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	11/13/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (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
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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based upon observation, interviews with residents and staff, review of resident records, facility documentation and policies, and in accordance with accepted professional standards and practices, it was determined the facility failed to maintain medical records on each resident that were complete and accurately documented for one of 13 resident records reviewed (Resident R6).Findings include:Review of the facility policy titled, Charting and Documentation revised July 2017, states all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. Review of facility policy titled, Prevention of Pressure Ulcers revised March 2022, states, Routinely assess and document the condition of the resident's skin per facility wound and skin care program for any signs and symptoms of irritation or breakdown. Review of facility policy titled Skin Integrity revised April 2022, states, Residents will be assessed/observed for risk of skin breakdown, utilizing the Braden scale . DON (Director of Nursing) or designee will be responsible for implementing and monitor the skin integrity program.The interdisciplinary plan of care will address problems, goals and interventions directed toward prevention of pressure injuries and/or skin integrity concerns identified. Review of Resident R6's clinical record revealed an admission date of April 2015 with the diagnoses with hemiplegia and hemiparesis (one sided weakness) following a cerebral infarction (stroke) affecting the resident's right dominate side. Review of Resident R6's pressure ulcer risk assessment dated [DATE], revealed the resident was bedfast (confined to bed), made occasional slight changes in (her/his) body position, required moderate to maximum assistance in moving and was assessed as a high risk for developing pressure sores. Resident R6 was at risk of changes in the resident's skin due to impaired mobility, incontinence, and a previously healed, unstageable pressure ulcer on the sacrum. Interventions included preventative skin care per facility policy. Review of Resident R6's Physicians' orders dated September 26, 2024, instructed bath/shower and skin check were to be done twice weekly, and instructed the initials of licensed nurse to indicate completion of shower/bath and skin check. Further review of Resident R6's September 2026 through October 2025's skin assessments and treatment administration record revealed no documented evidence that the resident's skin was check. This was confirmed with the DON on November 12, 2025, at 2:00 p.m. Review of Resident R6's skin assessment, dated November 2, 2025, observed a pressure area to the resident's left gluteal fold measuring, 2.5 cm x 0.5cm x 0.2 cm. Nursing progress note, dated November 2, 2025, reported that the Licensed Practical Nurse (LPN) assessed Resident R6 and found a pressure sore, on the resident's left gluteal fold. The same note indicated the skin area was cleansed with NSS (normal saline), pat dry, and covered with sterile 2x2 absorbent dressing, the resident was, Repositioned every two hours to relieve pressure, and the resident was Educated on importance of repositioning and adequate nutrition for wound healing. Continuing review of the nursing progress notes revealed for the next 10 days, from November 2, 2025, through November 11, 2025, nursing was documenting the pressure ulcer was being monitored, the treatment was in place, and the resident was being turned and repositioned. It was confirmed on November 12, 2025, at 2:00 p.m. with the Director of Nursing that Resident R6's left gluteal fold wound instead was a scar from a previous wound that since healed and no treatment was ordered from the physician. Nursing erroneously continued to document on the wound and that the treatment was in place for ten days. Observation of Resident R6 skin on November 13, 2025, at 12:00 p.m. with the DON revealing no open areas on or around the gluteal area. Furthermore, the facility developed care plan for the erroneous left gluteal fold wound due to Resident R6's non-compliance with turning and repositioning, refusal of showers, and care. During the interview with the DON, it was confirmed that ongoing staff documentation indicated the resident was being turned and repositioned, bathed and cared without noted noncompliance as stated in the care plan. 28 Pa Code 211.12(d)(1) nursing services28 Pa Code 211.12(d)(5) nursing services