a.m., 11:00 a.m., 4:00 p.m. and 9:00 p.m</p> <p>Review of nursing notes dated May 7, 2025, at 10:58 am, revealed resident was noted with blood sugar reading of 31, not responding to his name, not able to swallow, IM (intramuscular) glucagon 1 milligram (mg) administered, rechecked blood sugar after, it read 35. MD (physician) aware n/o (new order) given to send resident to emergency room for further evaluation.</p> <p>Further review of Resident R3's electronic medication administration record (e-TAR) revealed no documented evidence that the resident blood glucose level was assessed on May 7, 2025 at 7:30 am. It was noted that the blood glucose level was not obtained due to hospitalization, however - per documentation in nursing notes, Resident R3 was picked up by emergency personnel at 10:50 am for transfer to hospital.</p> <p>The facility did not ensure resident's blood glucose level was assessed timely at 7:30 a.m. as ordered by the physician.</p> <p>Findings confirmed with facility's Regional Clinical Nurse, Employee E4.</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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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa Code 211.12(d)(5) Nursing services		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on reviews of clinical records, interviews with staff, reviews of the facility assessment and policies and procedures reviews, it was determined that the facility failed to established criteria or a screening process for the safe escort to ensure the safety of residents for an approved leave of absence for one of nine residents reviewed. (Resident R8)</p> <p>Findings include:</p> <p>A review of the facility policy titled leave of absence dated February 24, 2025 indicated that the purpose of this policy was to ensure the health, safety and quality of life for all of the residents. The policy indicated that residents requesting either an independent and escorted leaves of absence from the facility must receive an order from their physician that indicates a leave of absence will be safe for there resident prior to leave being granted. The physician my deem an independent leave of absence to be unsafe, but may consider and approve an escorted leave of absence if they feel that escorted leaves of absence are in the best safety interest of the resident. Residents who have an approved escorted leave of absence must have the individual escorting them on a leave sign them out prior to their leave. Any denials of independent or escorted leaves of absence are at the discretion of the resident's physician; as as the physician may consider risks such as history of substance abuse and/or drug use, physical limitations and general health considerations.</p> <p>Review of Resident R8's clinical record revealed an admission Minimal Data Set (MDS-an assessment of care needs) dated February 24, 2025 that indicated Resident R8 was admitted to the facility on [DATE]. The resident's BIMS (brief interview of mental status) indicated that this resident was cognitively intact with a BIMS of 15. The resident was assessed as independent with activities of daily living and ambulation. The assessment indicated that the resident expressed that it was very important to involve her family in discussions about her care.</p> <p>The assessment indicated that this resident had a diagnosis of opioid use with withdrawal and the discharge plan was to return to the community.</p> <p>A review of the social worker assessment dated [DATE] revealed that Resident R8 was admitted to the facility for short term rehabilitation and plans were to return to the community. The social worker documented that that Resident R8 was in contact with her daughter for discharge planning. The social worker confirmed in this assessment that Resident R8 had drug and alcohol abuse with opioid use.</p> <p>Review of nursing note date May 5, 2025 revealed that the resident alert and oriented x 4 (situation, place, time and person).</p> <p>Review of nursing note dated May 6, 2025 at 9:04a.m. revealed resident had a death in family and requested escorted LOA (leave of absence). Per MD (physician), resident ok to have LOA with escort.</p> <p>Continued review of nursing documentation dated May 6, 2025 at 10:33 a.m. revealed Resident alert and verbally responsive . resident went home on LOA with a family member, stated she has a family emergency. resident stated she will be back around 10:00 pm today, upcoming nursing team will follow up.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of physician orders revealed that an order was obtained on May 6, 2026 at 8:46am. Resident may have LOA with escort.</p> <p>Interview with the physician, Employee E6, at 1:00 p.m., on May 29, 2025 revealed that the physician ordered a leave of absence with an escort for Resident R8 secondary to the resident's diagnosis of poly substance use disorder with opioid use. The physician explained that he wanted the resident to have a safe escort or an escort that would help protect the safety and well-being of Resident R8; while on a leave of absence from the facility, for a family emergency.</p> <p>Review of nursing note dated may 7, 2025 at 6:46 a.m. revealed Resident left LOA 5/6/25 and did not return on 11-7 shift and is still on LOA at this time.</p> <p>Continued review of nursing documentation dated May 7, 2025 at 7:59 a.m. revealed that report was given by charge nurse that resident on LOA, was supposed to come back by 10pm but not yet returned. Called placed to ER contact and resident cell number through out the night but no responses.</p> <p>Interview with the Administrator, Employee E5, at 1:30 p.m., on May 29, 2025 confirmed that the facility had not established criteria or a screening process for the safe escort and defined the job of the safe escort.</p> <p>Interview with the licensed practical nurse, Employee E8, at 11:30 a.m., on May 29, 2025 who was familiar with Resident R8 revealed that the friend, Resident R8 left the facility with on May 6, 2025 was not listed as a visitor for this resident since her admission on [DATE]. Resident R8's contact and family member was listed as her daughter.</p> <p>Clinical record review for May 7, 2025 revealed that Resident R8's daughter reported to the facility that the resident passed away from a drug overdose.</p> <p>28 PA. Code 211.10(a)(b)(c)(d) Resident care policies</p> <p>28 PA. Code 211.12(c)(d)(1)(3)(5) Nursing services</p> <p>28 PA. Code 201.14(a) Responsibility of licensee</p>		

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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>Based on review of clinical records, interview with residents and staff, it was determined facility did not implement infection prevention and control program for one of three residents reviewed (Resident R1)</p> <p>Findings include:</p> <p>Review of facility policy 'Isolation Steps: Categories of Transmission Based Precautions,' updated July 12, 2022, indicates that Enhanced Barrier Precautions expand the use of personal protective equipment (PPE) beyond situations in which exposure to blood and body fluids is anticipated and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of multidrug-resistant organisms (MDRO) to staff hands and clothing.</p> <p>Further review of policy indicates that all residents with the following condition should use EBP's: open wounds and/or indwelling medical devices (e.g., central line, urinary catheter, feeding tube, tracheostomy) regardless of MDRO colonization status who reside on a unit or wing where a resident known to be infected or colonized with a novel or targeted MDRO resides.</p> <p>Review of Resident R1's clinical record revealed that the resident was admitted to hospice services on May 22, 2025, with the diagnosis of hemiplegia and hemiparesis (paralysis/weakness) affecting right dominant side, pressure ulcer of sacral region - stage 4 (ulcer involving loss of skin layers, exposing muscle and bone, and chronic kidney disease.</p> <p>Review of Resident R1's care plan, revealed resident has pressure ulcer to sacrum, right heel and right lateral foot related to immobility , history of ulcers and thin/fragile skin. Further review of care plan revealed no evidence of interventions related to enhanced barrier precautions.</p> <p>Observations of Resident R1's room, on Thursday, May 29, 2025 at 11:00 am, revealed a door post indicating Resident R1 is on EBP's.</p> <p>Further observations revealed wound care treatment supplies in basins on floor; wound vacuum attached to residents sacral wound was touching the floor.</p> <p>During observations of wound care treatment, completed by Wound Care Nurse, employee E1 and Physician Assistant, employee E2 , on Thursday, May 29, 2025 at 11:45 am, Employee E1 and Employee E2 did not wear gowns during procedure. Employee E1 removed wedge pillow off of Resident R1's bed and placed it on floor - then proceeded to place same wedge pillow under resident's bare back, close to opened sacral wound. Employee E1 was also observed to place the end of wound vacuum which touched floor on resident's bed pad. Further observations revealed Employee E1 changing gloves by retrieving them from her pocket.</p> <p>Further observations of Resident R1's room environment revealed stale flowers on R1's bedside table attracting flies.</p> <p>Findings confirmed with Employee E1, Employee E2 and Licensed nurse, Employee E3.</p> <p>28 Pa. Code 211.10(c)(d) Resident care policies</p> <p>(continued on next page)</p>		

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