

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 02/10/2025
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 - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>39343</p> <p>Based on observation, interviews with residents, interviews with staff, review of facility documentation and clinical records, the facility failed to ensure each resident's dignity was maintained regarding cell phone use of staff, for one out of 24 residents reviewed. (R50).</p> <p>Findings include:</p> <p>Clinical record review revealed that Resident R50 was admitted in the facility on January 14, 2025, with diagnoses that included Permanent Atrial Fibrillation (a condition where the upper chambers of the heart (atria) beat irregularly and rapidly, and this rhythm persists for more than 12 months despite treatment attempts), and Type 2 Diabetes</p> <p>(chronic condition where the body does not use insulin effectively or does not produce enough insulin. Insulin is a hormone that helps glucose (sugar) from food enter cells for energy).</p> <p>Review of clinical records of Resident R50 revealed that the resident complained to a Licensed Nurse, Employee E9, on January 30, 2025, at 5:06 a.m., that Resident R50 could not sleep well, as Resident R50 felt that the Licensed Nurse E9's cell phone was very loud, causing unprofessional noise, and that Employee E9 did express her apology to the resident .</p> <p>In an interview on February 04, 2025, at 01:52 p.m., the Nursing Home Administrator and Director of Nursing stated that staff were not allowed to use cellphones in resident's room .</p> <p>28 Pa Code 211.12(d)(1)(5) Nursing services.</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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39343</p> <p>Based on review of facility policies and documentation, clinical record review and interviews with staff, it was determined that the facility failed to ensure that a resident remained free from verbal abuse, which resulted in emotional distress for one of 24 residents reviewed. (Resident R38)</p> <p>Findings include:</p> <p>Review of facility policy, Abuse Neglect or Exploitation' dated October 24, 2022, revealed 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. Continued review revealed; verbal abuse includes but is not limited to any use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend or disability.</p> <p>Review of Resident R38's quarterly MDS (Minimum Data Set - a mandatory periodic resident assessment tool), dated October 21, 2024, revealed that the resident was admitted to the facility on [DATE], and had diagnoses of Type 2 Diabetes Mellitus, Presence of Cardiac Pacemaker (a small, implantable medical device that helps regulate the heart's rhythm. It works by delivering electrical impulses to the heart muscle, ensuring that the heart beats at a consistent and healthy rate), and Dependence on Supplemental Oxygen.</p> <p>Review of facility documentation submitted to the Department of Health on November 21, 2024, revealed that on November 21, 2024, Resident R38 stated that a Nurse Aide, Employee E10, was attempting to throw a piece of paper in the trash-can, when the piece of paper hit Resident R38. The resident stated to the Nurse Aide that the paper hit him, and the Nurse Aide began to yell at the resident and stated, : f k you [Resident R38]. The Nurse supervisor intervened. The Nurse Aide, Employee E10 was immediately placed on administrative leave.</p> <p>Review of facility investigation documentation on the incident revealed that on November 22, 2024, the Administrator, and Director of Nursing spoke with the Nurse Aide E10 via phone, and the Nurse Aide stated: I had a conversation with a Licensed Nurse, and asked why I was working with a certain resident, because my assignment got switched. I was upset with my assignment. I tried to throw a piece of paper in [Resident R38]'s waste basket, but it did not make it. The piece of paper hit [Resident R38], and [Resident R38] called me an idiot. I basically cursed him out, I said the F word at him. I was burned out from working so much and lost my temper, I wanted to apologize to him for it.</p> <p>Review of facility investigation documentation related to the incident revealed that the Nursing Home Administrator obtained statements from all staff involved, interviewed residents, completed skin check on Resident R38, reviewed the video footage of the incident. The facility substantiated the allegation of verbal abuse of Employee E10 to Resident R38. The Employee E10 was placed on administrative leave and termination. Facility provided emotional support to Resident R38, and made the psych consult.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Employee E10's personnel file revealed that he was hired by the facility on November 25, 2023, as a Nurse Aide. Continued review revealed that Employee E10, received certification training on the prevention of elder abuse on January 11, 2024.</p> <p>Interview on February 6, 2025, at 1:35 p.m., with the Nursing Home Administrator (NHA) confirmed the findings.</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(c) Resident rights</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39343</p> <p>Based on observation, clinical record review, review of facility policy and staff interview, it was determined that the facility failed to provide appropriate respiratory care and services for one of 24 residents reviewed (R38).</p> <p>Findings include:</p> <p>Review of Resident R38's clinical record revealed the resident was initially admitted to the facility on [DATE]; diagnosed with Chronic Obstructive Pulmonary Disease (COPD- a common lung disease causing restricted airflow and breathing problems, in people with COPD, the lungs can get damaged or clogged with phlegm); and Dependence on Supplemental Oxygen.</p> <p>Review of clinical record indicated that Resident R38 was ordered on October 30, 2024, Oxygen at 2 Liters/Min, via Nasal Cannula, every Shift Continuously.</p> <p>On February 4, 2025, at 11:38 a.m., observed that Resident R38 was administered with Oxygen at 4 Liters/Min, via Nasal Canula., and not 2 Liters/Min, as ordered by the physician; and the same was confirmed with the Director of Nursing.</p> <p>28 Pa Code 211.12(d)(5) Nursing services</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>39343</p> <p>Ensure medication error rates are not 5 percent or greater.</p> <p>Based on observations, review of clinical records, and interviews with facility staff, it was determined that the facility failed to ensure that it was free of medication error rate of five percent or greater for one of six residents observed during medication administration (Resident R51).</p> <p>Findings include:</p> <p>On February 5, 2025, 11:01 a.m., observed that Employee E5, a Licensed Nurse, administered to Resident R51, the medicine, Memantine 5 milligrams (mg) tab, one tablet, by mouth, after crushing it; when asked the Licensed Nurse to double check the medicine, the nurse stated it was Memantine 5 mg tab, one tablet.</p> <p>Review of physician order for Resident R51, revealed an order, dated October 10, 2024, to administer Memantine HCL,ER 7 mg Capsule, give one capsule by mouth daily for Dementia.</p> <p>The Licensed Nurse, E5 did not follow the physician order to administer 7 mg of Memantine HCL, ER (enteric coated).</p> <p>Review of literature revealed that enteric-coated medicines (ER) should not be administered crushed.</p> <p>On February 5, 2025, 11:01 a.m., observed that Employee E5, a Licensed Nurse, administered to Resident R51, the medicine, Ferrous Sulfate 325 mg RED Type one tab, by mouth, after crushing it; when asked the Licensed Nurse to double check the medicine, the nurse stated it was Ferrous Sulfate 325 mg RED Type one tab.</p> <p>Review of physician order for Resident R51, revealed an order, dated February 5, 2025, to administer Ferrous Sulfate 325 mg RED Type, Take one Tablet by mouth once Daily for Anemia.</p> <p>Review of literature revealed that Ferrous Sulfate Tablet should not be administered crushed.</p> <p>At the time of the finding, during an interview with the Director of Nursing, confirmed the above findings.</p> <p>The facility incurred a medication error rate of 7.14%.</p> <p>28 Pa. Code 211.10(c) Resident care policies</p> <p>28 Pa. Code 211.12(d)(1)(2)(5) Nursing Services.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>47973</p> <p>Based on observations, interviews with staff, and a review of facility procedures, it was determined that the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety.</p> <p>Findings include:</p> <p>Review of policy titled, Sanitizing of Equipment revised May 2, 2022, revealed that employees must check the sanitizer for proper concentrating and record solution PPM on log.</p> <p>Review of policy titled, Labeling and Dating of Food revised April 3, 2023, revealed that All received food product must have a Date Received' clearly marked on the Package. Do not rely on the distributor or produce stickers for dating purposes. On large items, place the received date sticker beside the distributor sticker for easy viewing. Date and rotate items; first in, first out (FIFO). Discard food past the use-by or expiration date Use a date gun that lists the day, month and year that the item was received.</p> <p>Review of facility policy titles, Leftover Foods undated, revealed that Leftover foods shall be stored in appropriate refrigeration units for no more than 72 hours. Potentially hazardous foods shall be stored for no more than 24 hours.</p> <p>An initial tour of the main kitchen was conducted on February 4, 2025, at 10:00 a.m. with the Assistant Food Service Director, Employee E4, and revealed the following:</p> <p>Observations at 10:12 p.m. revealed kitchen staff, Employee E8, was manually washing dishware by utilizing the three-compartment sink. A test of the sanitizer concentration was conducted at 1:14 p.m. with the state surveyor and assistant food services director, Employee E4, utilizing the Quaternary Ammonium Compound test strip (QAC QR) which indicate da reading of 100 parts per million (ppm). Follow-up interview with Employee E4 confirmed the above-mentioned finding and that the concentration is inappropriate and should have correctly registered at 200 ppm.</p> <p>Review of the facility documentation titled, Pot Sink Temperature Sanitizing Concentration Log, for the months of February and January, 2025 revealed faulty test strips were taped to the Log. Observations of the attached test strips revealed inaccurate reading- all strips appeared white in color. Facility documentation provided by the facility failed to reveal evidence that proper concentration solution was maintained when utilizing the three-compartment sink. Interview with the AFSD, Employee E4 confirmed this finding.</p> <p>Observations of the main refrigerator revealed two 10-pound briskets were unlabeled and undated. Further observations revealed that burgers, lamb, pork boneless loin, and four 10-pound beef roasts were labeled with only the received date by the distributor.</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Further review revealed potentially hazardous food, including Buffalo Chicken breast dated January 30, 2025; two turkey breast dated January 30, 2025; cooked salami dated January 7, 2025, and 2 smoked ham dated January 30, 2025, remained refrigerated for more than 72 hours.</p> <p>28 Pa. Code: 201.14(a) Responsibility of licensee.</p> <p>28 Pa. Code 201.18(b)(3) Management</p>		

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<p>F 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Dispose of garbage and refuse properly.</p> <p>47973</p> <p>Based on observations and an interview with staff it was determined that the facility did not ensure that garbage and refuse was disposed of properly.</p> <p>Finding include:</p> <p>A tour of the Food Service Department was conducted on February 4, 2025, at 10:00 a.m. with the Assistant Food Service Director, Employee E4, and revealed the following concerns:</p> <p>Observation revealed a lot of debris around the compactor including used latex gloves, paper and plastic waste, and piles of leaves. Further observation revealed large puddles of oily liquid discharge from the trash compactor.</p> <p>An interview with the Assistant Food Service Director, Employee E4 on February 4, 2025, at approximately 10:30 a.m. confirmed the above findings.</p> <p>28 Pa. Code 201.18(b)(3) Management</p> <p>28 Pa. Code 207.2(a) Administrator's responsibility</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>39343</p> <p>Based on observation, review of facility policy and procedure and interviews with staff, it was determined that the facility failed to maintain an effective infection control program related appropriate cleaning techniques for medical equipment, on three of the six Medication Administration Reviews.</p> <p>Findings include:</p> <p>Review of Facility policy last approved on January 16, 2025, on Infection Control, indicated that the staff will follow established infection control procedures such as hand washing, antiseptic technique, gloves, and isolation precautions for administration of medications, as applicable. It also indicated that all reusable equipment will be decontaminated and/or sterilized between residents at the point-of-care.</p> <p>On February 5, 2025, 9:26 a.m., during medication administration, to Resident R9, Employee E6, a Licensed Nurse, used the sphygmomanometer (an instrument for measuring blood pressure), without disinfecting it, which was used for checking blood pressure of other residents.</p> <p>At the time of the finding, Employee E6 confirmed the same.</p> <p>On February 5, 2025, 9:57 a.m., during medication administration, to Resident R180, Employee E7, a Registered Nurse, used the sphygmomanometer without disinfecting it, which was used for checking blood pressure of other residents.</p> <p>On February 5, 2025, 10:07 a.m., during medication administration, to Resident R50, Employee E7, used the sphygmomanometer without disinfecting it, which was used for checking blood pressure of other residents.</p> <p>At the time of the finding, E7 confirmed the same.</p> <p>28 Pa Code 211.12 (d)(1)(5) Nursing services</p>		