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	06/16/2025

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, review of clinical records, facility documentation, and facility policy, it was determined the facility failed to ensure one of four residents reviewed was free of neglect, (Resident R1). This failure resulted in actual harm to Resident R1 who was not provided care by two nurse aides while experiencing a combative episode. Resident R1 grabbed onto nurse aide, who moved resident's arm, resulting in a fracture of the right humerus (arm). Finding includes: Review of the facility policy titled Abuse, Neglect or Exploitation, last dated October 2023, states, That each resident is provided with a safe environment where they are not subject to mental, physical, verbal, and sexual abuse. Residents shall also be protected from mistreatment, neglect, exploitation, and misappropriation of property. Review of Resident R1's quarterly Minimum Data Set, (MDS-assessment of resident needs) dated May 17, 2025, revealed the resident was assessed as severely cognitively impaired, diagnosed with Traumatic Brain Injury, Quadriplegic, (experiencing limited or complete loss of movement and sensation in their arms and hands), Multiple Sclerosis (disease progression effecting the brain and the spinal cord), and Dementia (decline in mental ability, interfering with activities of daily living). Further review of MDS assessment revealed the resident was incontinent of bowel and bladder, dependent on staff for toilet hygiene and transfers and required substantial/maximal assistance for bed mobility and personal hygiene. The resident was assessed as requiring maximum assistance with upper body dressing and total dependence with lower body dressing, Continued review of the MDS revealed that the resident had one side impairment of the upper extremities and impairment of both side to the lower extremities. The resident required substantial to maximum assistance with toileting. The resident displayed physical and verbal behaviors four to six days, but less than daily. Review of Resident R1's physician orders of October 19, 2024, revealed an order for nursing staff to document Resident R1's behaviors, including, combativeness, resistive to care, verbal and/or physical aggression, sexually inappropriateness, and wandering. Review of Resident R1's care plan dated February 19, 2025, revealed the resident required two staff assistance with bed mobility and deemed total dependance for toileting. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of Resident R1's nursing notes dated, March 29, 2025, revealed the resident was agitated, yelling. Additional review revealed the resident removed shirt and attempted to take off pants, while ripping up incontinence brief. Review of Resident R1's nursing notes dated, May 1, 2025, revealed the resident attempted to go outside unsupervised. When Resident R1 was redirected the resident cursed and yell including, I'm going to kill all of you. Review of Resident R1's physician note, dated May 11, 2025, indicated Resident R1 yells and refuses care at times. Review of the facility documentation submitted to the State Survey Agency on June 6, 2025 revealed, on June 4, 2025 while nurse aide, Employee E3 was providing care the resident was combative, the resident grabbed the CNA's (nurse aide) leg, when the CNA lifted the resident's arm to remove (her/his) hand from (his/her) leg he heard a pop sound. The resident then yelled out in pain. CNA notified RN (Registered Nurse) Supervisor, who assessed and notified the MD (physician) who ordered for resident to be sent to ED (Emergency Department) for evaluation. Review of incident investigation note dated June 4, 2025 at 10:10 p.m. revealed Resident sustained injury to right upper extremity during incontinence care and was transferred to [hospital] for further evaluation. Per CNA (nurse aide) resident was displaying combative behavior while [he/she] was being changed. Review of nursing notes dated June 5, 2025 at 9:06 a.m. revealed Resident unexpectedly admitted to the hospital 6/4/25. Continued review of nursing notes revealed a note dated June 8, 2025 at 3:59 p.m. Readmit to unit. DX (diagnosis) R (right) arm FX (fracture) Received resident AAOX1-2 (oriented to people, time, or place) in bed with soft cast removed and thrown on the floor. Review of Resident R1's hospital discharge documentation revealed, the resident was admitted to the hospital on [DATE] and discharged on June 6, 2025 with a diagnosis of closed fracture of distal end of right humerus (arm). Review of a brief description of the incident/accident from a written statement obtained from Nurse Aide (NA), Employee E3 who provided to Resident R1 care on June 4, 2025 revealed, while receiving incontinence care [Resident R1] became combative grabbed onto my thigh with both hands. While using my right hand, I attempted to move [Resident R1's] arm by the top of (her/his) wrist. [Resident R1] continued to press [his/her] arm towards me, for only a brief moment . before arm produced a loud pop and (she/he) no longer produced any force. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Continued review of the written statement revealed [Resident R1] became less agitated up to during and even after dinner. However, [Resident R1] became less agitated before I decided to change (her/him). While being changed (she/he) initially seem to be as combative is (she/he) is most days, however once I turned (her/him) to face towards me. (She/He) began screaming and grabbed onto my right thigh with both hands . [Resident R1] began to hurt my thigh as (she/he) grabbed me, and was not responsive to me asking (her/him) to let me go. I placed my right hand onto the top of (her/his) right wrist and began moving (her/him) arm away form my thigh towards (her/him) torso. [Resident R1] continued to reach for my body for a brief amount of time . before (her/his) arm produced a loud pop and (she/he) was and (she/he) was no longer producing force. I immediately alerted nursing staff and supervisor. Review of facility abuse investigation documentation revealed, the facility concluded the allegation of neglect was substantiated due to resident's need for two staff members during incontinence care for safety but only one nurse aide performed the care. Nurse aide, Employee E3 was terminated from employment on June 9, 2025. Interview with the Nursing Home Administrator and Director of Nursing on June 16, 2025 at approximately 11:00 a.m. confirmed Resident R1's combative behaviors, and failed to have the required two staff members present during care on June 4, 2025. The facility failed to ensure that two staff members provided care to Resident R1, who displayed combative behaviors during care. This failure resulted in actual harm to Resident R1 who was assisted by one staff member during care, resident became combative, grab the nurse aide's leg who proceeded to move the resident's arm and Resident R1 sustained a fracture of the right humerus. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(b)(1)(e)(1) Management. 28 Pa. Code 211.10(c)(d) Resident Care Policies. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.