STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395893	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Care Pavilion Nursing and Rehabilitation Center	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)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395893	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Care Pavilion Nursing and Rehabilitation Center	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)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on review of facility policy, review of clinical records, observations, and staff interviews, it was determined that the facility failed to develop a comprehensive person-centered care plan for one of 7 Residents reviewed (R2).Findings include:Review of clinical records indicated that Resident R2 was admitted in the facility on August 4, 2025. with the diagnoses of Homelessness, Anxiety Disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), and Psychoactive Substance Abuse (the harmful or hazardous use of substances that alter brain function, affecting mood, perception, cognition, and behavior). Review of information submitted to the State Survey Agency revealed that on August 29, 2025, at approximately 5:25 p.m., a staff member, receptionist, Employee E4, who was outside of the facility on her way back from her break and observed Resident R2, on the sidewalk at the corner of the facility. Employee E4 immediately returned the resident to the facility and notified the nursing supervisor of the situation. Resident R2 was immediately assessed, and no concerns were identified from assessment. Resident R2 was placed on one-to-one observation, and a wanderguard (devise adjacent to the body that activates the locking mechanism of doors leading to the outside of the nursing unit) was applied. Signs were placed on exit doors to alert staff and visitors that residents may try to follow them out of the facility and to please don't open or hold doors for residents. Review of Resident R2's nursing note dated August 29, 2025, indicated that around 5:20 p.m., resident was observed by security existing through the front door despite multiply attempted to redirect. She was later brought in by a staff member. who stated she found her at corner of the building. Resident is nonverbal but able to make cues. Keep saying bye-bye. She is exit- seeking, non-compliant with redirection and resident likes to sit in front lobby. Resident was initiated at 1:1 monitoring, wander guard applied on left leg, noted she was anxious, resident was wheelchair bound, siblings notified. Review of witness statement of Receptionist, Employee E4, regarding Resident R2's elopement on August 29, 2025, indicated as follows; at approximately 5:25 p.m., I was outside on my break when I saw Resident R2 on the sidewalk at the corner of the facility. I immediately brought resident back into the facility and notified the nursing supervisor of the elopement. During interview on September 9, 2025, at 10:12 a.m., the administrator stated as follows; on August 29, 2025, R2 was in the main lobby of the facility by the main entrance/exit doors. The Security Attendant, Employee E5, who was covering the Reception Desk while the Receptionist was on break buzzed a visitor out, releasing the lock on the door to allow egress. When the visitor coming into the facility entered the door, another visitor who was exiting grabbed the door before it closed and held the door for Resident R2 to exit in her wheelchair. The exiting visitor also held the second door for Resident R2, who proceeded to wheeled out of the facility; quickly, so as to avoid being seen. Resident R2 exited at approximately 5:25 P.M. and was quickly identified by the Receptionist, Employee E4, who was returning from her break. Employee returned the resident to the facility approximately five minutes later at 5:30 P.M. through an entrance at the rear of the facility. The incident was recorded, and we could see the events that led to the resident exit. On September 9, 2025, at 12:02 p.m., tried to interview Resident R2, in her room. Resident R2 was cognitively not able to answer the questions. On September 9, 2025, Employee E4 was not available for face-to-face interview. On September 9, 2025, at 3:12p.m., attempted to interview Receptionist, Employee E4 over telephone, Employee E4 did not answer the telephone call. On September 9, 2025, Employee E5 was not available for face-to-face interview. On September 9, 2025, at 3:14p.m., tried to interview Employee E5 over telephone, Employee E5 did not attend the telephone call. Review of Elopement Risk Evaluation dated August 5, 2025, for Resident R2, indicated that the resident was not at risk for elopement at that time. Review of Elopement Risk Evaluation dated August 19, 2025, for R2, indicated Resident R2 was at risk for elopement at that time. Elopement Risk Evaluation dated August 19, 2025, directed for intervention as; nurse should implement interventions as appropriate until IDT (interdisciplinary team) reviews for final decisions. Review of Resident R2's care plan failed did not include interventions to prevent elopement, based on the elopement risk assessment, the traffic of the facility at the front desk/main entrance, and the need for positioning of sufficient number of staff overseeing front desk or main entrance traffic. On September 10, 2025, at 1:30 p.m., during an interview with the Administrator, and the Director of Nursing, confirmed the above findings. 28 Pa Code 211.10 (c)(d) Resident care policies28 Pa Code 211.12(d)(1)(3)(5) Nursing services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395893	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Care Pavilion Nursing and Rehabilitation Center	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)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395893	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Care Pavilion Nursing and Rehabilitation Center	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)
F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, review of facility documentation, review of clinical records, and interviews with staff, it was determined that the facility failed to ensure proper supervision of residents during smoking hours which resulted in actual harm to Resident R1 who sustained first and second degree burn on face when nasal cannula ignited while smoking with oxygen in use for one of 38 residents reviewed (Resident R1). This deficiency was cited as past non compliance. Findings include: Review of undated Resident and Visitor Smoking Rules revealed the following: #1. No smoking is allowed indoors anywhere at Care Pavilion; including cigarettes, vape devices, etc. No smoking when oxygen is in use. #2. No smoking outside of the Walnut Street entrance/exit. #3. Residents and visitor smoking is only permitted in the designated outdoor smoking area (The Courtyard) during designated smoking times. Two designated staff members 'Smoking Monitors' are stationed in the smoking area at all times. #6. Residents are permitted to hold their own smokable tobacco products; however, they are not permitted to hold combustible devices such as lighters, matches, vape devices and other electronic smoking devices that contain a heating element. Review of Resident R1's clinical record revealed Resident R1 was admitted to the facility on [DATE], with diagnoses of End Stage Renal Disease (condition where the kidneys have permanently lost most of their ability to function), and dependent on Renal Dialysis. Review of Resident R1's Medicare 5-day MDS (Minimum Data Set- federally required resident assessment completed at specific intervals) assessment dated [DATE], section C0500, BIMS Summary Score revealed a score of 12 indicating Resident R1 had a moderate cognitive deficit. Section GG0170 Mobility J. Walk 50 feet with two turns: Once standing, the ability to walk at least 50 feet and make two turns was coded 04 (Supervision or touching assistance), K. Walk 150 feet: Once standing, the ability to walk at least 150 feet in a corridor or similar space was coded 88 (Not attempted due to medical condition or safety concerns). Review of Resident R1's Smoking Evaluation dated July 22, 2025, revealed under section #2. Resident did not use oxygen, Cognitive: #3. did not have Dementia, #4. did not have poor memory, under section Behavior: #7. no history of unsafe smoking habits, under section Evaluation: #13. Smoking Decision: Independent smoking is allowed. Further, the next smoking assessment was completed on August 28, 2025, where the resident was coded as Resident is not allowed to smoke. Review of Resident R1's August 2025 physician orders revealed an order for oxygen at 4L (liters)/Min (minute)-6L/Min via NC (nasal canula) - PRN (as needed) dated August 21, 2025, for supplementary oxygen. Review of Resident R1's nursing notes dated August 27, 2025, time stamped 3:35 PM revealed: Resident ambulated to unit in distress, resident was bleeding from lip with visible burn marks to face. [Resident R1] explained that (he/she) lit cigarette while nasal cannula was inserted. [Resident R1] stated (he/she) did not want RP (responsible party) called, visibly upset. [Resident R1] stated (he/she) snuck outside to smoke with oxygen tank. Transportation called for resident to be transferred to ER (Emergency Room). Resident provided cold rag with ice and A&D applied. DON (Director of Nursing)/SW (Social Worker) /Administrator made aware . EMT (Emergency Medical Transport) arrived transported to local hospital, oncoming nurse made aware. Review of Resident R1's nurse's notes dated August 28, 2025, revealed that Resident R1 returned from local hospital via ambulance transport status post self-inflicted accidental from smoking to burns to face, nose and lip areas. Upon return 1st/2nd degree burns to be left open to air. Burn lesions on face left worse than right around nasolabial folds. nares, upper lip with redness/swealing no open blisters. Noted scant bleeding. Resident reports 8/10 pain. Denies inner damage to oral mucosa. Review of facility investigation revealed that on August 27, 2025, at approximately 3:30 pm, Resident R1 returned to the unit from the courtyard bleeding from his/her lips with visible burn marks to the side of his/her face. Resident R1 stated he/she left the unit to smoke while using 02 (oxygen) tank and nasal canula was on. Interview with facility Nursing Home Administrator (NHA), Employee E1 conducted on September 9, 2025, at 9:03 AM revealed Resident R1 was a dialysis resident who came back from on-site dialysis treatment. Nursing Home Administrator, Employee E1 revealed that resident uses a wheelchair. Resident R1 returned from dialysis with portable oxygen, went to the smoking area with oxygen in use, took another resident's cigarette but forgot (he/she) had O2 on. Further facility administrator revealed that at the time of the incident, there was a resident Bar-B-Q and there were a lot of activities occurring in the courtyard. Observation of the door leading to the courtyard conducted on September 9, 2025, at 9:08 AM revealed that the door was located immediately to the left of the reception desk. Further observation revealed that Smoking monitor, Employee