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	02/05/2026

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on review of policy, review of clinical records and review of facility provided documentation, it was determined that facility did not ensure to complete a thorough investigation for two of 18 residents reviewed regarding facility reported incidents (Resident R42, R2)Review of facility policy ?Falls management program,' indicates that when a resident sustains a fall, the assessment process will include an investigation using the Fall investigation analysis sheet. This is to help identify the root cause and whether or not the fall was avoidable or unavoidable.Review of Resident R42 clinical record revealed medical diagnosis of Alzheimer's disease, pain in bilateral knees, osteoarthritis, long-term use of insulin.Review of physical therapy discharge recommendations, completed on March 20, 2025, indicate that R42 is to continue to walk and stand with supervision.Review of R42's care plan, dated August 14, 2025, indicates that R42 is at risk for falling related to confusion, history of falls, poor safety awareness, with following interventions, dated November 5, 2025: resident prefers to sit down the floor occasionally. Encourage to sit on the chair or bed if she is in her room, and walker within reach. Remind resident to use it - unable to reeducate due to cognition.Further review of R42's care plan, dated July 17, 2025, indicates the resident requires 1 person assist with rolling walker for ambulation.Review of R42's clinical record, revealed health status note, dated December 16, 2025 at 8:39 pm, stating R42 had a fall in her room at 7:15 in the morning. Fall was witnessed by nurse aide, employee E11.Further review of R42's progress notes revealed that R42 tripped over her own feet, resulting in head hematoma, closed non-displaced fracture of right middle finger, and right knee abrasion.Review of ?interview/statement form for investigative purposes falls,' completed by nurse aide, E11 on December 16, 2025 at 7:15 am, indicates no evidence that R42 was supervised during ambulation with walker; and no indication of preventative measures in place during fall incident.Interview with facility's physical therapist, employee E12 on Wednesday, February 4, 2025 at 12:00 pm, confirmed Resident R42 required supervision during ambulation with walker.Review of Resident R2's clinical record revealed medical diagnosis of Alzheimer's disease, polyosteoarthritis, muscle weakness.Review of physical therapy discharge recommendation notes for R2, completed on September 9, 2025, indicates R2 required supervision or touching assistance during ambulation.Review of R2's care plan, dated July 21, 2025, indicates the resident (R2) has an ADL self-care performance deficit related to Alzheimer's, with intervention to supervise/one person assist with walker for ambulation.Review of facility provided investigation report related to R2's fall, completed on November 6, 2025, indicates that R2 was observed walking into the dining room with her walker and appeared to have tripped over her own feet while placing her walker to the side and lost her balance causing her to fall onto her left side. Staff had witnessed the fall and unable to get to her in time to intercept the fall. The fall resulted in left hip fracture.Interview with facility's director of nursing and administrator on Thursday, February 5, 2025, at 12:30 pm, indicates the statement on investigative report related to R2's fall are inaccurate; further elaborating that R2 was actually on her way out of dining area further stating that an adequate amount of staff were present during incident.However, further review of investigation report revealed no evidence that all fall preventative measures were in place, including supervision.28 Pa Code 211.10(d) resident care policies28 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