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	12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Care Pavilion Nursing and Rehabilitation Center	6212 Walnut Street Philadelphia, PA 19139

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on review of facility policies, clinical record review and interviews with staff, it was determined that the facility failed to ensure that the Minimum Data Set (MDS) accurately reflected the resident's diagnoses and medical conditions for two of 42 residents reviewed (Residents R81 and R296). Findings include: Review of facility policy MDS 3.0 Completion dated reviewed December 2025, revealed, Persons completing part of the assessment must attest to the accuracy of the section they completed by signature and indication of the relevant sections. Review of progress notes for Resident R81 from November 4 through 11, 2025, revealed that the resident received hospice services and wound treatments to (his/her) foot. Review of Resident R81's wound consultant note, dated October 31, 2025, revealed that the resident had arterial ulcers [wounds caused by inadequate blood flow] to (his/her) right great, second and third toes. Review of Resident R81's Significant Change MDS (Minimum Data Set - a mandatory periodic resident assessment tool), dated November 11, 2025, revealed that the assessment was not coded to reflect the resident's hospice and vascular wounds. Interview on December 2, 2025, at 1:40 p.m. Employee E21, Assessment Coordinator, confirmed that Resident R81's hospice and vascular wounds were not coded on the resident's November 11, 2025, Significant Change MDS assessment. Review of Resident R296's quarterly Minimum Data Set (mds- a federal mandated assessment tool for all residents) dated November 14, 2025, revealed that the resident entered the facility August 11, 2025 with a cognition assessment brief interview of mental status (BIMS) score of 11 indicating moderate cognitive impairment, the resident has diagnosis of anxiety and suicide ideation. Review of Residents R296's clinical record revealed resident's diagnoses of schizophrenia (Chronic mental disorder causing a distorted view of reality, affecting how a person thinks, feels, and behaves), (alcohol use), suicide ideation (Thoughts or contemplation about ending one's own life) and anxiety disorder (Mental health condition marked by excessive, persistent, and disproportionate fear, wary, and dread that significantly interferes with daily life) dated August 13, 2025. Review of Resident R296's physician orders revealed that resident has been treated with the medications Ononzapine 10 mg to be given twice a day related to schizophrenia since August 11, 2025 and Risperdone 1 mg to be given a bedtime daily related to schizophrenia since August 11, 2025. Residents' physician records revealed that Resident R296 is actively being treated for schizophrenia with the medication Olonzipine 0.5 milligrams. Interview with Assessment Coordinator, Employee E21 on December 4, 2025 at 12:45 p.m. revealed that she's familiar with the resident and confirmed that the resident has a diagnosis of schizophrenia but did not meet the facility criteria after recent CMS audit therefore the diagnosis was taken off his minimum data set. This employee was unable to produce guidelines that she felt the resident did not meet criteria and also could not determine how this determination was made. 28 Pa Code 211.12(d)(1)(5) Nursing services 28 Pa Code 201.14(a) Responsibility of licensee

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of facility policies, clinical record reviews and interviews with staff, it was determined that the facility failed to update resident care plans related to hospice care, life code status, vascular wounds and tube feedings for two of 42 residents reviewed (Residents R81 and R336). Findings include: Review of facility policy, Baseline Care Plan, Comprehensive Care Plan and Ongoing Care Plan Updates dated October 1, 2024, revealed, Nursing staff will update the care plan related to physician's orders and/or changes in care needs. The nursing staff will initiate and/or update acute care plans for the resident as they are warranted. Observation on December 1, 2025, at 1:35 p.m. revealed Resident R81 was resting in bed. The resident's right foot was gangrenous (death of body tissue due to lack of blood flow). Review of progress notes for Resident R81 from August 15, 2025, through December 2, 2025, revealed that the resident received hospice services and wound treatments to his foot. Review of active physician orders for Resident R81 revealed an order, dated November 18, 2025, for hospice care. Continued review revealed on order, dated September 5, 2025, for DNR status (do not resuscitate - do not perform lifesaving interventions in the event the resident has no pulse and had stopped breathing). Review of Resident R81's wound consultant note, dated November 26, 2025, revealed that the resident had arterial ulcers [wounds caused by inadequate blood flow] on the first through fourth digits on his right foot and that the wound appeared gangrenous. Review of Resident R81's care plan, dated January 6, 2021, revealed that the resident had both DNR and Full Code (allows for all interventions needed to restore breathing or heart functioning, including chest compressions, a defibrillator and insertion of a breathing tube) listed on his care plan. Continued review of Resident's R81's care plan, dated December 29, 2020, revealed that the resident had potential for skin impairment. There was no indication on the care plan that to reflect that the resident's right foot had arterial ulcers on the first through fourth digits and that the wound was gangrenous. Further review of Resident R81's care plan revealed that there was no care plan developed to specifically meet the resident's needs related to hospice care. Interview on December 5, 2025, at 10:25 a.m. the Director of Nursing confirmed that Resident R81's care plan had not been updated related to the resident's wounds, hospice needs or to accurately reflect the resident's current code status. Review of Resident R336's clinical record revealed the resident was admitted to the facility on [DATE], for multiple conditions including dysphagia (swallowing difficulties), oropharyngeal phase (difficulty initiating a swallow and can result in health complications, particularly aspiration pneumonia). Review of Resident R336's August 28, 2025, physician's orders revealed the resident had an enteral feeding order for Glucerna 1.2 (or equivalent dayshift AC) enteral liquid via feeding pump at 65 ml/hr until total volume of 1300 ml has infused every dayshift, and document total volume infused. Review of Resident R336's clinical record revealed a care plan for enteral nutrition for Nepro (a therapeutic nutrition product specifically designed for individuals on dialysis and is suitable for tube feeding) at 70 ml/hr. for 15 hours, initiated on November 27, 2023. Interview on December 1, 2025, at 1:50 p.m. with Employee E3, Licensed Nurse, revealed that she checked the August 27, 2025, order for Resident 336's tube feeding and confirmed that care plan should be updated to reflect the order of Glucerna 1.2 at 65 ml/hr. via the feeding pump. 28 Pa Code 211.10(c)(d) Resident care policies 28 Pa Code 211.12(d)(1)(5) Nursing services

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, review of facility documentation, and interviews with residents and staff, it was determined the facility failed to provide adequate supervision to Resident R284 with a diagnosis of alcohol dependency upon return from a leave of absence (Resident R284). The facility failed to ensure that a resident was properly secured during transportation to an outside appointment which resulted in the resident sliding out of the transportation van. (Resident R12) Findings include: Findings include:Review of facility policy title Substance Use Disorder (SUD) dated October 24, 2022, revealed under POLICY: To ensure the preservation of every resident's right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. With this policy Focus Health Network affirms a commitment to maintain a drug-free environment for the health and safety of individuals in the facility but recognizes that residents with a history of substance use disorder may be at increased risk for illegal or prescription drug overdose if the resident continues using substances while residing in the nursing home. Continued review of policy under section revealed Definition: Substance use disorder (SUD) is defined as recurrent use of alcohol and/or drugs that causes clinically and functionally significant impairment. Further review of same policy, under section titled Facility Assessment: revealed Assessment of residents with history of Substance Use Disorder, Interventions to prevent substance use-family/resident counselling. Upon admission, the facility will educate residents and their responsible party on the Substance Use Disorder (SUD) policy. Review of Resident R284's clinical record revealed, Resident R284 was admitted to the facility on [DATE], with diagnosis of Alcohol Dependence with withdrawal, Hypertension (high blood pressure), prostate cancer and history of falling, Review of Resident R284's physician's note dated September 30, 2025, revealed Resident R284 had a history of alcohol use disorder and to continue Naltrexone (prescription medication use to treat alcohol disorders) for alcohol consumption cessation. Review of Social Worker's documentation for Resident R284 dated October 1, 2025, revealed Resident R284 mentioned (he/she) has a history of drinking alcohol. Review of Resident R284's admission Minimum Data Set assessment dated [DATE], revealed the resident was assessed with a BIMS score of 15, which indicated the resident was cognitively intake and was able to make needs known. Review of Resident R284's care plan dated September 30, 2025, revealed the resident had behavior problem of ETOH (alcohol) abuse r/t (related) physical aggression, verbal aggression. Continue review of the resident's care plan did not include a care plan or interventions related to education/counseling resident/family related to substance use during a leave of absence and/or on the facility's policy on substance use. Review of Resident R284's nursing notes revealed on November 7, 2025, at 10:46 a.m. Resident R284 went on an escorted leave of absence with family member in stable condition. Review of facility documentation titled Release of Responsibility for Leave of Absence revealed the following: Resident R284's name, date of November 7, 2025, Time was 10:46am. Expected return at approximately: November 7, 2025, time: 10:46am. Further review of the form revealed Resident R284's handwritten name/signature dated November 7, 2025, and an illegible escort signature dated November 7, 2025. Further, there was no time indicated on the signatures. Review of Resident R284's nursing note dated November 8, 2025, time stamped 6:50 a.m. revealed Resident R284 was received in bed, slept most of the shift, no with no complaints of pain or discomfort. Review of Resident R284's incident fall documentation dated November 8, 2025, at 2:44 p.m. revealed the nurse was notified by resident's roommate that Resident R284 was on the floor. Nurse came into room and seen resident sitting on the side of bed with cut on (his/her) forehead. Resident had a cup in (his/her) hand which contained beer, (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	sitting on the floor was a bag that contained six cans of beer, four were opened. Resident state (he/she) was sitting on the side of bed when (he/she) started to fall asleep and fell and hit (his/her) head. Resident R284 sustained a laceration on the forehead. Further four empty cans of beer and one small empty bottle of unknown liquid was found with resident. Further, resident had a smell of alcohol. Resident R284 did not tell staff how he got the alcohol. Continued review of the fall incident documentation revealed that a skin assessment was completed and the cut on the resident's scalp was cleaned with normal saline and dressing applied. Resident's vitals signs were taken and 911 (Emergency Medical Services) called. Resident was admitted to the local hospital. Additional review of the fall incident documentation indicated Resident R284 was alert and oriented to place, people and time. The Resident was independent with transfer and ambulation was found at baseline. Resident was last seen by staff during rounds around 2pm in stable condition in the room. Resident was out on approved LOA (leave of absence) with family a day prior. Immediate intervention was provided by nursing staff. Diagnostic imaging done at hospital positive for C1 (first cervical vertebra) fracture. Review of Resident R284's clinical record revealed no documented evidence Resident R284 was assessed upon return from leave of absence, or any further supervision of the resident with a history of alcohol dependency upon return from leave of absence. Interview with Director of Nursing (DON), Employee E2 conducted on December 22, 2025, at 2:04 p.m. revealed that the Release of Responsibility for Leave of Absence form was completed by the nurse on the unit and given to the front desk. Further. DON, Employee E2 revealed that there is no logbook at the front desk to sign residents in and out. Further interview with DON, Employee E2 revealed that resident returned from the escorted leave of absence on the same day, November 7, 2025. Interview with Resident R284 conducted on December 2, 2025, at 1:34 p.m. confirming fallen on November 8, 2025. The resident did not disclose the events that led to the fall or reason for falling. Review of the facility's policy titled Facility's Wheelchair Transportation Safety Policy undated, requires multiple procedures to ensure resident safety during transport. Staff responsible for transportation must undergo appropriate training, and driver motor-vehicle records must be checked upon hire and annually. Vehicles must be equipped with emergency communication devices, maintained according to manufacturer guidelines, and inspected routinely with documented checklists. Before loading a resident, staff must visually inspect equipment, ensure safety straps are intact, and park on a flat, unobstructed area. During loading, the staff must ensure that the wheelchair is fully on the lift platform, resident's hands remain on their lap, brakes are engaged, and safety restraints are applied before raising the lift. Once inside the vehicle, wheelchairs must be secured using the manufacturer-specified restraint system compatible with the resident's chair. The vehicle must not move until all wheelchairs are fully secured and seatbelts are fastened. Review of Resident's R12's quarterly Minimum Data Set (MDS -a federal mandated assessment tool for all residents) dated September 2, 2025, revealed that the resident was admitted to the facility on [DATE]. The resident was assessed with a Brief Interview of Mental Status (BIMS) score of 15 indicating this resident was cognitively intact. Continued review of the MDS revealed that the resident was wheelchair dependent and required partial assistance for sit-to-stand and supervision for transfers. Resident R12's diagnosis of anxiety and an absence of left leg below the knee. Review of the documentation submitted to the State Survey Agency revealed that on July 16, 2025, at approximately 2:00 p.m., Resident R12 was accompanied with a nursing assistant out on an appointment. On the return back to the facility, the contracted transportation driver hit a bump leading to the resident partially sliding out of the wheelchair. According to escort the wheelchair was only partially locked. Resident was transported to the hospital noting that there were no bone fractures. Interview with Resident R12 on (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	December 2, 2025, at approximately 1:15 p.m. revealed that on July 16, 2025, (she/he) was coming back to the facility in the contracted transportation van, and (she/he) did not have a safety belt, and (his/her) wheelchair was not secured. The driver hit a bump, and (she/he) fell, out of the wheelchair landing with the wheelchair on top of (her/him). Resident R12 described being in excruciating pain, and demanding be taken to the hospital. Interview on December 3, 2025, at 10:15 a.m. with Nursing assistant, Employee E34, confirmed she was with the resident and she was seated in the front seat of the transport van, when the driver hit a pothole and the wheelchair moved. Resident R12 partially slid off the wheelchair. The van driver immediately stopped the van and secured the resident back in the wheelchair and brought the resident back to the facility. Nursing assistant, Employee E34 confirmed she has since gone on appointments outside the facility with this resident and has not been educated since the incident on any safety protocols or wheelchair safety securing or transport protocol. Review of the facility documentation dated July 16, 2025, revealed that the transportation company confirmed reviewing a video of the incident and determined that the driver did not properly secure the resident and was at fault. 28 Pa. Code 201.14(b) Responsibility of Licensee 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 201.21(c) Use of Outside Resources 28 Pa. Code 201.29 (a) Resident Rights 28 PA. Code 211.12(d)(1)(3)(5) Nursing services

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. Based on clinical record review and interviews with staff, it was determined that the facility failed to ensure a resident's hospice services were accurately reflected in the clinical record for one of two residents reviewed for hospice (Resident R81). Findings include: Review of progress notes for Resident R81 from August 15, 2025, through December 2, 2025, revealed that the resident received hospice services. Continued review of Resident R81's progress notes revealed that there were no notes regarding the resident's clinical condition or choice related to the election of hospice services. Review of physician orders revealed no physician orders for hospice care from September 5, 2025, until November 18, 2025. The above findings were reviewed with the Director of Nursing on December 5, 2025, at 10:25 a.m. 28 Pa Code 211.5(f)(i)(ii) Medical records

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews with residents and staff, it was determined that the facility failed to ensure a safe, functional, sanitary, and comfortable environment for residents, staff and the public for two of seven nursing units reviewed (3 [NAME] nursing unit, 3 East nursing unit.) and the boiler room. Findings include: Tour of the 3 East nursing unit on December 1, 2025, at 11:41 a.m. revealed the following: Resident room [ROOM NUMBER] the fan had fallen off of the wall, the dresser was missing a drawer, the bed remote had frayed wires, two holes in the floorboards were noted, a ceiling panel was loose and floor tiles were taped together.The dining room had five tables that were unsteady and wobbled when leaned on\.The cabinet in the dining room was covered in built-up debris and missing several handles. Tour of the 3 [NAME] nursing unit on December 1, 2025, at 11:02 a.m. revealed the following: Resident room [ROOM NUMBER] toilet was clogged, full of feces and unable to be flushed. Resident R45 stated that staff flush briefs down the toilet, which clogs it, and that it happens often. Also in resident room [ROOM NUMBER] there was a hole in the baseboard behind Resident R375's tube feeding pump. Resident room [ROOM NUMBER] the bathroom overhead light was not working. Resident room [ROOM NUMBER] the bathroom light had no cover and there was a large hole above the baseboard. Resident room [ROOM NUMBER] PTAC unit had wires sticking out from the underside of the unit, the drywall was torn apart next to the sink and the toilet lid cover was too large for the toilet so that the lid would not close properly; The pantry had two floor tiles missing, water was leaking from the water supply line to the floor, there were towels on the floor to absorb the water, and there was no refrigerator on the unit for the storage of resident foods; The medication storage room contained two oxygen tanks stored without holders; The PTAC unit in the dining room was being supported by five pieces of stacked wood pieces; Three tables in the dining room were unstable and wobbled when leaned on; Two windows in the dining room had no screen and one of them would not close all the way due to a missing piece of the window frame. The above findings were reviewed with Employee E12, Maintenance Director, on December 4, 2025, at 9:23 a.m. Observations during the initial tour of the building on December 1, 2025, at 10:05 a.m. revealed the following: Observations on the 2nd Floor [NAME] Unit revealed the fluorescent lighting in the ceiling was out and dark near rooms [ROOM NUMBERS]. Observations in the central bathroom on 2nd Floor [NAME] revealed an unlocked door and renovations inside the bathroom where all the floor tiles and baseboards had been removed leaving dangerous open holes in the floor where drain grates were removed. Observation in room [ROOM NUMBER] bed A revealed that the headboard of the bed was off and leaning against the wall. Observation in room [ROOM NUMBER] revealed that the baseboards were lose and there were holes in the wall above the baseboard near the sink and the walls were scuffed with dark marks. Observation in room [ROOM NUMBER] revealed that the walls were scuffed and dirty with black marks. Observation in room [ROOM NUMBER] revealed that the baseboards were lose and the walls were wavy and scuffed with dark marks. Observation in room [ROOM NUMBER] revealed that the baseboards were lose and the walls were scraped with dark marks. Observations on the 3rd Floor [NAME] Unit revealed PTECC/HVAC wall units in rooms [ROOM NUMBERS] that the bottom panel was missing or lose on the floor exposing dangerous sharp edges and internal parts. Observations on the 1st Floor East unit the door to the employee bathroom was broken and lose and the metal door frame was disconnected from the floor causing the entire unit to move when pushed on. Observations during a tour of the boiler room on December 3, 2025, at 11:50 a.m. with the Maintenance Director, Employee E12 and the Regional Maintenance Manager, Employee E13 revealed standing water covering most of the floor all the way to the doorway threshold entering the hall outside the kitchen. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Maintenance Director revealed that the hot water holding tank had been leaking and the facility was planning on replacing it. He was unsure how long the leaking had been going on. Observation of the 3 [NAME] nursing unit on December 1, 2025, at 11:02 a.m. revealed that the central shower room was undergoing renovations. The toilet, shower and bath fixtures had been removed from the room, and the flooring had been removed, exposing concrete flooring. There were multiple deep holes in the floor in the area where the toilet had been removed as well as in the center of the room. Multiple ceiling panels had fallen and were caved in. Continued observation of the 3 [NAME] shower room revealed that the construction area was unsecured. Interview on December 1, 2025, at 11:20 a.m. Resident R45 stated that a week ago he went into the 3 [NAME] shower room to use the toilet when he noticed that all of the fixtures were removed. The resident stated that now he has to use a shower room on another nursing unit. Interview on December 2, 2025, at 9:32 a.m. Employees E25 and E26, nurse aides, confirmed that the 3 [NAME] shower room was under construction and that the doors to the room have been left unsecured. The employees confirmed that residents have to use shower rooms on other units due to the construction. Interview on December 4, 2025, at 9:23 a.m. Employee E12, Maintenance Director, confirmed that the 3 [NAME] shower room was under construction for repairs and renovations due to leaks. Observation of the East Stairwell on December 5, 2025, at 10:33 a.m. revealed that the roof access door was open, which would allow weather elements and pests to enter the building. Continued observation of the East Stairwell and interview with the Nursing Home Administrator on December 5, 2025, at 10:45 a.m. confirmed that the roof access door should not be left open. 28 Pa Code 201.14(a) Responsibility of licensee 28 Pa Code 201.14(a) Responsibility of licensee