

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395467	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/02/2024
NAME OF PROVIDER OR SUPPLIER Cathedral Village		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>41471</p> <p>Based on the review of clinical records, interviews with staff, review of employees' personnel files and review of facility policy, it was determined that the facility failed to promote resident rights related to the communication to residents of an alleged violation reported to the facility which affected the safety and wellbeing of 63 residents at the facility for one of six personnel files reviewed. (Employee E21)</p> <p>Findings Include:</p> <p>Review of facility policy Abuse Neglect or Exploitation revealed that It is the policy of Facility Name facilities 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.</p> <p>Exploitation: An act or course of conduct, including misrepresentation or failure to obtain informed consent which results in monetary, personal or other gain of profit for the perpetrator or monetary or personal loss to the resident.</p> <p>Misappropriation of Resident's Property: Includes but is not limited to the deliberate misplacement, exploitation, or wrongful (temporary or permanent) use of a resident's belongings or funds without the resident's consent. Also includes denying the resident of property for personal gain or satisfaction.</p> <p>Residents or residents' representatives shall be informed of all reports filed on the residents' behalf regarding abuse, neglect and/or misappropriation unless informing the resident would put the resident at risk of serious harm, or the resident, representative for either a competent or incompetent resident.</p> <p>Substantiated incidents require the Administrator or designee to: 1. Report to the licensing/certifying authorities, any actions by a court of law, which would indicate an employee is unfit for service. 2. Analyze the occurrences to determine what changes in policy, procedure or practice that may be needed to prevent further occurrences.</p> <p>(continued on next page)</p>

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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of facility documentation dated February 2, 2024, revealed that A concern was brought to this NHA(Administrator) on February 2, 2024, at approximately 10:13 a.m. regarding a licensure investigation . Currently this employee is not working in the building. Cathedral Village has reached out to this employee for more details and clarification. Employee informed us that she will provide required documents.</p> <p>Further review of Employee E21's personnel file revealed that upon hire Employee E21, Registered Nurse, presented a registered nursing license with the name (First name and last name). This license was active on the hire date, and the licensure status was also verified and found to be in good standing. The individual (RN) remained on administrative leave while facility conducted investigation and did not submit any further documentation.</p> <p>Continued review of the documentation revealed that background checks including criminal history were verified under Employee E21's real name (which included a name with three parts, last name included two parts). License was verified under a similar name (but only had two parts to the name, last name with only one part) as this was the name provided on the nursing license she presented. Both Social security card and driver's license were presented with a name that has three parts. Employee 21 name on the identification document provided was different from the RN license.</p> <p>Interview with previous Facility Administrator (Administrator at the time of the alleged incident), on April 12, 2024, at 2:00 p.m. stated Employee E21 provided a fraudulent RN license by obtaining identity of another person with similar name. She stated this employee was being investigated by multiple law enforcement agencies for identity theft and fraud.</p> <p>Review of facility documentation from November 23, 2023, to February 24, 2024, revealed that Employee E21 provided care and services in the capacity of a registered nurse to 63 residents over 30 shifts. Employee E21 provided care to approximately 20 residents per shift.</p> <p>Interview with the Administrator on May 2, 2024, at 11:00 a.m. stated facility did not inform resident or resident representative of the investigation related to Employee E21 who provided medications and treatments to the resident while employed by the facility.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 201.18(b)(1) Management</p> <p>28 Pa. Code: 201.29(b)(c) Resident rights</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>41471</p> <p>Based on the review of clinical records, interviews with staff, review of facility policy, it was determined that the facility failed to conduct a thorough and complete investigation of an alleged violation of identity theft involving 63 residents of the facility for one of six personnel files reviewed. (Employee E21)</p> <p>Findings Include:</p> <p>Review of facility policy Abuse Neglect or Exploitation revealed that It is the policy of Facility Name facilities 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.</p> <p>Exploitation: An act or course of conduct, including misrepresentation or failure to obtain informed consent which results in monetary, personal or other gain of profit for the perpetrator or monetary or personal loss to the resident.</p> <p>Misappropriation of Resident's Property: includes but is not limited to the deliberate misplacement, exploitation, or wrongful (temporary or permanent) use of a resident's belongings or funds without the resident's consent. Also includes denying the resident of property for personal gain or satisfaction.</p> <p>Allegations of abuse, neglect, mistreatment of residents or misappropriation of property shall be reported immediately to the supervising nurse or, in PC/AL the administrator designee and documented on an Incident Report.</p> <p>Investigative skills shall be used to identify injuries, provide treatment of identified injuries, to determine circumstances that might contribute to incident.</p> <p>Review of facility documentation dated February 2, 2024, revealed that A concern was brought to this NHA(Administrator) on February 2, 2024, at approximately 10:13 am regarding a licensure investigation . Currently this employee is not working in the building. Cathedral Village has reached out to this employee for more details and clarification. Employee informed us that she will provide required documents.</p> <p>Further review of the documentation revealed that upon hire Employee E21, Registered Nurse, presented a registered nursing license with the name (First name and last name). This license was active on the hire date, and the licensure status was also verified and found to be in good standing. The individual (RN) remained on administrative leave while facility conducted investigation and did not submit any further documentation.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Continued review of Employee E21's personnel file revealed background checks including criminal history were verified under Employee E21's real name (which included a name with three parts, last name included two parts). License was verified under a similar name (but only had two parts to the name, last name with only one part) as this was the name provided on the nursing license she presented. Both social security card and driver's license were presented with a name that has three parts. Employee 21 name on the identification document provided was different from the RN license.</p> <p>Interview with previous Facility Administrator (Administrator at the time of the alleged incident7), on April 12, 2024, at 2:00 p.m. stated Employee E21 provided a fraudulent RN license by obtaining identity of another person with similar name. She stated this employee was being investigated by multiple law enforcement agencies for identity theft and fraud.</p> <p>Review of facility documentation from November 23, 2023, to February 24, 2024, revealed that Employee E21 provided care and services in the capacity of a registered nurse to 63 residents over 30 shifts. Employee E21 provided care to approximately 20 residents per shift.</p> <p>Continued review of the facility documentation revealed no evidence that the facility obtained statements or interviewed residents who received care and services from Employee E21.</p> <p>Facility investigation revealed no evidence that there were statements from staff responsible for hiring Employee E21, verifying license or completing competency evaluation for Employee E21.</p> <p>Interview with the Administrator on May 2, 2024, at 11:00 a.m. confirmed that the facility investigation did not include statements or interviews from residents and staff responsible for hiring Employee E21, verifying license or completing competency evaluation for Employee E21.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee.</p> <p>28 Pa. Code 201.18(e)(1) Management.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>48347</p> <p>Based on review of clinical records and interviews with staff, it was determined that the facility failed to revise/update a care plan with a new intervention for one of eight clinical records reviewed. Resident R53</p> <p>Findings include:</p> <p>Review of Resident R53's clinical record revealed that Resident R53 was admitted to the facility January 25, 2024 with diagnoses of sepsis (the body's extreme reaction to an infection), Pneumonia (inflammation and fluids in the lungs caused by bacteria, fungal, or viral infection), COPD,(Chronic Obstructive Pulmonary Disease, an inflammatory lung disease that causes airflow blockage), resp failure (a condition in which the blood does not have enough oxygen or too much carbon dioxide), Alzheimer Disease (a neurodegenerative disease that destroys memory and thinking skills)Type 2 Diabetes (a chronic condition when the body does not use insulin properly and results in has high blood sugar levels), and Hypomagnesemia low level of the electrolyte magnesium.</p> <p>Review of Resident R53's nursing notes revealed documentation that Resident R53 was expressing belligerent, agitated, uncooperative behaviors beginning February 27, 2024, and continuing through the month of March 2024. The clinical records indicate that the physician was notified and had ordered a medication Ativan (Lorazepam, a sedative used to relieve symptoms of anxiety) to be given as needed. Further review of the nursing notes revealed that resident's behaviors were being monitored daily.</p> <p>Review of Resident R53's care plan dated January 25, 2023, revealed that there was no care plan developed related to Resident R53's belligerent and uncooperative behaviors.</p> <p>Interview with Licensed nurse, Employee E2 April 15, 2024, at 1:10 p.m, confirmed that Resident R53 has displayed newly recognized unfavorable behaviors addressed by the nursing staff and physicians. Employee E2 revealed that Resident R53's care plan had not been updated to address the behaviors.</p> <p>28 Pa. Code 211.10(c) Care plan policies</p> <p>28 Pa. Code 211.12 (d)(1) Nursing services</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43277</p> <p>Based on observations, review of clinical records, and resident and family interviews, it was determined that the facility failed to ensure dependent resident received assistance with personal hygiene for six of 31 residents reviewed (Resident R2, R8, R32, R60, R1, and R10).</p> <p>Findings Include:</p> <p>Review of Resident R10's Comprehensive Minimum Data Set (MDS - federally mandated resident assessment and care screening) dated April 1, 2024, revealed the resident was dependent (helper does all of the effort) for shower/bathing and personal hygiene. Further review of the MDS revealed the resident was cognitively impaired.</p> <p>Review of Resident R2's quarterly MDS dated [DATE], revealed the resident required partial/moderate assistance (helper lifts, holds, or supports trunk or limbs) with shower/bathing.</p> <p>Review of Resident R8's quarterly MDS dated [DATE], revealed the resident required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with shower/bathing.</p> <p>Review of Resident R32's quarterly MDS dated [DATE], revealed the resident required substantial/maximal assistance (helper lifts or holds trunk or limbs) with shower/bathing.</p> <p>Review of Resident R60's quarterly MDS dated [DATE], revealed the resident required partial/moderate assistance with shower/bathing.</p> <p>Review of Resident R1's quarterly MDS dated [DATE], revealed the resident required substantial/maximal assistance with shower/bathing.</p> <p>Interview on April 10, 2024, at 12:20 p.m. with Resident R10's family member revealed concerns that the resident is not getting routine showers. Further interview with the family member revealed Resident R10 was supposed to have a shower on Tuesday night, April 9, 2024, but was unsure because the resident's hair looked dirty.</p> <p>Observations on April 10, 2024, at 1:05 p.m. revealed Resident R10 was in the dining room having lunch. Observations confirmed Resident R10's hair looked unkept and dirty.</p> <p>Interview on April 10, 2024, at 2:45 p.m. with another family member of Resident R10 revealed if Resident R10 misses a shower on the scheduled shower day, the resident needs to wait until the next scheduled shower day to be bathed.</p> <p>Interviews with alert and oriented Resident's R2, R8, R32, R60, R1 during the group meeting on April 11, 2024, at 11:00 a.m. revealed sufficient staff is not available, and resident's will subsequently not be provided showers due to lack of staff.</p> <p>(continued on next page)</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Via email communication on April 15, 2024, at 12:10 p.m. with the Nursing Home Administrator regarding shower/bathing documentation revealed the X's on the shower sheet represent the days that the shower are not scheduled, when you see a number . that is the date that the aides documented.</p> <p>Review of Resident R10's shower sheet revealed the resident was scheduled for bathing on Tuesday and Friday nights. Further review of Resident R10's March and April 2024 shower sheets revealed the last time nursing staff documented giving a shower was March 1, 2024.</p> <p>Review of Resident R2's shower sheet revealed the resident was scheduled for bathing on Wednesday and Saturday mornings. Further review of Resident R2's March and April 2024 shower sheets revealed only one documented shower on March 23, 2024. No documented showers given for April 2024.</p> <p>Review of Resident R8's shower sheet revealed the resident was scheduled for bathing on Wednesday and Saturday evenings. Further review of Resident R8's March and April 2024 shower sheets revealed the only documented showers given were March 20, March 23, and April 3, 2024.</p> <p>Review of Resident R32's shower sheet revealed the resident was scheduled for bathing on Tuesday and Friday mornings. Further review of Resident R32's March and April 2024 shower sheets revealed only one documented shower on March 1, 2024. No documented showers given for April 2024.</p> <p>Review of Resident R60's shower sheet revealed the resident was scheduled for bathing on Monday and Thursday nights. Further review of Resident R60's March and April 2024 shower sheets revealed no documented showers given for March and April 2024.</p> <p>Review of Resident R1's shower sheet revealed the resident was scheduled for bathing on Wednesday and Saturday mornings. Further review of Resident R1's March and April 2024 shower sheets revealed no documented showers given for March and April 2024.</p> <p>28 Pa. Code 201.14 (a) Responsibility of Licensee</p> <p>28 Pa. Code 211.10 (d) Resident Care Policies</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>43277</p> <p>Based on review of facility policy, review of clinical records, and family interview, it was determined that the facility failed to ensure one resident received medication in accordance with physician orders for one of 19 residents reviewed (Resident R10).</p> <p>Findings Include:</p> <p>Review of facility policy Medication Administration dated December 22, 2023, revealed resident shall receive all medications per the orders of the physician including the correct time.</p> <p>Interview on April 10, 2024, at 2:45 p.m. with Resident R10's family member revealed concerns that the resident does not always receive his Parkinson's (a chronic and progressive disorder that affects the nervous system and causes movement problems) medication timely.</p> <p>Review of Resident R10's physician orders revealed an order dated July 5, 2023, for Carbidopa-Levodopa (medication used to treat symptoms of Parkinson's disease) daily at 6AM, 10AM, 2PM, and 6PM with specific instructions DO NOT ADMINISTER ON FLEX-TIME, for Parkinson's disease.</p> <p>Review of Resident R10's medication administration confirmed the resident did not receive his Carbidopa-Levodopa medication timely/per physician orders on the following days/times:</p> <ul style="list-style-type: none"> -February 5, 2024, given at 4:06 p.m. instead of 6:00 p.m. -February 10, 2024, given at 12:23 p.m. instead of 10:00 a.m. -February 12, 2024, given at 4:21 p.m. instead of 6:00 p.m. -February 15, 2024, given at 8:45 p.m. instead of 6:00 p.m. -February 17, 2024, given at 12:01 p.m. instead of 10:00 a.m. -February 20, 2024, given at 8:57 p.m. instead of 6:00 p.m. -February 22, 2024, given at 8:45 p.m. instead of 6:00 p.m. -February 23, 2024, given at 4:33 a.m., 12:08 p.m., and 8:19 p.m. Missed 2:00 p.m. dose and other doses not given timely. -March 1, 2024, given at 9:03 p.m. instead of 6:00 p.m. -March 10, 2024, given at 4:23 p.m. instead of 6:00 p.m. -March 11, 2024, nurse staff did not administer 6:00 a.m. and 2:00 p.m. dose. -March 13, 2024, given at 4:00 p.m. instead of 6:00 p.m. <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-March 24, 2024, given at 1:17 p.m. instead of 10:00 a.m. and immediately given again at 1:19 p.m. instead of 2:00 p.m. Also given at 4:03 p.m. instead of 6:00 p.m.</p> <p>28 Pa. Code 211.9 (a)(1) Pharmacy Services</p> <p>28 Pa. Code 211.9 (d) Pharmacy Services</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>41471</p> <p>Based on the review of clinical records, review of facility policy, observations, and interview with the staff, it was determined that the facility did not ensure that a resident with limited range of motion received appropriate services according to the professional standards of practice for one of two residents reviewed. (Resident R14)</p> <p>Findings Include:</p> <p>Review of a facility policy Restorative care program dated February 4, 2022, revealed that Presbyterian Senior Living facilities will provide restorative services which prevent decline and/or maintain the highest practicable level of functioning in accordance with state and federal regulation.</p> <p>Review of physician orders for Resident R14 dated February 14, 2024, revealed an order to keep splint on left upper extremity at all times, may remove for showers.</p> <p>Observation of Resident R14 on April 11, 2024, at 12:00 p.m. revealed that the resident was not wearing a splint as ordered by the physician to the left upper extremity.</p> <p>Observation of Resident R14 on April 12, 2024, at 2:45 p.m. revealed that the revealed that the resident not wearing a splint as ordered by the physician to the left upper extremity. This observation was confirmed by Employee E15, Registered Nurse.</p> <p>Observation of Resident R14 on April 15, 2024, at 12:04 p.m. revealed that the resident was not wearing a splint as ordered by the physician to the left upper extremity. This observation was confirmed by Employee E14, Licensed Practical Nurse.</p> <p>28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services</p> <p>28 Pa. Code: 201.18 (b)(2) Management</p> <p>28 Pa. Code: 211.10 (d) Resident care policies</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>43277</p> <p>Based on review of facility documentation, review of clinical record, and staff interview, it was determined that the facility failed to provide assistance devices necessary to prevent an avoidable accident from occurring for one of two residents reviewed for falls (Resident R57).</p> <p>Findings Include:</p> <p>Review of Resident R57's Quarterly Minimum Data Set (MDS - federally mandated resident assessment and care screening) dated January 7, 2024, revealed the resident had diagnoses of dementia (loss of cognitive functioning that interferes with daily life and activities), Parkinson's Disease (a chronic and progressive disorder that affects the nervous system and causes movement problems), history of falling, and abnormalities of gait and mobility.</p> <p>Further review of the MDS revealed Resident R57 had impairment on both sides of lower extremities and used a wheelchair for mobility device. Continued review of the MDS revealed the resident was dependent (helper does all the effort) on staff for sit to stand (the ability to come to a standing position from sitting in a wheelchair).</p> <p>Review of information submitted to the State Survey Agency on March 7, 2024, revealed on March 6, 2024, Resident R57 was being seated in the dining room by a nurse aide when Resident R57 grabbed onto a table attempting to stand from wheelchair and fell forward onto the floor.</p> <p>Review of facility documentation, incident report dated March 6, 2024, revealed nurse aide, Employee E11, was assisting Resident R57 in her wheelchair to her seat position in the dining room at approximately 4:50 p. m. Resident R57 grasped the dining room table while wheelchair was moving and attempted to stand at the same time, causing Resident R57 to go forward landing on the floor. Continued review of the incident report revealed the wheelchair leg rests were not checked off as being used at the time of the incident.</p> <p>Interview on April 12, 2024, at 1:34 p.m. with the Director of Nursing, Employee E2, revealed Resident R57 had significant cognitive impairments and history of behaviors of spontaneously grabbing anything within reach and planting feet on floor while being pushed in the wheelchair. Further interview with the Director of Nursing, Employee E2, confirmed Resident R57 should always have footrests on the wheelchair while in use due to behavior of planting feet on floor.</p> <p>Further interview on April 12, 2024, at 1:34 p.m. with the Director of Nursing, Employee E2, confirmed footrests were not in use at the time of Resident R57's fall on March 6, 2024.</p> <p>28 Pa. Code 201.14 (a) Responsibility of Licensee</p> <p>28 Pa. Code 211.10 (d) Resident Care Policies</p>		

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NAME OF PROVIDER OR SUPPLIER Cathedral Village		STREET ADDRESS, CITY, STATE, ZIP CODE 600 East Cathedral Road Philadelphia, PA 19128	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41471</p> <p>Based on the review of clinical records, facility policy and interviews with staff, it was determined that the facility failed to ensure that pain management was provided consistent with physician orders and standards of practice for one of one resident reviewed for pain management. (Resident R14)</p> <p>Findings include:</p> <p>Review of Resident R14's clinical record revealed that Resident R14 was admitted to the facility with diagnosis including age related osteoporosis (a bone disease that develops when bone mineral density and bone mass decreases, or when the structure and strength of bone changes) with current pathological fracture left femur, vascular dementia and anxiety.</p> <p>Review of MDS (Minimum Data Set) assessment dated [DATE], revealed that the resident was on a scheduled pain medication regimen and received as needed pain medication. There was no non-medication intervention for pain. It was also revealed that the resident experienced pain almost constantly and it frequently affected sleep and occasionally affected day-to day activities.</p> <p>Review of physician order for Resident R14 dated April 1, 2024, revealed an order for Acetaminophen (analgesic pain medication) 325 milligrams (mg) take two tablets every six hours for pain.</p> <p>Review of progress note for Resident R14 dated April 10, 2024, revealed that the resident complained of pain, she stated she felt the pain like she was going to have a baby. It was documented as the pain medication given.</p> <p>Review of Medication Administration Record for the month of April 2024 revealed no evidence that the pain medication was administered on April 10, 2024.</p> <p>Review of physician progress note dated April 5, 2024, revealed a medication order for Oxycodone 5 mg as needed.</p> <p>Review of active physician orders for Resident R14 for the month of April 2024 revealed that the Oxycodone was not included in the active medication list.</p> <p>Review of clinical record for Resident R14 revealed no documented reason for not following the physician recommendation of Oxycodone.</p> <p>Interview with the Director of Nursing (DON) on April 15, 2024, at 11:00 a.m. confirmed that there was that no evidence that the pain medication was administered on April 10, 2024, when resident complained of pain. DON confirmed that there was no pain assessment completed when resident complained of pain. DON also confirmed that there was no documented reason for not following the physician recommendation of Oxycodone.</p> <p>28 Pa. Code 211.10(c) Patient care policies</p> <p>28 Pa. Code 211.12(d)(1) Nursing services</p>		

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<p>F 0726</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41471</p> <p>Based on the review of facility documentation, review of personnel records and interviews with staff, it was determined that the facility failed to ensure six of six employees possessed the appropriate skills and competencies to provide nursing and related care and services to assure resident safety and to attain or maintain the highest practicable physical, mental, and psychosocial wellbeing of each resident. Further, review of Employee E21's personnel file revealed that the Employee E21 was an unlicensed staff, who provided care and services as a Registered Nurse, without verifiable educational background and registration as a nurse. This failure placed 63 residents who received care and services from Employee E21 at the facility, at risk of injury and/ or harm and resulted in an Immediate Jeopardy situation. (Employees E16, 17, 18, 19, 20 and 21).</p> <p>Findings Include:</p> <p>Review of the Professional Nursing Law The Act of [DATE] P.L 317, No 69, revealed that Section 3. Registered Nurse, Clinical Nurse Specialist, Certified Registered Nurse Anesthetist, Use of Title and Abbreviation R.N., C.N.S. or C.R.N.A.; Credentials; Fraud.--(a) Any person who holds a license to practice professional nursing in this Commonwealth, or who is maintained on inactive status in accordance with section 11 of this act, shall have the right to use the titles nurse and registered nurse and the abbreviation R. N. No other person shall engage in the practice of professional nursing or use the titles nurse or registered nurse or the abbreviation R.N. to indicate that the person using the same is a registered nurse, except that the title nurse also may be used by a person licensed under the provisions of the act of [DATE] (1955 P.L. 1211, No.376), known as the Practical Nurse Law. No person shall sell or fraudulently obtain or fraudulently furnish any nursing diploma, license, record, or registration or aid or abet therein. (b) An individual who holds a license to practice professional nursing in this Commonwealth who meets the requirements under sections 6.2 and 8.5 of this act to be a clinical nurse specialist shall have the right to use the title clinical nurse specialist and the abbreviation C.N.S. No other person shall have that right.</p> <p>Review of job description for Registered Nurse (RN) revised on [DATE], revealed that Education and Experience Requirements: Current state professional nursing license, one to two years' experience, geriatric/long term care experience preferred, maintain or able to obtain current CPR certification. Job accountabilities. 1. Plan, directs and provides resident care according to physician orders and the interdisciplinary plan of care. 2. Communicates changes in resident's condition in a timely fashion to include but not limited to physicians, other disciplines, the following shift, and family members. 3. Administer medications, treatments in compliance with federal, state and local laws and with the community policies and procedures. 6. Performs venipuncture to obtain blood.</p> <p>Further review of job description for Registered Nurse revealed that skills and competencies are required for the job accountabilities including; Administering medications and treatments, performs venipuncture to obtain blood specimens according to community practice, use of standard precautions to prevent spread of communicable disease, enforces and trains proper infection control practices to team members, exhibits knowledge of and effectively executes disaster plans and communicates changes in residents' condition in a timely fashion to include but not limited to the RN, physician other disciplines the following shift and family members.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Review of a blank facility competency evaluation form indicated that the facility developed a competency evaluation program with performance indicators to ensure that the nurses including RNs and LPNs have the competency to perform necessary job accountabilities which indicated if a job function are met or not met.</p> <p>Review of facility documentation dated February 2, 2024, revealed that A concern was brought to this NHA (Administrator) on February 2, 2024, at approximately 10:13 am regarding a licensure investigation for an employee of Cathedral Village. Currently this employee is not working in the building. Cathedral Village has reached out to this employee for more details and clarification. Employee informed us that she will provide required documents.</p> <p>Further review of the documentation revealed that upon hire Employee E21, Registered Nurse, presented a registered nursing license with the name (First name Last name). This license was active on the hire date, and the licensure status was also verified and found to be in good standing. The individual (RN) remained on administrative leave while facility conducted investigation and did not submit any further documentation.</p> <p>Continued review of the documentation revealed that background checks including criminal history were verified under Employee E21's real name (which included a name with three parts, last name included two parts). License was verified under a similar name (but only had two parts to the name, last name with only one part) as this was the name provided on the nursing license she presented. Both Social security card and driver's license were presented with a name that has three parts. Employee 21's name on the identification document provided was different from the RN license. There was no documentation available to indicate if the facility human resource or other facility staff clarified the discrepancy in the name.</p> <p>A request for competency evaluation for Employee E21 was requested from the Nursing Home Administrator on [DATE] at 2:17 p.m. Facility did not provide evidence of competency evaluation for Employee E21.</p> <p>Review of Employee E21's personnel file revealed that the employee was offered the job as an RN with a hire date of [DATE]. Further review of the personal file revealed that the employee worked in the facility as an RN until February 1, 2024. Employee worked 30 shifts as an RN, which 23 of the 30 shift she worked independently providing all responsibilities as an RN.</p> <p>Continued review of Employee E21's personnel file did not include any verifiable nursing or any related education. Personnel files did not include any competency evaluation form.</p> <p>Review of facility documentation from [DATE], to February 24, 2024, revealed that Employee E21 administered medications to residents including anxiolytics, antihypertensive, antipsychotics, Parkinson's medications, antidepressants, anticonvulsants, anticoagulant, antibiotics, diuretics, beta blockers (slows heart rate, treat chest pain), anti-diabetic medication, steroids, antiviral medications, which require monitoring of side effects.</p> <p>Review of clinical record also revealed that Employee E21 administered resident complex resident assessment which needed specialized skills and competencies including wound care, neurological assessments, administered insulin, admission assessments, skin assessments change of condition assessments and PICC line assessments.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>There was no documentation available to review to determine that facility ensured Employee E21 was competent in performing these services.</p> <p>Review of facility documentation from [DATE], to February 24, 2024, revealed that Employee E21 provided care and services in the capacity of a registered nurse to 63 residents over 30 shifts. Employee E21 provided care to approximately 20 residents per shift.</p> <p>A review of the facility record revealed that the facility had one resident with PICC line/Midline catheter who received treatment and care from the staff such as dressing change, medication and fluid administration, site assessment and monitoring.</p> <p>Interview with the Director of Nursing (DON) on [DATE], at 11:00 a.m. stated nursing staff provided care for residents with PICC lines and midline.</p> <p>A review of the facility record revealed that the facility had residents with pressure ulcers (injuries to the skin and underlying tissue, primarily caused by prolonged pressure on the skin.) and other wounds who received care and services from staff such as dressing change and wound assessment.</p> <p>A request for the evidence of PICC line/midline/ IV care and wound care staff competencies or annual evaluations of additional 5 selected licensed and registered nurses, Employee E16, 17, 18, 19, 20 were made to the Nursing Home Administrator and Director of nursing on April</p> <p>Facility was not able to provide evidence of PICC line/midline/ IV care and wound care staff competencies or annual evaluations of 5 selected licensed and registered nurses.</p> <p>During an interview on [DATE], at 11:30 a.m. the Nursing Home Administrator confirmed that the nursing staff competencies or annual evaluations related to PICC line/midline/ IV care and wound care was not completed for the nursing staff in the past year. The Nursing Home Administrator also confirmed that the facility did not have a process of competency evaluation. The Nursing Home Administrator stated facility has a competency evaluation program developed to evaluate the competencies of the nurse but the facility did not implement the program for the nurses.</p> <p>An Immediate Jeopardy situation was identified to the Nursing Home Administrator on [DATE], at 4:00 p.m. for the facility's failure to ensure that Employee E21, (unlicensed staff who provided care and services as a Registered Nurse without verifiable educational background as a nurse) possessed appropriate skill sets and competencies to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial wellbeing of each resident This failure placed 63 residents who received care and services from Employee E21 at the facility at risk of injury and or harm and resulted in an immediate jeopardy situation.</p> <p>The facility submitted a written plan of action on [DATE], at 9:00 p.m. and implemented the plan of action which included:</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Employee A was immediately removed from the schedule and placed on administrative leave. Incident reported to local police department and Department of Health in accordance to local and state laws. Legal counsel notified of multi state and identity theft investigations and agencies informed. Department of State who issues licenses will be informed on [DATE]. Legal counsel notified that state's Attorney General is involved. An electronic health record audit was completed on [DATE] by the Nursing Home Administrator or designee to review residents who may have received care or treatment from Employee E21. Current residents identified from this audit will be interviewed by a Licensed Nurse and Social Worker. This inquiry will include a statement from the individual related to medication administration, evaluations and assessments, wound care, and general care and nursing services provided was completed [DATE]. A physical head to toe skin evaluation of the residents in the assignments of Employee E21 was completed on [DATE]- [DATE].</p> <p>An audit was conducted by the Human Resource Department to ensure that licensed staff have a skills competency completed and present in their employee file within the last year on [DATE]. Any licensed staff identified not to have had skills competency completed will have the competency completed prior to their next scheduled shift; all staff completed by [DATE].</p> <p>An audit was completed by human resource department on current licensed nurses employed by PSL (Presbyterian Senior Living) at the community to ensure compliance with licensure verification on [DATE], no variances identified. The human resource department team members at the community were re-educated on new hire/pre- employment processes for licensed staff by the [NAME] President of Employee Relations or designee on [DATE].</p> <p>The Human Resource department team members at the community were re-educated by the [NAME] President of Employee Relations or designee on- the requirement to ensure that all licensed staff have a current skill competency checklist completed at new hire during the orientation period and then annually in their employee file to ensure that all licensed staff possess competencies, education, and license as applicable to provide nursing care, all staff completed by. [DATE].</p> <p>On [DATE], at 11:40 a.m. the action plan was reviewed, personell records were reviewed, interviews were conducted with staff to confirm that the in-service education was completed. Facility audits were reviewed.</p> <p>The Immediate Jeopardy was lifted on [DATE], at 11:40 a.m.</p> <p>Refer to F839</p> <p>28 Pa. Code 201.14 (a)(b) Responsibility of licensee</p> <p>28 Pa. Code: 201.18 (b)(1)(e)(1)(2) Management</p> <p>28 Pa. Code 211.12 (c)(d)(3)(5) Nursing services</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>48347</p> <p>Based on observation, staff interviews, and review of facility policy, it was determined that the facility failed to ensure that all drugs and biologicals used in the facility were stored in accordance with professional standards for one of three medication carts observed. (Second-floor medication cart)</p> <p>Findings include:</p> <p>Review of facility policy titled Medication Storage in the facility dated May 2018, revealed that only licensed nurses, pharmacy personnel, and those lawfully authorized to administer medications permitted to access medications. Medication rooms, carts, and medication supplies are locked when not attended by persons with authorized access.</p> <p>Observation of the Second-floor medication cart on April 10, 2024 at 11:12 a.m. revealed the cart positioned outside the second-floor nursing office (an enclosed office surrounded by windows), was left unattended, unlocked with the sixth drawer left open to view all contents contained in the drawer. The cart directly faced two elevators on the floor.</p> <p>Observation on April 10, 2024, at 11:17 a.m. revealed Licensed staff, Employee E 88 exiting the nurses office approaching the unlocked medication cart. Employee E8 closed the drawers of the cart then locked the cart.</p> <p>Interview with Licensed staff, Employee E8 at time of observation revealed that she was inside the office assisting another resident. Employee E8 stated that she only walked away from the unlocked cart for one minute. She was coming right back to the cart.</p> <p>28 Pa. Code 211. 12(d)(1) Nursing services</p> <p>28 Pa. code 211.9(a)(1) Pharmacy services</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>43277</p> <p>Based on review of facility documentation, observations, and staff and resident interviews, it was determined that the facility failed to provide food that was served at palatable temperatures for two of two nursing units observed (second and third floor nursing units).</p> <p>Findings Include:</p> <p>Interview during the initial tour of the kitchen on April 10, 2024, at 10:15 a.m. with the Food Service Director, Employee E5, revealed each dining room on the 2nd and 3rd floor nursing units have small kitchens that are equipped with steam tables for serving the dining rooms and residents who eat in their rooms.</p> <p>Review of dining committee notes for the 3rd floor nursing unit, dated March 20, 2024, revealed resident concerns included cold food.</p> <p>Interviews during the group meeting on April 11, 2024, at 11:00 a.m. with alert and oriented Residents R2, R59, R8, R32, R60, and R1 revealed food is often cold both when eating in the dining room and when served in rooms.</p> <p>Interview on April 11, 2024, at 12:20 p.m. with the Food Service Director, Employee E5, revealed dietary staff are responsible for checking temperatures the of food items held on the steam tables in the 2nd and 3rd floor dining rooms before beginning meal service.</p> <p>Review of facility documentation Daily Temperature Checklist revealed temperature standards for the entree is 155-165 degrees Fahrenheit and vegetable is 145-155 degrees Fahrenheit.</p> <p>A test tray was made on April 11, 2024, at 12:23 p.m. with food plated directly from the steam table in the 3rd floor dining room with the Food Service Director, Employee E5. Temperatures taken by the Food Service Director, Employee E5, revealed the breaded veal was 127 degrees Fahrenheit and the broccoli was 104 degrees Fahrenheit. Further, the surveyor tasted the food items which confirmed temperatures were not palatable for temperature.</p> <p>On April 11, 2024, at 12:35 p.m. in the 2nd floor dining room the Food Service Director, Employee E5, temped the food items directly on the steam table which revealed the veal was 123 degrees Fahrenheit and the broccoli was 103 degrees Fahrenheit.</p> <p>Observations on April 12, 2024, at 9:04 a.m. revealed a stainless-steel tray delivery cart on the 2nd floor nursing unit in front of the nurse's station with about 14 breakfast trays waiting to be passed to residents, including Resident R17.</p> <p>Follow-up observations on April 12, 2024, at 9:28 a.m. revealed Resident R17 was just served her breakfast tray.</p> <p>Interview on April 12, 2024, at 9:31 a.m. with Resident R17 revealed the cream of wheat (hot breakfast cereal) was lukewarm and that the resident has been eating cold food for a long time.</p> <p>(continued on next page)</p>		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(3) Management

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<p>F 0809</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times.</p> <p>43277</p> <p>Based on facility documentation, observations, and resident interviews, it was determined that the facility failed to provide meals in accordance with resident preferences for two of two nursing units observed (Second and Third Floor Nursing Units).</p> <p>Findings Include:</p> <p>Review of facility documentation Meal Service Times revealed breakfast is served between 8:00 a.m. and 9:00 a.m., and lunch is served between 12:00 p.m. and 1:00 p.m.</p> <p>Interview during the initial tour of the kitchen on April 10, 2024, at 10:15 a.m. with the Food Service Director, Employee E5, revealed each dining room on the 2nd and 3rd floor nursing units have small kitchens that are equipped with steam tables for serving the dining rooms and residents who eat in their rooms.</p> <p>Interviews during the group meeting on April 11, 2024, at 11:00 a.m. with alert and oriented residents R2, R59, R8, R32, R60, and R1 revealed residents need to wait long periods of time in the dining room to be served a meal. Residents reported going to the dining room when lunch is supposed to start at 12:00 p.m. but can wait up to 45 minutes to be served.</p> <p>Observations on April 11, 2024, at 12:17 p.m. in the 3rd floor dining room revealed approximately nine residents were waiting to be served lunch (Resident R11, R8, R24, R55, R9, R63, R26, R69, and R53).</p> <p>Observations on April 11, 2024, at 12:35 p.m. in the 2nd floor dining room revealed approximately 10-15 residents who were sitting in the dining room were still not served. Observations revealed the dietary employee who was responsible for plating the meals from the steam table was still taking orders from the residents at 12:35 p.m. and had not yet began plating resident lunches for the dining room.</p> <p>Interview on April 11, 2024, at 12:35 p.m. with the Food Service Director, Employee E5, confirmed Dietary Employee who was responsible for plating resident meals was also taking resident orders.</p> <p>Follow-up observations on April 11, 2024, at 12:40 p.m. in the 3rd floor dining room revealed Residents R11 was just served at 12:40 p.m. and the other residents (Resident R8, R24, R55, R9, R63, R26, R69, and R53) were still not served. Resident R24 kept asking staff where her sandwich was.</p> <p>Observations on April 12, 2024, revealed the following residents were served breakfast after 9:00 a.m. Resident R51 and R48 were served at 9:25 a.m., Resident R17 was served breakfast at 9:31 a.m., Resident R47 was served breakfast at 9:34 a.m.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>(continued on next page)</p>		

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<p>F 0809</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>28 Pa. Code 201.18(b)(3) Management</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395467	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/02/2024
NAME OF PROVIDER OR SUPPLIER Cathedral Village		STREET ADDRESS, CITY, STATE, ZIP CODE 600 East Cathedral Road Philadelphia, PA 19128	
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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>41471</p> <p>Based on the review of clinical records, job descriptions, facility documentation and interviews with staff, it was determined that the Nursing Home Administrator (NHA) and the Director of Nursing (DON) did not effectively manage the facility to make certain that proper procedures were followed in the facility related to ensuring that professional staff possessed required licenses or registration in accordance with applicable state law. That nursing staff possessed appropriate skills and competencies to provide nursing and related care and services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial wellbeing of each resident. This failure resulted in Employee E21, unlicensed staff, who provided care and services as a Registered Nurse, without verifiable educational background, registration and appropriate skills and competencies, as a nurse and placed residents at the facility at risk of injury and or harm and resulted in immediate jeopardy situation.</p> <p>Findings Include:</p> <p>Review of the job description for the Nursing Home Administrator (NHA) revealed that Responsible for health center operation in accordance with the established policies and procedures of Facility Name as well as in compliance with federal, state and local regulations. Responsible for ensuring quality of care, resident rights, effective team members and fiscal stability of campus. Responsible for or makes recommendations regarding the recruitment, interviewing, hiring, training, supervision and implementation corrective action health center team members.</p> <p>Review of the job description for the Director of Nursing (DON) revealed that Responsible for the organization, supervision, administration and overall management of the nursing service program. Develops and maintains nursing policies, procedures, objectives and standards of practice. Responsible for or makes recommendations regarding the recruitment, interviewing, hiring, training, supervision and implementation corrective action for nursing department personnel.</p> <p>Review of facility documentation dated February 2, 2024, revealed that A concern was brought to this NHA(Administrator) on February 2, 2024, at approximately 10:13 a.m. regarding a licensure investigation . Currently this employee is not working in the building. Cathedral Village has reached out to this employee for more details and clarification. Employee informed us that she will provide required documents.</p> <p>Further review of the documentation revealed that upon hire Employee E21, Registered Nurse, presented a registered nursing license with the name (First name and Last name). This license was active on the hire date, and the licensure status was also verified and found to be in good standing. The individual (RN) remained on administrative leave while facility conducted investigation and did not submit any further documentation.</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Continued review of the documentation revealed that background checks including criminal history were verified under Employee E21's real name (which included a name with three parts, last name included two parts). License was verified under a similar name (but only had two parts to the name, last name with only one part) as this was the name provided on the nursing license she presented. Both Social Security card and driver's license were presented with a name that has three parts. Employee 21 name on the identification document provided was different from the RN license. There was no documentation available to indicate if the facility human resource or other facility staff clarified the discrepancy in the name.</p> <p>Review of Employee E21's personnel file revealed that the employee was offered the job as an RN with a hire date of November 22, 2023. Further review of Employee E21's personnel file revealed that the employee worked in the facility as an RN until February 1, 2024. Employee worked 30 shifts as an RN, which 23 of the 30 shift she worked independently providing all responsibilities as an RN.</p> <p>Based on the deficiencies identified in this report, the Nursing Home Administrator and Director of Nursing failed to fulfill essential duties and responsibilities of their position to ensure that the Federal and State guidelines and Regulations were followed, contributing to the Immediate Jeopardy situation.</p> <p>Refer to F726 and F839</p> <p>28 Pa Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 201.18(b)(1) Management</p> <p>28 Pa. Code 201.18(b)(3) Management</p>		

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<p>F 0839</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Employ staff that are licensed, certified, or registered in accordance with state laws.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41471</p> <p>Based on the review of facility documentation, review of personal records and interviews with staff, it was determined that the facility failed to ensure that a professional staff possessed required nursing license in accordance with applicable state law. Review of one of six personnel files revealed that Employee E21, who was an unlicensed staff, and provided care as a Registered Nurse, to 63 residents. Employee E21 did not have a verifiable educational background and registration, as a Registered Nurse. This failure resulted in an Immediate Jeopardy situation to 63 residents who received care and services from Employee E21. (Employee E21).</p> <p>Findings Include:</p> <p>Review of the Professional Nursing Law The Act of [DATE] P.L 317, No 69, revealed that Section 3. Registered Nurse, Clinical Nurse Specialist, Certified Registered Nurse Anesthetist, Use of Title and Abbreviation R.N., C.N.S. or C.R.N.A.; Credentials; Fraud.--(a) Any person who holds a license to practice professional nursing in this Commonwealth, or who is maintained on inactive status in accordance with section 11 of this act, shall have the right to use the titles nurse and registered nurse and the abbreviation R. N. No other person shall engage in the practice of professional nursing or use the titles nurse or registered nurse or the abbreviation R.N. to indicate that the person using the same is a registered nurse, except that the title nurse also may be used by a person licensed under the provisions of the act of [DATE] (1955 P.L. 1211, No.376), known as the Practical Nurse Law. No person shall sell or fraudulently obtain or fraudulently furnish any nursing diploma, license, record, or registration or aid or abet therein. (b) An individual who holds a license to practice professional nursing in this Commonwealth who meets the requirements under sections 6.2 and 8.5 of this act to be a clinical nurse specialist shall have the right to use the title clinical nurse specialist and the abbreviation C.N.S. No other person shall have that right.</p> <p>Review of job description for Registered Nurse revised on [DATE], revealed that Education and Experience Requirements: Current state professional nursing license, one to two years' experience, geriatric/long term care experience preferred, maintain or able to obtain current CPR certification. Job accountabilities. 1. Plan, directs and provides resident care according to physician orders and the interdisciplinary plan of care. 2. Communicates changes in resident's condition in a timely fashion to include but not limited to physicians, other disciplines, the following shift, and family members. 3. Administer medications, treatments in compliance with federal, state and local laws and with the community policies and procedures. 6. Performs venipuncture to obtain blood</p> <p>Review of facility information dated February 2, 2024, revealed that A concern was brought to this NHA(Nursing Home Administrator) on February 2, 2024, at approximately 10:13 a.m. regarding a licensure investigation .Currently this employee is not working in the building. Cathedral Village has reached out to this employee for more details and clarification. Employee informed us that she will provide required documents.</p> <p>Further review of the documentation revealed that upon hire on [DATE], Employee E21, presented a Registered Nurse's license with the name (First name and Last name). This license was active on the hire date, and the licensure status was also verified and found to be in good standing.</p> <p>(continued on next page)</p>		

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<p>F 0839</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Continued review of the documentation revealed that background checks including criminal history were verified under Employee E21's real name (which included first name and last name which had two parts). The Registered nurse license was verified under a similar name (but only the last name with only one part) as this was the name provided on the nursing license she presented. Both Social security card and driver's license were presented with a last name that had two parts. Employee 21's last name on the identification document provided was different from the RN license. There was no documentation available to indicate if the facility human resource or other facility staff clarified the discrepancy with Employee E21's last name.</p> <p>Interview with previous facility Nursing Home Administrator (Administrator at the time of the alleged incident), on [DATE], at 2:00 p.m. stated Employee E21 provided a fraudulent RN license by obtaining identity of another person with similar name. Facility did not follow up on the discrepancy between the name provided and the name on the license. Facility also did not ask the employee to provide the copy of the license issues by the state to the individual who possessed the license. Facility only verified and kept copy of the license which was available online to the public. She confirmed that the Employee E21 obtained identity of another individual who possessed a RN license with similar name and worked in the facility for 4 months and provided care to the residents including medication administration and licensed/registered nurse's assignments.</p> <p>Review of Employee E21's personal file revealed that the employee was offered the job as an RN with a hire date of [DATE]. Further review of the personal file revealed that the employee worked in the facility as an RN till February 1, 2024. Employee worked 30 shifts as an RN, which 23 of the 30 shift she worked independently providing all responsibilities as an RN.</p> <p>Continued review of Employee E21's personal file did not include any verifiable nursing or any related education.</p> <p>Review of facility documentation from [DATE], to February 24, 2024, revealed that Employee E21 administered medications to residents including anxiolytics, antihypertensive, antipsychotics, Parkinson's medications, antidepressants, anticonvulsants, anticoagulant, antibiotics, diuretics, beta blockers (slows heart rate, treat chest pain), anti-diabetic medication, steroids, antiviral medications, which require monitoring of side effects.</p> <p>Review of clinical record also revealed that Employee E21 administered resident complex resident assessment which needed specialized skills and competencies including wound care, neurological assessments, administered insulin, admission assessments, skin assessments change of condition assessments and PICC line assessments.</p> <p>There was no documentation available to review to determine that facility ensured Employee E 21 was competent in performing these services.</p> <p>Review of facility documentation from [DATE], to February 24, 2024, revealed that Employee E21 provided care and services in the capacity of a registered nurse to 63 residents over 30 shifts. Employee E21 provided care to approximately 20 residents per shift.</p> <p>(continued on next page)</p>		

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<p>F 0839</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>An Immediate Jeopardy situation was identified to the Nursing Home Administrator on [DATE], at 4:00 p.m. for the facility's failure to ensure that professional staff possessed required licenses or registration in accordance with applicable state law. This failure resulted in Employee E21, unlicensed staff, who provided care and services as a Registered Nurse, without verifiable educational background and registration, as a nurse and placed 63 residents at the facility at risk of injury and or harm and resulted in an Immediate jeopardy situation.</p> <p>The facility submitted a written plan of action on [DATE], at 9:00 p.m. and implemented the plan of action which included:</p> <p>Employee 21 was immediately removed from the schedule and placed on administrative leave. Incident reported to local police department and Department of Health in accordance to local and state laws. Legal counsel notified of multi state and identity theft investigations and agencies informed. Department of State who issues licenses who be informed [DATE]. Legal counsel notified that state's Attorney General is involved. An audit was completed by human resource department on current licensed nurses employed by PSL at the community to ensure compliance with licensure verification as applicable according to the job description and state laws on [DATE]. All licensed staff after the initial audit have also been audited by the Human Resource department prior to employment.</p> <p>The policy for employee onboarding process was updated and revised on [DATE] to ensure licensed staff are appropriately licensed and educated as applicable according to the job description and state laws. The Human Resource department team members at the community were re-educated by the [NAME] President of Employee Relations or designee on the updated policy on [DATE].</p> <p>All licensed staff after the initial audit which was completed on [DATE] have also been audited by the Human Resource department prior to employment. Audits started [DATE] no concerns identified and will continue to be completed biweekly according to new employee orientation schedule. Audits will continue to be going forward.</p> <p>On [DATE], at 11:40 a.m. the action plan was reviewed, personal records were reviewed, interviews were conducted with staff to confirm that the in-service education was completed. Facility audits were reviewed.</p> <p>The Immediate Jeopardy was lifted on [DATE], at 11:40 a.m.</p> <p>28 Pa. Code 201.14 (a)(b) Responsibility of licensee</p> <p>28 Pa. Code: 201.18 (b)(1)(e)(1)(2) Management</p> <p>28 Pa. Code 211.12 (c)(d)(3)(5) Nursing services</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>48347</p> <p>Based on review of facility policy, observation, and staff interviews, it was determined that the facility failed to follow acceptable infection control practices during dining for one of 12 resident observed. (Employee E7)</p> <p>Findings include:</p> <p>Review of the facility policy titled Infection control policy revised January 13, 2022, states the primary purpose of infection control in the facility is to maintain a sanitary environment for all personal residents, visitors, and the general public.</p> <p>Review of facility policy titled Nutrition and Hydration for Residents Unable to Feed Themselves, revealed that if a residents needing assistance for dining, it is then the NA (nursing assistant) job to feed them. Further review of this policy revealed that the temperature of the food should be tested by placing the employees' hand over the food to sense the heat. The policy further states that Do not touch the food to test the temperature.</p> <p>Observation of Resident R65 being assisted with dining on April 12, 2024, 8:35 a.m., revealed the resident was served a bowl of cream of wheat (a hot cereal). Resident R65 was observed with nurse aide, Employee E7 seated to the resident right at the table to assist resident R65 with the consumption of her meal. Nurse aide, Employee E7 was observed inserting her index finger into the resident's bowl of cream of wheat to check for the temperature, then wiped hand in napkin. Nurse aide, Employee E7 was then observed pouring ice cubes into the cereal.</p> <p>Interview with Nurse aide, Employee E7 at time of observation stated that she placed her hand over the bowl to indicate the temperature of it. Employee E was instructed by dietary staff to wash her hands, apply gloves and resident was given a new bowl of cereal.</p> <p>28 Pa. Code 211.6 (f) Dietary services</p>		

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Implement a program that monitors antibiotic use.</p> <p>41471</p> <p>Based on a review of facility documentation, facility policies and staff interviews, it was determined that the facility failed to maintain an effective antibiotic stewardship program that includes a system to effectively monitor antibiotic usage for three of four months of antibiotic stewardship program data reviewed. (January 2024, February 2024, and March 2024).</p> <p>Findings Include:</p> <p>Review of facility policy Antibiotic Stewardship dated May 31, 2023, revealed the The antibiotic stewardship policy is a set of commitments and actions designed to optimize the treatment of infections while reducing the adverse events associated with antibiotic use such as the threat of antibiotic resistance. 4. Monitoring measures for antibiotics use and outcomes will be implemented and reported through the community QUAPI process. 9. Data will be monitored monthly to review the number of new antibiotics ordered to determine if criteria were met.</p> <p>Review of facility documentation for the month of January 2024 revealed that the facility used 13 antibiotics for 19 residents. Further review of facility documentation revealed that a review of antibiotic usage for appropriateness or if the usage criteria were met was not completed for the antibiotics prescribed according to facility antibiotic stewardship program.</p> <p>Review of facility documentation for the month of February 2024 revealed that the facility used 9 antibiotics for 10 residents. Further review of facility documentation revealed that a review of antibiotic usage for appropriateness or if the usage criteria were met was not completed for the antibiotics prescribed according to facility antibiotic stewardship program.</p> <p>Review of facility documentation for the month of March 2024 revealed that the facility used 17 antibiotics for 24 residents. Further review of facility documentation revealed that a review of antibiotic usage for appropriateness or if the usage criteria were met was not completed for the antibiotics prescribed according to facility antibiotic stewardship program.</p> <p>Interview with the Director of Nursing (DON) on April 15, 2024, at 11:00 a.m. confirmed that a review of antibiotic usage for appropriateness or if the usage criteria were met was not completed for the antibiotics prescribed according to facility antibiotic stewardship program.</p> <p>28 Pa. Code 211.10(d) Resident care policies.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services</p>		