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	06/10/2026

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews with residents and staff, the facility failed to maintain clean, safe and homelike environment on three of seven nursing units reviewed (1 East unit, 2 East unit, 2 [NAME] unit). Findings include: Observation on June 9, 2026, at 9:48 a.m. of the 1 East unit revealed multiple missing and stained ceiling tiles in the hallway by the shower rooms. Observation on June 9, 2026, at 10:45 a.m. of the 2 East unit revealed multiple missing and stained ceiling tiles in the hallway by the shower rooms. room [ROOM NUMBER] had a large missing ceiling tile directly above the handwashing sinks and a ceiling tile that was caving in directly above the toilet. Observation on June 9, 2026, at 10:52 a.m. of the 2 [NAME] unit revealed that the PTAC (heating and cooling unit) in the dining/activity room was open underneath and the unit was being held up by a piece of wood. room [ROOM NUMBER] had food and debris all over the floor, the floors were heavily soiled with grime, the PTAC unit had an open exposed area, the tray tables were heavily soiled and the dresser was missing a bottom drawer. room [ROOM NUMBER] the floor was heavily soiled, with grime and debris crusted along baseboards and behind furniture. room [ROOM NUMBER] the floor was heavily soiled, with grime and debris crusted along baseboards and behind furniture; clothes were strewn across the floor and an oxygen tank was standing up in the room without a holder. room [ROOM NUMBER] beds B and C had full urine bottles on the beds and dresser, B bed and floor were soiled with feces, clothes were piled up on the floor with debris along the baseboards and behind the dressers and the PTAC unit had an open exposed area. The above findings were reviewed with the Nursing Home Administrator and Director of Nursing on June 10, 2026, at 12:00 p.m. 28 Pa Code 201.24(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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policies, clinical record reviews and interviews with staff, it was determined that the facility failed to investigate an injury of unknown origin to rule out abuse and neglect for one of three residents reviewed for wounds (Resident R4).Findings include: Review of facility policy Abuse dated reviewed June 1, 2025, revealed, Neglect occurs when the facility is aware of, or should have been aware of, goods or services that a resident(s) requires but the facility fails to provide them to the resident(s), that has resulted in or may result in physical harm, pain, mental anguish, or emotional distress. Continued review revealed, Neglect may be the result of a pattern of failures or may be the result of one or more failures involving one resident and one staff person's the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Further review revealed, Investigation of injuries of Unknown Origin or Suspicious injuries must be immediately investigated to rule out abuse.Review of Resident R4's Significant Change MDS assessment (Minimum Data Set - a mandatory periodic resident assessment tool), dated March 23, 2026, revealed that the resident was admitted to the facility on [DATE], with diagnoses including cerebrovascular disease (damage to the brain from interruption of its blood supply), and end stage renal disease (a medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life). Continued review revealed that the resident was severely cognitively impaired, received hospice services and tube feedings. Further review revealed that the resident was dependent for all activities of daily living, including toileting, bathing, dressing, hygiene, bed mobility and transfers.Review of Resident R4's care plan, dated initiated October 21, 2025, revealed that the resident was at risk for impairments to skin integrity related to impaired mobility. Interventions included to monitor/document location, size and treatment of skin injuries and to report abnormalities, failure to heal, or signs/symptoms of infection to the physician.Review of Resident R4's Wound Consultant Report authored by wound physician, dated June 3, 2026, revealed the resident was seen for follow-up of multiple wounds and initial evaluation of a right hallux (big toe) trauma wound. The report notes the right hallux wound was a full thickness (severe injury extending through the skin layers into the subcutaneous tissue) wound with infection. Wound measurements were 3.8 cm (centimeters) length by 3.2 cm width by 0.3 cm depth, with an area of 12.16 square centimeters. The report noted adipose (fat) tissue was exposed and the wound probed to bone, indicative of osteomyelitis (bone infection). The report further noted the periwound (tissue surrounding the wound) had signs of infection. Continued review of Resident R4's clinical record, including progress notes, nursing assessments, skin assessments, care plan, hospice notes and dialysis notes failed to reveal evidence the right hallux wound was observed or assessed prior to the wound consultant report on June 3, 2026.Interview on June 10, 2026, at 8:53 a.m. with the facility's wound team, consisting of Employee E6, Licensed Nurse; Employee E7, Licensed Nurse; and Employee E8, Wound Consultant; revealed they were not aware of how, why, or when Resident R4 acquired the right hallux wound. Employee E6 stated staff nurses are expected to complete an incident report and document in the notes any new skin impairments. Review of Resident R4's TARs revealed Employee E9, licensed nurse, provided wound treatments to Resident R4 on May 27, 28, 29 and June 1, 2, 3, 4 and 5, 2026.Interview on June 10, 2026, at 9:17 a.m. Employee E9, Licensed Nurse, confirmed she provided regular care, including wound treatments, to Resident R4. Employee E9 stated she does not recall the resident having any toe wounds.Interview on June 10, 2026, at 9:35 a.m. Employee E4, Assistant Director of Nursing, revealed no incident reports had been completed related to Resident R4's right hallux wound. Continued interview revealed staff nurses are responsible for completing incident reports and notes for any new skin impairments.Interview on June 10, 2026, at 9:40 a.m. Employee E2, Director of Nursing revealed he was unaware of Resident R4's right hallux (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wound. The Director of Nursing confirmed a full-thickness wound with exposed adipose tissue would not become infected on the same day that it occurred and the wound would have occurred prior to its discovery on June 3, 2026.Follow-up interview on June 10, 2026, at 10:12 a.m. the Director of Nursing confirmed there was no documentation of the right hallux wound and no incident report prior to the wound being discovered as infected by the wound team on June 3, 2026. The Director of Nursing revealed the wound care team are expected to immediately enter treatment orders for all wounds after their assessments. The Director of Nursing confirmed there was no transcription or communication of treatment orders for Resident R4's right hallux wound. Further, the Director of Nursing stated he was not aware of the right hallux wound until it was brought to his attention by the survey team.28 Pa Code 201.18(b)(1) Management28 Pa Code 211.12(d)(1)(3)(5) Nursing services

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews and interviews with staff, it was determined the facility failed to identify a full-thickness foot wound with exposed adipose (fat) tissue in a timely manner, for one of three residents reviewed for wounds. This failure resulted in actual harm to Resident R4 who developed an infection of the right big toe. (Resident R4) Findings include: Review of Resident R4's Significant Change MDS assessment (Minimum Data Set - mandatory periodic resident assessment tool), dated March 23, 2026, revealed the resident was admitted to the facility on [DATE], with diagnoses including Cerebrovascular Disease (damage to the brain from interruption of its blood supply), and End Stage Renal Disease (medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life). Continued review of Resident R4's MDS assessment revealed the resident was severely cognitively impaired, received hospice services and enteral tube feedings. Further review revealed Resident R4 was dependent for all activities of daily living, including toileting, bathing, dressing, hygiene, bed mobility, and transfers. Review of Resident R4's care plan, dated initiated October 21, 2025, revealed the resident was at risk for impairments to skin integrity related to impaired mobility. Interventions included to monitor/document location, size, and treatment of skin injuries and to report abnormalities, failure to heal, or signs/symptoms of infection to the physician. Review of Resident R4's Wound Consultant Report, dated May 27, 2026, revealed the resident was seen for follow-up of multiple wounds and initial evaluation of a right medial (inner) ankle arterial wound (wound caused by poor blood flow) and a right lower leg trauma wound. Both wounds were noted as granulation (healthy skin tissue) and had no signs of infection. The wound consultant recommended for both the right medial ankle and right lower leg wounds to be cleansed with normal saline and a xeroform (medicated gauze) dressing. Further review of the Wound Consultant Report dated May 27, 2026; revealed Resident R4 also had wounds requiring treatments to the sacrum, right medial (inner) knee, left medial knee, right proximal tibia (lower leg) and right ischium (hip). Review of Resident R4's Wound Consultant Report authored by wound physician, dated June 3, 2026, revealed the resident was seen for follow-up of multiple wounds and initial evaluation of a right hallux (big toe) trauma wound. The report notes the right hallux wound was a full thickness (severe injury extending through the skin layers into the subcutaneous tissue) wound with infection. Wound measurements were 3.8 cm (centimeters) length by 3.2 cm width by 0.3 cm depth, with an area of 12.16 square centimeters. The report noted adipose (fat) tissue was exposed and the wound probed to bone, indicative of osteomyelitis (bone infection). The report further noted the periwound (tissue surrounding the wound) had signs of infection. The wound consultant recommended for the wound to be cleansed with normal saline, treated with a honey dressing and covered with a border dressing every other day. Further review of the Wound Consultant Report from June 3, 2026, revealed Resident R4 also had wounds that required treatments to the sacrum, right medial knee, left medial knee, right proximal tibia, right ischium, right lower leg and right medial ankle. Review of Resident R4's Treatment Administration Records (TARs) for May and June 2026 revealed resident received wound care treatments every other day to the right tibia, left ankle, left knee and right knee; and daily treatments to the right ischium and sacrum. Continued review of TARs failed to reveal evidence of Resident R4 was prescribed or received any treatments to the right medial ankle and the right lower leg wounds. Further review of TARs failed to reveal evidence Resident R4 was prescribed or received any treatments to the right hallux wound. Continued review of Resident R4's clinical record, including progress notes, nursing assessments, skin assessments, care plan, hospice notes and dialysis notes failed to reveal evidence the right hallux wound was observed or assessed prior to the wound consultant report on June 3, 2026. Interview on June 10, 2026, at 8:53 a.m. with the facility's wound team, consisting of Employee E6, Licensed Nurse; Employee E7, Licensed Nurse; and Employee E8, Wound Consultant; revealed (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	they were not aware of how, why, or when Resident R4 acquired the right hallux wound. Employee E6 stated the wound team assesses all wounds weekly and upload their reports into the clinical records. Employee E6 stated staff nurses are expected to complete an incident report and document in the notes any new skin impairments. Employees E6, E7 and E8 were not able to recall any specific clinical details regarding Resident R4's wounds and stated there are a lot of wounds in the facility. Resident R4 was not available for observation or assessment at the time of the survey. Continued review of Resident R4's TARs revealed Employee E9, licensed nurse, provided wound treatments to Resident R4 on May 27, 28, 29 and June 1, 2, 3, 4 and 5, 2026. Interview on June 10, 2026, at 9:17 a.m. Employee E9, Licensed Nurse, confirmed she provided regular care, including wound treatments, to Resident R4. Employee E9 stated she does not recall the resident having any toe wounds. Interview on June 10, 2026, at 9:35 a.m. Employee E4, Assistant Director of Nursing, revealed no incident reports had been completed related to Resident R4's right hallux wound. Continued interview revealed staff nurses are responsible for completing incident reports and notes for any new skin impairments. Interview on June 10, 2026, at 9:40 a.m. Employee E2, Director of Nursing revealed he was unaware of Resident R4's right hallux wound. The Director of Nursing confirmed a full-thickness wound with exposed adipose tissue would not become infected on the same day that it occurred and the wound would have occurred prior to its discovery on June 3, 2026. Follow-up interview on June 10, 2026, at 10:12 a.m. the Director of Nursing confirmed there was no documentation of the right hallux wound and no incident report prior to the wound being discovered as infected by the wound team on June 3, 2026. The Director of Nursing revealed the wound care team are expected to immediately enter treatment orders for all wounds after their assessments. The Director of Nursing confirmed there was no transcription or communication of treatment orders for Resident R4's right hallux wound. Further, the Director of Nursing stated he was not aware of the right hallux wound until it was brought to his attention by the survey team. 28 Pa Code 211.5(f)(i)(ii)(iii)(vii)(ix) Medical records 28 Pa Code 211.12(d)(1)(3)(5) Nursing services

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on review of communication records, facility documentation and interviews with staff, it was determined that the facility failed to provide medical records in a timely manner to the Area Agency on Aging as required by law, for one of one records reviewed (Resident R2). Findings include: Service Access and Management, Inc, (SAM) works on behalf of the Philadelphia Corporation for Aging and has been designated by the Commonwealth of Pennsylvania Department of Aging as the Area Agency on Aging in Philadelphia. SAM is authorized to receive and investigate allegations of abuse, neglect, financial exploitation and abandonment of older Philadelphians in accordance with the Older Adults Protective Services Act. Review of Title 45 Code of Federal Regulations Section 164.512(c)(1) revealed that disclosures of protected health information are permitted when the entity reasonably believes an individual to be a victim of abuse, neglect or domestic violence. Review of electronic communication records revealed that on May 18, 2026, at 11:06 a.m. SAM sent a request for medical records for Resident R2, including most recent physician note, most recent assessment and investigative documents pertaining to an allegation of abuse. The electronic communication was addressed to Employee E1, Administrator, and Employee E5, Director of Social Work. Continued review of electronic communication records revealed that additional requests for Resident R2's records were made by SAM on May 20, 22 and 27, 2026. These requests were again addressed to Employees E1 and E5. An additional request noted that a representative from SAM spoke with Employee E2, Director of Nursing, on May 28, 2026. The request indicated that they were still waiting for physician notes and abuse investigation documents for Resident R2. The request was addressed to Employees E1, E5 and E10, social worker. During Entrance Conference on June 9, 2026, at 9:00 a.m. with facility administrative staff, evidence was requested regarding the provision of the medical records to SAM related to Resident R2. Employee E2, Director of Nursing, stated that he was not aware of the request. Interview on June 9, 2026, at 10:19 a.m. with Employee E5, Director of Social Work, stated that she made the Administrator and Director of Nursing aware of the request from SAM. Employee E5 stated that Employee E10 was the facility social worker responsible for Resident R2. Employee E5 stated that Employee E10 would be the one responsible for sending the clinical documents to SAM and that the Director of Nursing would be the one responsible for sending the abuse investigation documents to SAM. Follow-up interviews on June 9, 2026, at 12:25 p.m., 1:55 p.m. and 2:55 p.m. with Employee E5 revealed that she was unable to provide any evidence that the requested records for Resident R2 were sent to SAM at the time that they were requested. Employee E10 was unavailable for interview. 28 Pa Code 201.24(a) Responsibility of licensee28 Pa Code 211.5(b)(2)(i) Medical records28 Pa Code 211.12(d)(3) Nursing services

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of facility documentation and interviews with residents and staff, the facility failed to maintain an effective pest control program for seven of seven nursing units reviewed (1 East unit, 1 [NAME] unit, 2 East unit, 2 [NAME] unit, 3 East unit, 3 [NAME] unit, 4 [NAME] unit). Findings include: Interview on June 9, 2025, during entrance conference, the Nursing Home Administrator revealed that the facility recently contracted with a new pest control company due to ongoing pest issues. Interview on June 9, 2026, at 9:20 a.m. Resident R7, on the 1 [NAME] unit, stated that the mice and roaches problem has not gotten any better. Observation, at the time of the interview, Resident R7 opened a dresser drawer and showed that there were mouse droppings throughout the clothes and linens in the drawer. Interview on June 9, 2026, at 9:48 a.m. on the 1 East unit, a laboratory technician who requested to remain anonymous, stated that they come into the facility at 3:00 a.m. and always see mice, roaches and flies. The employee stated that they do not feel comfortable working at the facility because of the pests. Interview on June 9, 2026, at 9:50 a.m. Resident R8, on the 1 East unit, stated that mice run out from under the PTAC (heating and cooling) unit. Observation, at the time of the interview, revealed pink fiberglass insulation with open avoids and mouse droppings underneath the PTAC unit. Interview on June 9, 2026, at 10:10 a.m. Resident R9, on the 1 East unit, stated that a mouse had eaten through the packaging of her sandwich. Observation, at the time of the interview, revealed that Resident R9 had numerous opened and soiled food containers surrounding her in bed. The bedside tray table was heavily soiled with debris and a styrofoam cup on the tray table was completely encased in fruit flies. Numerous flies were observed flying around the resident. Multiple roaches were observed in a glue trap behind the resident's bed. Continued interview, Resident R9 and her roommate Resident R10, stated that they see mice everyday run across the room. Observation on June 9, 2026, at 10:50 a.m. room [ROOM NUMBER], on the 2 East unit, revealed numerous flies in the room. Observation on June 9, 2026, at 10:55 a.m. room [ROOM NUMBER], on the 2 [NAME] unit, revealed mice droppings along the baseboards in the room. Several open bags of clothes were noted on the floor with mice droppings noted in the clothes. Review of pest control report, dated May 27, 2026, revealed that cockroaches were observed near the reception desk and 3rd floor nurse stations. Rooms 351, 355, 356, 357, 359 and 370 were inspected and treated for roaches, mice and ants. A mouse was observed in room [ROOM NUMBER]. Rats were observed in the front of the facility. The pest control company recommended deep cleaning of all rooms and noted that floors have been neglected; debris, spills, mice droppings and urine odors were found throughout the listed rooms and hallways. Review of pest control report, dated June 5, 2026, revealed that excessive mice activity was observed on each floor. Rooms 301, 316, 162, 175, 201 and 318 were treated for roaches, mice and ants and that excessive mouse activity was found in each room. The pest control company met with maintenance and housekeeping staff and recommended that the facility would benefit from improved sanitation. The above findings were reviewed with the Nursing Home Administrator and Director of Nursing on June 10, 2026, at 12:00 p.m. 28 Pa Code 201.24(a) Responsibility of licensee