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	03/25/2026

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 - 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 review of clinical documentation and interviews with staff, it was determined that the facility did not ensure that one resident was free from accidents and hazards related to inappropriate transfers for one of five residents reviewed. This deficiency is cited as past non-compliance. (Resident R1) Findings include: Review of Resident R1's clinical record revealed that the resident was admitted to the facility on [DATE], and had diagnoses including Alzheimer's disease (progressive degenerative disease of the brain, resulting in loss of reality contact), chronic kidney disease, and depression (major loss of interest inpleasurable activities). Review of facility documentation submitted to the State Survey Agency on February 28, 2026, revealed [Resident R1] was gently guided to the floor matt by one aide during transfer from bed to chair. When reviewing incident and care plan IDT (Inter-Disciplinary Team) noted that care plan reflects transfer utilizing 2 person stand up lift. Resident did not sustain any injury. Resident was immediately assessed, no injuries noted. Vital Signs stable. MD (physician) and responsible party notified. Therapy to re evaluate to ensure the use of stand up lift is the most appropriate mode of transfer.Review of the incident investigation confirmed that Nurse aide, Employee E3 was assisting the resident with morning care on February 28, 2026. A witness statement from Nurse aide, Employee E3, emailed on March 2, 2026, stated [I] was assistanting [Resident R1] to get up for the day he was sitting on the edge of the bed stood him up he couldn't stand so I assisted him down the floor and got staff help to get him up go report from [Employee E4] he was stand and pivot. A record of a verbal statement from Nurse aide, Employee E4, dated March 2, 2026, stated I thought (he/she) was a pivot to the chair.[Nurse aide, Employee E3] did not ask anyone for any assistance in putting the resident in the chair. A written statement from Nurse aide, Employee E4, signed March 2, 2026, stated I gave report at the start of shift to the CNA (Nurse aide) on [Resident R1]. She also had a copy of the assignment and also had access to the Kardex (electronic system which contains documentation on the care needs of a resident). A statement from Licensed nurse, Employee E5, stated Pt (patient) has 2 cuts on (her/his) forehead, above the [right] & [left] eyes, a bump in between the cuts, & a black eye. Mouth was bleeding too, I wiped the blood and noticed that the patient has a small cut insider (her/hids [right] upper mouth.I checked the side of the bed & noticed that there was blood on the [right] corner side of the bed frame. Review of the care plan for Resident R1 revealed an intervention dated July 21, 2025, that stated The resident requires sit to stand lift (a type of mechanical lift that enables safe transfer between surfaces) with 2 staff assistance for transfers. Review of the documentation related to transfers for Resident R1 revealed that from February 24 through February 28, 2026, that out of nine documented assisted transfers, four were appropriately documented as a two person assist, while five were documented as one person assist. For those same nine transfers, four were appropriately documented as total dependence on staff, while three were documented as extensive assistance (resident is involved in the transfer, but staff bear some of the resident's weight during the activity), one was documented as independent (the staff provides no help or supervision), and one was documented as not applicable. During an interview on March 25, 2026, at 11:15 a.m., the Nursing Home Administrator (NHA), (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

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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 - Minimal harm or potential for actual harm Residents Affected - Few	Employee E1, revealed that during the investigation, Nurse aide, Employee E3 was found to have not appropriately ensured that the method of transfer for Resident R1 was consistent with the plan of care. The NHA also confirmed that any mechanical lift requires two nursing staff to operate. Documentation was presented on March 25, 2026, by the NHA, alleging that the facility had initiated a plan of correction on March 2, 2026, related transfer safety. The facility alleged a date of compliance of March 5, 2026. The plan of correction stated the following:Resident lowered to the floor matt during transfer; no injuries. Care plan reviewed and found to be 2 person stand up lift for all transfers.Care plans will be reviewed for transfers using stand up lifts to ensure they are linked to Kardex. Completion date: 3/4/26The Director of Nursing or Designee will re educate the nursing staff on utilizing Kardex for transfer status. Return demonstration from licensed nurses and care aides in regards to accessing Kardex. Completed: 3/4/26.The Director of Nursing or Designee will complete a random audit on 3 residents weekly x 4 weeks and then monthly x 2 months who are stand up lift transfers to ensure stand up lift transfer is noted on the assignment sheets. Audits will be forwarded to the Quality Assurance Team for review and any recommendations needed. Facility education record and subsequent audits were verified for completion. Staff were interviewed to verify education of appropriate verification method for transfer status. Random staff and resident interviews were conducted to verify compliance with the plan of correction. QAPI records reviewed to verify ongoing monitoring. Observations on the units revealed staff to be utilizing the Kardex to verify transfer status. Further observation confirmed residents were being safely transferred in accordance with the plan of care. No continuing concerns were identified through record review, interview or observation. This deficiency was cited as past non-compliance.28 Pa. Code 201.14. (a) Responsibility of licensee28 Pa Code 201.18(b)(1) Management