STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395467	A. BLDG: 00 B. WING:	02/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
CATHEDRAL VILLAGE STATE LICENSE NUMBER: **030402**	**600 E CATHEDRAL ROAD** **PHILADELPHIA, PA 19128**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT Based on a Medicare/Medicaid Recertification Survey, Civil Rights Compliance Survey, State Licensure Survey, completed on February 10, 2025, it was determined that Cathedral Village, was not in compliance with the requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities and the 28 PA Code, Commnwealth of Pennsylvania of Long Term Care Licensure regulations related to the health portion of the survey process.	F 0000		
F 0550 SS=D		F 0550		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: | (X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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F 0550 SS=D	Continued from page 1 483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.	F 0550	1.R50 was evaluated by social service worker, had no ill effects noted from event, and is no longer a community resident. 2.Nursing Home Administrator or designee will complete a random audit on all shifts to monitor for team member compliance with "Cell Phone Policy" to ensure dignity is maintained for current residents by 2/28/25. 3.The Nursing Home Administrator or designee will provide re-education to current team members on the "Cell Phone Policy" including cell phone use in resident care areas is prohibited and the "Dignity Policy" by 3/10/25. 4.The Nursing Home Administrator or designee will complete a random audit on 5 residents who are receiving care to ensure compliance with the community "Cell Phone Policy" and "Dignity Policy" weekly for 4 weeks and then monthly for 2 months. The results of these audits	Completion Date: **03/18/2025** Status: **APPROVED** Date: **02/27/2025**

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F 0550 SS=D	Continued from page 2 §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by:	F 0550	will be forwarded to Quality Assurance Process Improvement team for review and recommendations.	

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F 0550 SS=D	Continued from page 3 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). Findings include: 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 (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). Review of clinical records of Resident R50 revealed that the resident complained to a Licensed	F 0550		

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F 0550 SS=D	Continued from page 4 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 . 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 . 28 Pa Code 211.12(d)(1)(5) Nursing services.	F 0550		
F 0600 SS=D		F 0600		

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F 0600 SS=D	Continued from page 5 483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by:	F 0600	1.E10 is no longer employed at the community. R38 was evaluated by a licensed team member on 11/21/2024 and no physical injuries were noted. R38 was also provided with emotional support and remains in the community with no ill effects from the event. 2.The social service worker or designee will complete a random audit on all shifts to monitor for team member compliance with the community "Abuse, Neglect, or Exploitation Policy" for current residents by 2/28/25. 3.The Nursing Home Administrator or designee will provide re-education to current team members on the "Abuse, Neglect, or Exploitation Policy" by 3/10/25. 4.The Nursing Home Administrator or designee will complete a random audit on 5 residents who are receiving care to ensure compliance with the community "Abuse, Neglect, or Exploitation Policy"	Completion Date: **03/18/2025** Status: **APPROVED** Date: **02/27/2025**

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F 0600 SS=D	Continued from page 6	F 0600	weekly for 4 weeks and then monthly for 2 months. The results of these audits will be forwarded to Quality Assurance Process Improvement team for review and recommendations.	

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F 0600 SS=D	Continued from page 7 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) Findings include: 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".	F 0600		

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F 0600 SS=D	Continued from page 8 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 September 1, 2022, 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. 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	F 0600		

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F 0600 SS=D	Continued from page 9 administrative leave. 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." 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	F 0600		

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F 0600 SS=D	Continued from page 10 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. 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. Interview on February 6, 2025, at 1:35 p.m., with the Nursing Home Administrator (NHA) confirmed the findings. 28 Pa Code 201.14(a) Responsibility of licensee 28 Pa Code 201.18(b)(1) Management 28 Pa Code 201.29(c) Resident rights	F 0600		

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F 0695 SS=D		F 0695		

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F 0695 SS=D	Continued from page 12 483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by:	F 0695	1.R38's oxygen was immediately adjusted to reflect the physicians order for 2 liters/min via nasal cannula at the time of notification. R38 experienced no ill effects from this event. 2.The Director of Nursing or designee will conduct an audit on current residents who are ordered oxygen to ensure compliance with physicians order by 2/28/25. 3.The Director of Nursing or designee will provide re-education to current licensed staff on the "Oxygen Policy" and "Physician Orders Policy" including the requirement to adhere to the orders of the prescriber by 3/10/25. 4.The Director of Nursing or designee will complete a random audit on up to 5 residents who are ordered oxygen to ensure compliance with the physicians/providers orders weekly for 4 weeks and then monthly for 2 months. The results of these audits	Completion Date: **03/18/2025** Status: **APPROVED** Date: **02/27/2025**

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F 0695 SS=D	Continued from page 13	F 0695	will be forwarded to Quality Assurance Process Improvement team for review and recommendations.	

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F 0695 SS=D	Continued from page 14 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). Findings include: Review of Resident R38's clinical record revealed the resident was initially admitted to the facility on September 1, 2022; 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. 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. On February 4, 2025, at 11:38 a.m., observed that	F 0695		

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F 0695 SS=D	Continued from page 15 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. 28 Pa Code 211.12(d)(5) Nursing services	F 0695		
F 0759 SS=D		F 0759		

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F 0759 SS=D	Continued from page 16 483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by:	F 0759	1.R51's medication orders were reviewed and clarified by the physician including the addition of an order that licensed staff may crush crushable medications on 2/10/2025. R51 experienced no ill effects from this event. E5 was re-educated on the "Medication Administration Policy" the "Do Not Crush" listing. 2.The Director of Nursing or designee will conduct an audit on current residents medications orders to ensure that residents have an order, if applicable, that licensed staff may crush, crushable medications by 2/28/25. The Director of Nursing or designee will audit the medication pass of current residents to ensure compliance with physicians medication orders and that only applicable medications are being crushed by 2/28/25. 3.The Director of Nursing or designee will provide re-education to current licensed staff on the "Medication Administration Policy"	Completion Date: **03/18/2025** Status: **APPROVED** Date: **02/27/2025**

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	395467	A. BLDG: __00_____ B. WING: _____	02/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
CATHEDRAL VILLAGE STATE LICENSE NUMBER: **030402**	**600 E CATHEDRAL ROAD PHILADELPHIA, PA 19128**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0759 SS=D	Continued from page 17	F 0759	and the "Do Not Crush" listing including the requirement to adhere to the orders of the prescriber by 3/10/25. 4.The Director of Nursing or designee will complete a random audit on the medication pass of 5 residents to ensure compliance with physicians medication orders and that only applicable medications are being crushed weekly for 4 weeks and then monthly for 2 months. The results of these audits will be forwarded to Quality Assurance Process Improvement team for review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0759 SS=D	Continued from page 18 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). Findings include: 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. 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. The Licensed Nurse, E5 did not follow the physician	F 0759		

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F 0759 SS=D	Continued from page 19 order to administer 7 mg of Memantine HCL, ER (enteric coated). Review of literature revealed that enteric-coated medicines (ER) should not be administered crushed. 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. 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. Review of literature revealed that Ferrous Sulfate Tablet should not be administered crushed. At the time of the finding, during an interview with	F 0759		

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F 0759 SS=D	Continued from page 20 the Director of Nursing, confirmed the above findings. The facility incurred a medication error rate of 7.14%. 28 Pa. Code 211.10(c) Resident care policies 28 Pa. Code 211.12(d)(1)(2)(5) Nursing Services.	F 0759		
F 0812 SS=F		F 0812		

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F 0812 SS=F	Continued from page 21 483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:	F 0812	1.All undated or outdated food was discarded, the manually washed dishware were re-washed utilizing the dishwasher, and the sanitizer concentration used in the three compartment sink was adjusted to meet the required threshold following the event. 2.The Dining Manager or designee will conduct an audit on current foods being stored in the kitchen and on the nursing units to ensure no undated or outdated food items are present, The Dining Manager or designee will also conduct an audit testing the concentration of the sanitizer in the pot sink to ensure compliance with community policies and requirements by 2/28/25. 3.The Corporate Director of Dining or designee reviewed and if indicated, updated community policies for: "Sanitizing of Equipment Policy" including the "Pot sink Temperature Sanitizing Concentration Log;" "Labeling and Dating of Food Policy;" and	Completion Date: **03/18/2025** Status: **APPROVED** Date: **02/27/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0812 SS=F	Continued from page 22	F 0812	"Leftover Foods Policy" by 2/28/25. The Director of Dining or designee will provide re-education on current policies to dining team members: "Sanitizing of Equipment Policy" including the "Pot sink Temperature Sanitizing Concentration Log;" "Labeling and Dating of Food Policy;" and "Leftover Foods Policy" by 3/10/25. 4.The Dining Manager or designee will complete an audit reviewing dates are listed in accordance with policy for foods being stored in the kitchen or nursing units, reviewing the sanitizer	

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F 0812 SS=F	Continued from page 23 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. Findings include: 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." 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 distributer or produce stickers for dating purposes. On large items, place the received date sticker beside the distributer 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	F 0812		

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F 0812 SS=F	Continued from page 24 was received." 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." 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: 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	F 0812		

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F 0812 SS=F	Continued from page 25 concentration is inappropriate and should have correctly registered at 200 ppm. 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. 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 distributer. Further review revealed potentially hazardous food,	F 0812		

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F 0812 SS=F	Continued from page 26 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. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(3) Management	F 0812		
F 0814 SS=F		F 0814		

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F 0814 SS=F	Continued from page 27 483.60(i)(4) Dispose Garbage and Refuse Properly §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by:	F 0814	1.The area surrounding the trash compactor is clean and free from debris and oily liquids 2.The Dining Manager or designee will conduct an audit on the area surrounding the trash compactor to ensure that it is clean and free of debris and oily liquids and in compliance with community policies and requirements by 2/28/25. 3.The Director of Dining or designee will provide re-education on community policies on properly disposing of garbage to dining team members: by 3/10/25. 4.The Dining Manager or designee will complete an audit reviewing the area surrounding the trash compactor, ensuring that it is clean and free from debris and oily liquids weekly for 4 weeks and then monthly for 2 months. The results of these audits will be forwarded to Quality Assurance Process Improvement team for review and recommendations.	Completion Date: **03/18/2025** Status: **APPROVED** Date: **02/28/2025**

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F 0814 SS=F	Continued from page 28 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. Finding include: 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: 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. An interview with the Assistant Food Service Director, Employee E4 on February 4, 2025, at approximately 10:30 a.m. confirmed the above findings. 28 Pa. Code 201.18(b)(3) Management	F 0814		

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F 0814 SS=F	Continued from page 29 28 Pa. Code 207.2(a) Administrator's responsibility	F 0814		
F 0880 SS=D		F 0880		

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F 0880 SS=D	Continued from page 30 483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	F 0880	1.R9, R180, and R50 experienced no ill effects from this event. E6 and E7 were immediately re-educated on the "Instrument Cleaning and Reuseable Equipment- Infection Control" and the requirement to decontaminate and/or sterilize reuseable equipment between residents at the point of care. The sphygmomanometer's utilized were sanitized following this event. 2.The Director of Nursing or designee will audit the sanitization of reuseable equipment between residents during medication pass at the point of care of current residents to ensure compliance with the "Instrument Cleaning and Reuseable Equipment- Infection Control" by 2/28/25. 3.The Director of Nursing or designee will provide re-education to community staff on the "Instrument Cleaning and Reuseable Equipment- Infection Control" and the requirement to decontaminate and/or sterilize reuseable equipment	Completion Date: **03/18/2025** Status: **APPROVED** Date: **02/27/2025**

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F 0880 SS=D	Continued from page 31 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	F 0880	between residents at the point of care by 3/10/25. 4.The Director of Nursing or designee will complete a random audit on up to 5 residents who require vital sign equipment to be utilized for medication parameters to ensure compliance with the "Instrument Cleaning and Reuseable Equipment- Infection Control" including the sanitization of reuseable equipment between residents" weekly for 4 weeks and then monthly for 2 months. The results of these audits will be forwarded to Quality Assurance Process Improvement team for review and recommendations.	

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F 0880 SS=D	Continued from page 32	F 0880		

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CATHEDRAL VILLAGE STATE LICENSE NUMBER: 030402	600 E CATHEDRAL ROAD PHILADELPHIA, PA 19128

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F 0880 SS=D	Continued from page 33 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. Findings include: 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. On February 5, 2025, 9:26 a.m., during medication administration, to Resident R9, Employee E6, a Licensed Nurse, used the sphygmomanometer (an	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395467	A. BLDG: __00_____ B. WING: _____	02/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
CATHEDRAL VILLAGE STATE LICENSE NUMBER: 030402	600 E CATHEDRAL ROAD PHILADELPHIA, PA 19128

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F 0880 SS=D	Continued from page 34 instrument for measuring blood pressure), without disinfecting it, which was used for checking blood pressure of other residents. At the time of the finding, Employee E6 confirmed the same. 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. 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. At the time of the finding, E7 confirmed the same. 28 Pa Code 211.12 (d)(1)(5) Nursing services	F 0880		

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P 5520		P 5520		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: | (X6) DATE:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395467	A. BLDG: 00 B. WING:	02/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
CATHEDRAL VILLAGE STATE LICENSE NUMBER: **030402**	**600 E CATHEDRAL ROAD** **PHILADELPHIA, PA 19128**

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P 5520	Continued from page 1 Nursing services. (3) Effective July 1, 2024, a minimum of 1 nurse aide per 10 residents during the day, 1 nurse aide per 11 residents during the evening, and 1 nurse aide per 15 residents overnight. This REGULATION is not met as evidenced by:	P 5520	1.Facility to ensure that nurse's aide ratios are maintained in accordance with regulatory requirements. 2.Staffing Coordinator or designee will conduct an audit of staffing schedules from 2/22/25-2/28/25 to verify nurse aide ratios each shift if discrepancies are identified regulatory requirements will be reviewed by the Nursing Home Administrator and Staffing Coordinator. 3.Nursing Home Administrator or designee will reeducate Staffing Coordinator on the Department of Health's Guidance for Calculating Staff to Resident Ratios and Direct Nursing Care Hours by 3/4/25. 4.Staffing Coordinator or designee will conduct audits 2 days per week involving all three shifts x 4 weeks and then 2 days per month involving all three shifts audits per x 2 months to ensure that nurse aide ratios are consistent with regulatory requirements. The results of these	Completion Date: **03/18/2025** Status: **APPROVED** Date: **02/27/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395467	A. BLDG: __00_____ B. WING: _____	02/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
CATHEDRAL VILLAGE STATE LICENSE NUMBER: **030402**	**600 E CATHEDRAL ROAD PHILADELPHIA, PA 19128**

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P 5520	Continued from page 2	P 5520	audits will be forwarded to Quality Assurance Process Improvement team for review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395467	A. BLDG: 00 B. WING:	02/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
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P 5520	Continued from page 3 Based on review of nursing staff schedules, punch reports and interviews with staff, it was determined that the facility failed to maintain required staffing ratios, including one nurse aide per 10 residents during the day shift, one nurse aide per 11 residents during the evening shift and one nurse aide per 15 residents during the overnight shift, on 8 of 21 days reviewed (July 4, 6, 7, and 8, 2024; November 25, 27, 28, and 29, 2024). Findings include: Review of facility census data revealed that on July 4, 2024, the facility census was 79, which required 59.25 hours of nurse aides during the day shift. Review of the nursing time schedules, and punch reports revealed 56.00 hours of nurse aide care was provided during the shift. No additional excess higher-level staff were available to compensate this deficiency. Review of facility census data revealed that on July 6, 2024, the facility census was 77, which required	P 5520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395467	A. BLDG: 00 B. WING:	02/10/2025

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P 5520	Continued from page 4 57.75 hours of nurse aides during the day shift. Review of the nursing time schedules, and punch reports revealed 55.00 hours of nurse aide care was provided during the shift. No additional excess higher-level staff were available to compensate this deficiency. Review of facility census data revealed that on July 6, 2024, the facility census was 77, which required 38.50 hours of nurse aides during the overnight shift. Review of the nursing time schedules, and punch reports revealed 33.00 hours of nurse aide care was provided during the shift. No additional excess higher-level staff were available to compensate this deficiency. Review of facility census data revealed that on July 7, 2024, the facility census was 78, which required 58.50 hours of nurse aides during the day shift. Review of the nursing time schedules, and punch reports revealed 55.00 hours of nurse aide care was provided during the shift. No additional excess higher-level staff were available to compensate this	P 5520		

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P 5520	Continued from page 5 deficiency. Review of facility census data revealed that on July 8, 2024, the facility census was 78, which required 49.77 hours of nurse aides during the overnight shift. Review of the nursing time schedules, and punch reports revealed 46.00 hours of nurse aide care was provided during the shift. No additional excess higher-level staff were available to compensate this deficiency. Review of facility census data revealed that on November 25, 2024, the facility census was 73, which required 69.00 hours of nurse aides during the evening shift. Review of the nursing time schedules, and punch reports revealed 60.00 hours of nurse aide care was provided during the shift. No additional excess higher-level staff were available to compensate this deficiency. Review of facility census data revealed that on November 27, 2024, the facility census was 72, which required 54.00 hours of nurse aides during	P 5520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5520	Continued from page 6 the day shift. Review of the nursing time schedules, and punch reports revealed 47.00 hours of nurse aide care was provided during the shift. No additional excess higher-level staff were available to compensate this deficiency. Review of facility census data revealed that on November 27, 2024, the facility census was 72, which required 36.00 hours of nurse aides during the night shift. Review of the nursing time schedules, and punch reports revealed 30.00 hours of nurse aide care was provided during the shift. No additional excess higher-level staff were available to compensate this deficiency. Review of facility census data revealed that on November 28, 2024, the facility census was 72, which required 49.09 hours of nurse aides during the evening shift. Review of the nursing time schedules, and punch reports revealed 46.00 hours of nurse aide care was provided during the shift. No additional excess higher-level staff were available to compensate this deficiency.	P 5520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5520	Continued from page 7 Review of facility census data revealed that on November 28, 2024, the facility census was 72, which required 36.00 hours of nurse aides during the night shift. Review of the nursing time schedules, and punch reports revealed 30.00 hours of nurse aide care was provided during the shift. No additional excess higher-level staff were available to compensate this deficiency Review of facility census data revealed that on November 29, 2024, the facility census was 72, which required 54.00 hours of nurse aides during the day shift. Review of the nursing time schedules, and punch reports revealed 47.00 hours of nurse aide care was provided during the shift. No additional excess higher-level staff were available to compensate this deficiency. Review of facility census data revealed that on November 29, 2024, the facility census was 72, which required 49.09 hours of nurse aides during the evening shift. Review of the nursing time	P 5520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5520	Continued from page 8 schedules, and punch reports revealed 44.00 hours of nurse aide care was provided during the shift. No additional excess higher-level staff were available to compensate this deficiency. Review of facility census data revealed that on November 29, 2024, the facility census was 72, which required 36.00 hours of nurse aides during the night shift. Review of the nursing time schedules, and punch reports revealed 32.00 hours of nurse aide care was provided during the shift. No additional excess higher-level staff were available to compensate this deficiency. Staffing calculations, nursing staff schedules and staff punch reports were reviewed with the Nursing Home Administrator on February 7, 2024, at 11:00 a.m. The Nursing Home Administrator confirmed that the required staffing ratios for nurse aides were not met on the above dates.	P 5520		
P 5530		P 5530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5530	Continued from page 9 Nursing services. (4) Effective July 1, 2023, a minimum of 1 LPN per 25 residents during the day, 1 LPN per 30 residents during the evening, and 1 LPN per 40 residents overnight. This REGULATION is not met as evidenced by:	P 5530	1.Facility to ensure that LPN ratios are maintained in accordance with regulatory requirements. 2.Staffing Coordinator or designee will conduct an audit of staffing schedules from 2/22/25-2/28/25 to verify LPN ratios each shift if discrepancies are identified regulatory requirements will be reviewed by the Nursing Home Administrator and Staffing Coordinator. 3.Nursing Home Administrator or designee will reeducate Staffing Coordinator on the Department of Health's Guidance for Calculating Staff to Resident Ratios and Direct Nursing Care Hours by 3/4/25. 4.Staffing Coordinator or designee will conduct audits 2 days per week involving all three shifts x 4 weeks and then 2 days per month involving all three shifts audits per x 2 months to ensure that nurse aide ratios are consistent with regulatory requirements. The results of these	Completion Date: **03/18/2025** Status: **APPROVED** Date: **02/27/2025**

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P 5530	Continued from page 10	P 5530	audits will be forwarded to Quality Assurance Process Improvement team for review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5530	Continued from page 11 Based on review of nursing staff schedules, punch reports and interviews with staff, it was determined that the facility failed to maintain required staffing ratios, including one LPN (Licensed Practical Nurse) per 25 residents during the day shift, one LPN per 30 residents during the evening shift, and one LPN per 40 residents during the overnight shift, on six of 21 days reviewed (July 2, and 6, 2024; November 25, 26, 27, and 28, 2025. Findings include: Review of facility census data revealed that on July 2, 2024, the facility census was 80, which required 25.00 hours of LPNs during the day shift. Review of the nursing time schedules, and punch reports revealed 24.00 hours of LPN care was provided during the shift. Review of facility census data revealed that on July 6, 2024, the facility census was 77, which required 15.40 hours of LPNs during the evening shift. Review of the nursing time schedules, and punch	P 5530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5530	Continued from page 12 reports revealed 8.00 hours of LPN care was provided during the shift. Review of facility census data revealed that on November 25, 2024, the facility census was 73, which required 23.36 hours of LPNs during the day shift. Review of the nursing time schedules, and punch reports revealed 15.00 hours of LPN care was provided during the shift. Review of facility census data revealed that on November 26, 2024, the facility census was 72, which required 23.04 hours of LPNs during the day shift. Review of the nursing time schedules, and punch reports revealed 22.00 hours of LPN care was provided during the shift. Review of facility census data revealed that on November 27, 2024, the facility census was 72, which required 23.04 hours of LPNs during the day shift. Review of the nursing time schedules, and punch reports revealed 16.00 hours of LPN care was provided during the shift.	P 5530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5530	Continued from page 13 Staffing calculations, nursing staff schedules and staff punch reports were reviewed with the Nursing Home Administrator on February 4, 2025, at 11:00 a.m. The Nursing Home Administrator confirmed that the required staffing ratios for LPNs were not met on the above dates.	P 5530		
P 5640		P 5640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5640	Continued from page 14 Nursing services. (2) Effective July 1, 2024, the total number of hours of general nursing care provided in each 24-hour period shall, when totaled for the entire facility, be a minimum of 3.2 hours of direct resident care for each resident. This REGULATION is not met as evidenced by:	P 5640	1.Facility to ensure that HPPD requirements are maintained in accordance with regulatory requirements. 2.Staffing Coordinator or designee will conduct an audit of HPPD from 2/22/25-2/28/25 to verify HPPD in accordance with regulation and if discrepancies are identified regulatory requirements will be reviewed by the Nursing Home Administrator and Staffing Coordinator. 3.Nursing Home Administrator or designee will reeducate Staffing Coordinator on the HPPD regulatory requirements by 3/4/25. 4.Staffing Coordinator or designee will conduct audits 2 days per week x 4 weeks and then 2 days per month x 2 months to ensure that HPPD are consistent with regulatory requirements. The results of these audits will be forwarded to Quality Assurance Process Improvement team for	Completion Date: **03/18/2025** Status: **APPROVED** Date: **02/27/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5640	Continued from page 15	P 5640	review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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CATHEDRAL VILLAGE STATE LICENSE NUMBER: 030402	600 E CATHEDRAL ROAD PHILADELPHIA, PA 19128

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
P 5640	Continued from page 16 Based on review of nursing time schedules, punch reports and staff interviews, it was determined that the facility failed to provide a minimum of 3.20 hours of direct nursing care per resident on three of 21 days reviewed (November 25, 27, and 29, 2024). Findings include: Review of facility census data, punch reports and nursing time schedules revealed that on November 25, 2024, the facility census was 73, and a total of 231.00 direct nursing staff hours were provided, which equaled 3.16 hours of direct nursing care per resident. Review of facility census data, punch reports and nursing time schedules revealed that on November 27, 2024, the facility census was 72, and a total of 226.00 direct nursing staff hours were provided, which equaled 3.14 hours of direct nursing care per resident. Review of facility census data, punch reports and	P 5640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395467	A. BLDG: __00_____ B. WING: _____	02/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
CATHEDRAL VILLAGE STATE LICENSE NUMBER: **030402**	**600 E CATHEDRAL ROAD PHILADELPHIA, PA 19128**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
P 5640	Continued from page 17 nursing time schedules revealed that on November 29, 2024, the facility census was 72, and a total of 228.00 direct nursing staff hours were provided, which equaled 3.17 hours of direct nursing care per resident. Staffing calculations, nursing staff schedules and staff punch reports were reviewed with the Nursing Home Administrator on February 4, 2025, at 11:00 a.m. The Nursing Home Administrator confirmed that the required staffing minimum of 3.20 hours of direct nursing care per resident was not met on the above dates.	P 5640		

Certified End Page

CATHEDRAL VILLAGE

STATE LICENSE NUMBER: 030402

SURVEY EXIT DATE: 02/10/2025

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeanne Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen MD
Debra L. Bogen, MD, FAAP
Secretary of Health

Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY