STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395467	A. Building B. Wing	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cathedral Village	600 East Cathedral Road Philadelphia, PA 19128

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. 36609 Based on the review of facility documentation, review of clinical records, and interviews with resident and staff, it was determined the facility failed to monitor the temperature of a hot liquid before being served to a resident. This failure resulted in actual harm to Resident R1 who spilled hot water and sustained a second degree burn on the forearm for one of two resident records reviewed (Resident R1). Findings include: Review of Resident R1's admissions, Minimum Data Set (MDS- assessment of resident needs) dated August 12, 2024, revealed a BIMS (brief interview for mental status) score of 14 which indicated that the resident was cognitively intact. Continued review of the MDS revealed that the resident had physical impairments to both sides of her upper body, used a walker for ambulating, was occasionally incontinent of bowel and bladder, had a history of falls, and was dependent on staff (helper does all the effort to complete the task) for her activities of daily living including eating.) The same MDS had diagnoses for the resident that included dementia (cognitive loss) arthritis (joint pain), and osteoporosis (brittle weak bones). Review of nursing note, dated September 8, 2024, stated Resident R1 spilled hot water on her right forearm and knee. Her forearm was noted to have a wrinkled layer of skin that was intact measuring 8 x 7.5 cm and a redden area on her knee measuring 12 x 12 cm. Review of the wound consultant notes dated September 12, 2024, revealed that Resident R1 was assessed with a second degree burn to her right forearm measuring 9 x 6.5 x 0.1 cm with 100% of epithelial tissue (first stage in wound healing) and scant drainage. (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 0689 Level of Harm - Actual harm Residents Affected - Few	Review of facility documentation revealed the Nursing Home Administrator (NHA) and the Director of Nursing (DON) conducted a telephone interview with Nursing Assistant (NA), Employee E3, who served Resident R1 hot water for the resident's tea. The NA, Employee E3, stated she went to the dining room to get juice for the resident and a dietary aide was there to assist her. The NA, Employee E3 said the dietary aide was no longer in the dining room when the NA, Employee E3 went back for the hot water. The NA, Employee E3 indicated she then took a standard mug and filled it with hot water from the coffee dispensers located in the dietary area of the dining room and then served it to Resident R1. Approximately 30 minutes later the NA, Employee E3 was informed that Resident R1 burned herself taking the lid off the mug. The documentation further revealed the NA, Employee E3 was, Unaware of how hot the water was coming out of the dispenser. Interview conducted with Resident R1 on September 19, 2024, at approximately 1:00 p.m. the resident confirmed that the nursing assistant handed her a mug of hot water and left the room. The resident stated, I had a very hard time taking the white lid off the mug because my hands don't work so well. It slipped out of my hands and hot water spilled on my arm and all over my chair where I was sitting. Observation conducted during the interview revealed a gauze bandage wrapped around Resident R1's right wrist and forearm. The Assistant Director of Nursing removed the bandages to reveal the burn. Instead of seeing the resident's normal dark skin color, the skin appeared raw and red with outer white edges, approximately 8 x 4 cm in length. The resident said. It (the burn) still hurts but it is getting much better. Interview with the Nutrition Coordinator, Employee E6 during lunch observation on September 19, 2024, at approximately 1:30 p.m. indicated the dietary department is responsible for servicing hot beverages. It was observed that the hot liquids were taken from the coffee/water dispenser and served in carafe where they are cooled down to a safe temperature prior to being served to the residents. Dietary logs for the month of September 2024 revealed coffee and hot water temperatures were obtained and within the specified temperature standards listed on the log forms which was between 145-155 degrees. Interview with the Food Service Director, Employee E5 on September 19, 2024, at 1:30 p.m. revealed that the facility was currently working on developing a policy on the temperature of hot beverages at the time of service. Interview with NA, Employee E3 was attempted on September 19, 2024, via phone but no returned called was received. The facility failed to ensure safe hot water temperatures prior to being served to Resident R1. This failure resulted in actual harm to Resident R1 who spilled the hot water and sustained a second degree burn on her right forearm. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.6(c)(d) Dietary Services