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	07/17/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, review of facility documentation, review of clinical records, and staff interview it was determined that the facility failed to conduct a complete and thorough investigation to rule out an allegation of neglect for one of four residents reviewed (Resident R4). Findings Include: Review of facility policy Abuse Neglect or Exploitation reviewed July 2, 2025, revealed neglect is the failure of the facility, or its employees, to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress to the resident despite knowledge that the care and services were required.Further review of facility policy revealed events involving evidence of abuse and neglect should be thoroughly investigated including obtaining statements from all potential persons who might have had contact with the resident in the previous 24 hours or within the timeframe that has been identified.Review of Resident R4's comprehensive Minimum Data Set (MDS - federally mandated resident assessment and care screening) dated March 4, 2025, revealed the resident was admitted to the facility on [DATE], and had a Brief Interview for Mental Status (BIMS - assesses for cognitive impairments) score of 14 (cognitively intact).Review of Resident R4's MDS dated [DATE], revealed the resident had diagnoses of arthritis (inflammation of the joints), polyosteoarthritis (arthritis that affects multiple joints simultaneously), and muscle weakness.Further review of Resident R4's MDS dated [DATE], revealed the resident used a walker and wheelchair for mobility devices and required supervision/touching assistance for walking 10-150 feet and toilet transfers (the ability to get on and off the toilet/commode).Review of Resident R4's comprehensive care plan dated April 18, 2025, revealed the resident had impaired functional status related to transfers, walking, and toileting.Review of Resident R4's comprehensive care plan dated April 18, 2025, revealed the resident was at risk for falling related to pain with movement and osteoarthritis.Review of Resident R4's clinical record revealed a nursing note dated April 14, 2025, at 1:14 a.m. by licensed nurse (LPN), Employee E5, that indicated during routine rounds the nurse aide informed LPN, Employee E5, that Resident R4 was found lying on the bathroom floor at approximately 11:40 p.m. Per documentation, Resident R4 stated he/she attempted to call for help to use the bathroom, but when no one responded, she decided to ambulate independently and subsequently ended up on the floor.Interview on July 17, 2025, at 2:15 p.m. with Director of Nursing, Employee E2, revealed no incident report or investigation was available related to Resident R4's allegation of neglect that no staff responded to the resident's need for assistance with the bathroom and subsequent fall.28 Pa. Code 211.12 (d)(5) Nursing services.

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Number of residents sampled: 3Number of residents cited: 2the facility did not ensure a medication error rate of < 5%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 two of three residents observed during medication administration (Residents R32, and R67). Findings include: On July 15, 2025, at 9:35 a.m., observed that Employee E6, a Licensed Nurse, administered to Resident R67, the medicine, Citalopram (Celexa) 20 mg, and Citalopram (Celexa) 10 mg tablets, totaling Citalopram (Celexa) 30 mg.Review of physician order for Resident R67, revealed an order, dated March 27, 2025, to administer Citalopram (Celexa) 20 mg, by mouth every day for Generalized Anxiety Disorder. But, the Licensed Nurse, E6, did not follow the physician order as E6 administered to Resident R67, the medicine, Citalopram (Celexa) 20 mg, and Citalopram (Celexa) 10 mg tablets, totaling Citalopram (Celexa) 30 mg.At the time of the finding, during an interview with E6, confirmed the above findings.On July 15, 2025, at 10:10 a.m., observed that Employee E6, a Licensed Nurse, dispensed and crushed the following medicines and was going to administer to Resident R32; Clopidogrel 75 mg tablet, Senna Plus Stool Softener tablet.Review of physician order for Resident R32, revealed an order, dated October 23, 2024, to administer Clopidogrel 75 mg tablet, do not crush; and Senna Plus Stool Softener tablet, do not crush.But, the Licensed Nurse, E6, did not follow the physician order. At the time of the finding, during an interview with E6, confirmed the above findings. The facility incurred a medication error rate of 11.54%. Pa Code:211. 12(d)(1)(2)(5) Nursing Services.

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on observation, interview, and clinical record review, it was determined that the facility failed to correctly administer medications in accordance with physician orders for two of three residents observed during medication administration observed, resulting in a significant medication error (Residents R32, and R67).Based on observation, interview, and clinical record review, it was determined that the facility failed to correctly administer medications in accordance with physician orders for two of three residents observed during medication administration observed, resulting in a significant medication error (Residents R32, and R67).Findings include:On July 15, 2025, at 9:35 a.m., observed that Employee E6, a Licensed Nurse, administered to Resident R67, the medicine, Citalopram (Celexa) 20 mg, and Citalopram (Celexa) 10 mg tablets, totaling Citalopram (Celexa) 30 mg.Review of physician order for Resident R67, revealed an order, dated March 27, 2025, to administer Citalopram (Celexa) 20 mg, by mouth every day for Generalized Anxiety Disorder.But, the Licensed Nurse, E6, did not follow the physician order as E6 administered to Resident R67, the medicine, Citalopram (Celexa) 20 mg, and Citalopram (Celexa) 10 mg tablets, totaling Citalopram (Celexa) 30 mg.At the time of the finding, during an interview with E6, confirmed the above findings.On July 15, 2025, at 10:10 a.m., observed that Employee E6, a Licensed Nurse, dispensed and crushed the following medicines and was going to administer to Resident R32; Clopidogrel 75 mg tablet, Senna Plus Stool Softener tablet.Review of physician order for Resident R32, revealed an order, dated October 23, 2024, to administer Clopidogrel 75 mg tablet, do not crush; and Senna Plus Stool Softener tablet, do not crush.But, the Licensed Nurse, E6, did not follow the physician order. At the time of the finding, during an interview with E6, confirmed the above findings.The facility incurred a medication error rate of 11.54%.Pa Code:211. 12(d)(1)(2)(5) Nursing Services.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Number of residents sampled: n/aNumber of residents cited: n/a the facility did not ensure food was stored, prepared, and served in accordance with professional standards of practice Based on observations and interviews with staff, it was determined that the facility did not ensure that food was stored, prepared, distributed and served in accordance with professional standards for food service safety.Findings include:Review of facility policy titled, Labeling and Dating Food, dated February 25, 2025, revealed that All received food product must have a Date Received' clearly marked on the package and that distributer dating is not to be followed.A tour of the Food Service Department was conducted on July 14, 2025, at 10:30 a.m. with the Assistant Foodservice Director, Employee E3, and the Food Service Director (FSD), Employee E4. Observations revealed the following food items were defrosted and dated July 14, 2025; multiple food items were observed labeled with the same date- the first date of the survey: eye of round bottom; raw ground beef; to boxes of 40- pounds chicken thighs.In an interview at approximately 10:37 a.m., the FSD, Employee E4, stated, they must've taken off the original dates and labeled with todays. The FSD acknowledged that the items confirmed that the food items mentioned above were labeled on that day specifically due to the survey. The FSD as unable to provide documentation or other evidence verifying that the food items were delivered or prepared on July 14, 2025.Continued interview confirmed that the facility failed to accurately label food items with the correct date of receipt or preparation, which is necessary to ensure proper food rotation, storage, and safety in accordance with regulatory requirements.Further observation failed to reveal a received date on the following foods: two boxes of 40-pound chicken thighs; jumbo wings; brisket; beef chuck 8/2 lbs.; two five-pound beef hot dogs; and veal.28 Pa. Code 201.14(a) Responsibility of licensee