

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395637	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/12/2026
NAME OF PROVIDER OR SUPPLIER Holy Family Home		STREET ADDRESS, CITY, STATE, ZIP CODE 5300 Chester Avenue Philadelphia, PA 19143	
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 0689 Level of Harm - Actual harm Residents Affected - Few	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility policies, clinical records, facility documentation, staff, resident and family interviews, it was determined the facility failed to ensure that Resident R1 was adequately secured in a transportation van. This failure resulted in actual harm for Resident R1 who fell while being transported in the van and sustained a fracture of the left distal femur and fracture of the right distal tibia, requiring transfer to the hospital and surgery for one of three residents reviewed. (Resident R1) Findings Include: Review of facility policy titled, Wheelchair Transport with revision date of June 2025 revealed, Policy- To move a resident who cannot move from one location to another without assistance. Further review of the policy indicates under, Purpose- to fulfill physical, social, psychological or spiritual needs. Review of Resident R1's clinical records revealed Resident R1 was admitted to the facility on [DATE] with the diagnoses of Chronic Pain (persistent or long-lasting pain that continues for more than three to six months), Drusen of Macula (small, yellow, waste-product deposits of lipids and proteins that accumulate under the retina, serving as a primary early indicator of Age-Related Macular Degeneration -AMD), Anxiety Disorder (mental health condition characterized by excessive, persistent, and uncontrollable fear or worry that interferes with daily life), Major Depressive Disorder (serious, common mood disorder characterized by persistent sadness, low energy, and loss of interest in daily activities for at least two week), Muscle Weakness (decrease in the ability to exert force with your muscles, meaning they do not contract or move as expected) Osteoarthritis (chronic joint disease, occurring when protective cartilage at the ends of bones wears down over time, causing pain, stiffness, and reduced mobility), and Edema (swelling caused by excess fluid trapped in the body's tissues). Review of information submitted to the State Survey Agency on, dated February 21, 2026, revealed, [Resident R1], awake, alert, and oriented times three (people, places and situations), BIMS (Brief Interview for Mental Status) of 15 (cognitively intact), non-ambulatory for seven years and requires mechanical sit to stand life for transfers. Continued review of information submitted to the State Survey Agency, revealed at approximately 7:00 p.m., Resident R1 was returning to the facility after an outing with family member via wheelchair van transport. According to Resident R1's family member, who accompanied resident on the van, Resident R1 began sliding under the cross-body seatbelt, sliding down to the floor in front of the wheelchair. Resident's daughter and transport driver attempted to lift resident back up into chair but were unable to and proceeded back to the facility. RN (Registered nurse) notified, entered the van to see [Resident R1] seated on (his/her) right hip, legs together bending in front of (him/her) facing towards the left and was complaining of pain. RN notified 911(Emergency Medical Services) who arrived within 5 minutes. [Resident R1] transferred by EMTs (Emergency Medical Technicians) from van into the ambulance then transported to the hospital ER (Emergency Room). Review of Resident R1's nursing progress note dated February 21, 2026, revealed Called to the entrance of the house just before 7 p.m. When I arrived outside, I found resident sitting on the floor of the handicap van with (his/her) legs beneath (him/her), having slid out of the wheelchair during the ride home from the outing. Resident was with (his/her) daughter and the driver. Resident had been secured with the (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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F 0689 Level of Harm - Actual harm Residents Affected - Few	<p>handicap van seat belt in the transport wheelchair which was secured in the handicap van with 4 straps to the floor. Daughter had attempted to keep (resident) from sliding out of the wheelchair but was unable due so. Resident was complaining of pain to (his/her) legs. According to daughter, resident did not hit (his/her) head as (he/she) slowly slid out of the wheelchair. Was unable to assess resident thoroughly or obtain vital signs due to (his/her) position inside the handicap van. Called 911 (Emergency Medical Services) immediately. First responders arrived shortly thereafter and assisted (resident) out of the van and onto a stretcher in order to transport (him/her) to emergency room for further evaluation. Primary Care Physician notified of incident and transfer to Emergency Room. Resident left via ambulance around 7:25 pm. Chaplain present and gave blessing before resident left. Review of Resident R1's hospital record dated February 21, 2026, revealed, Eighty-five year old (female/male) with left periprosthetic distal femur (thigh) fracture. Right distal tibial (leg) shaft fracture status post slip forward under wheelchair seat belt from wheelchair. Review of Resident R1's nursing progress note dated February 27, 2026 revealed, Resident R1 returned from hospital post status- Left femur Open Reduction (surgical procedure used to stabilize and heal a fractured left femur by realigning the bone and securing it with internal hardware) and Internal Fixation (Weight Bearing As Tolerated) and Right tibial minimally displaced distal tibial fracture casted base of toes to below knee (Non-Weight Bearing). Left lateral thigh with dressings from hip extending to 8 inches above knee - dressing with moderate amount of strike through on dressings, treatment with wound dressing ointment twice a day. [Resident R1] indicated (he/she) does not want to be on any additional pain meds (he/she) was on in hospital, only wants the pain meds (he/she) was receiving at the facility. Review of facility investigation into the fall incident sustained by Resident R1 revealed a statement from (van driver) Employee E3 indicated, In person interview held with (van driver), Employee E3 witnessed by Director of Nursing Employee E2 and Nurse supervisor Employee E4 and (Director of Maintenance) Employee E5. I arrived at 2PM on Saturday [DATE], to pick up the resident and (his/her) daughter. I got (him/her) in the van facing forward and hooked the wheelchair to the four points anchor in the van and put on the seat belt. Daughter sat in the back passenger seat. Fifteen minutes into the ride, (she/he) said (she/he) was slipping, I stopped and re-adjusted (her/his) seat belt. (She/he) said (her/his) pants material and cushion is what causes the slipping. We arrived five minutes later and I wheeled (her/his) backwards out of the van. I gave (her/his) my number to text me when they were ready, but they said they would be ready around 6:00 p.m. or 6:30 p.m. I picked them up and wheeled (her/his) into the van and strapped (her/his) as I did earlier. (Resident) spoke about enjoying dinner, there was nothing different with (him/her). Five minutes into the ride (he/she) mentioned (he/she) was slipping again; I told (him/her) I was going to stop to re-adjust (his/her) seat belt. (He/she) said (he/she) was fine keep going. (His/her) daughter asked if (he/she) was sure and (he/she) said yes. I was focusing on the traffic; I don't know if the daughter did anything to help. I was going the speed limit, but at this point traffic was heavy, so I was moving about ten miles per hour. I turned on (he/she) said (he/she) was slipping again; I stopped and when I opened the door, (he/she) was sitting on the footrest. The daughter and I tried to put (him/her) back in (his/her) chair, but we couldn't. I said let's call for help. Daughter stated let's keep going. During interview held with Resident R1 on March 12, 2026, at 10:31 a.m. the resident was asked Did you apply your own seatbelt? the resident stated No the driver did, we started going, and it seems to me like he was going faster and it made me nervous he might have gotten nervous, I said I was slipping and my daughter was next to me, by the time he pulled over I was already on the ground and I don't remember much after that. I had the best time when I was out with my family. Interview held with Resident R1's daughter on March 12, 2026, at 10:55 a.m. revealed Resident R1's daughter met Resident R1 and (van driver) Employee E3 at the facility to ride over to their destination. Resident R1 was transferred to the van and there were no issues on the ride over. On the way back I thought he had strapped (him/her) in the same way as on the ride over but a few minutes in (he/she) started to say (he/she) felt a little loose. We were going through a busy nearby intersection, and as we were (continued on next page)</p>		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	<p>going through (he/she) slide down off of the chair. The driver then pulled over right away but [Resident R1] was already down on the floor of the van. Resident R1's daughter stated her and (Van driver) Employee E3 attempted to lift Resident R1 back into the chair but they were unable to, so she asked van driver, Employee E3 to go back to the facility. Review of facility investigation documents revealed a written statement from Licensed nurse, Employee E4, Called to the entrance of the house just before 7 pm. When I arrived outside, I found resident sitting on the floor of the handicap van with (his/her) legs beneath (him/her), having slid out of the wheelchair during the ride home from the outing. Resident was with (his/her) daughter and the driver. Resident had been secured with the handicap van seat belt in the transport wheelchair which was secured in the handicap van with 4 straps to the floor. Daughter had attempted to keep (him/her) from sliding out of the wheelchair but was unable do so. Resident was complaining of pain to (his/her) legs. According to daughter, resident did not hit (his/her) head as (he/she) slowly slid out of the wheelchair. Was unable to assess resident thoroughly or obtain vital signs due to (his/her) position inside the handicap van. Called 911 immediately. First responders arrived shortly thereafter and assisted (him/her) out of the van and onto a stretcher in order to transport (him/her) to the emergency room for further evaluation. Primary Care Physician notified of incident and transfer to Emergency Room. Daughter followed resident to Emergency Room. Resident left via ambulance around 7:25 pm. Chaplain present and gave blessing before resident left. Review of map directions revealed the destination to the nursing facility was a total distance of 5.4 miles which would take approximately 19 minutes to drive. Interview held with the Nursing Home Administrator Employee E1 and the Director of Nursing (DON), Employee E2 at 9:50 a.m. on March 12, 2026. were asked what occurred with Resident R1 having a fall in the transportation van. The Director of Nursing Employee E2 stated, Resident R1 had a requested to go out with family to celebrate (his/her) birthday with (his/her) family. Resident R1 went with no issues but on the way back slide out of (his/her) chair, the driver and daughter attempted to get resident back in but couldn't, they proceeded back to the facility and at that point 911 was called and Resident R1 was taken to the hospital. When asked what type of van and chair it was DON, Employee E2 revealed it was a facility transport van and a standard wheelchair. When asked who fastened Resident R1's seatbelt DON Employee E2 stated van driver, Employee E3 did. DON, Employee E2 revealed when the van driver, Employee E3's statement was taken they described fastened the seat belt but when asked to demonstrate the belting it was determined by the facility that Employee E3 failed the ensure the wheelchair was properly belted under the arms of wheelchair to obtain and maintain maximum securement. Interview held with the licensed nurse supervisor, Employee E4 who was the nurse supervisor the night the incident occurred, I was informed (he/she) was back and that there was trouble, so I immediately went to the entrance, found (him/her) half sitting and half lying. It was obvious (he/she) had slid and (he/she) was saying that (he/she) just wanted to go to bed but it hurts. I immediately called 911 due to me completing an initial assessment and realizing it was a situation that needed emergent attention. Interview held on March 12, 2026 at 12:44 p.m. with the Director of Maintenance, Employee E5. revealed I have experience with driving vehicles, securing people, moving people and stuff like that is why I was designated to be the trainer to teach, to re-educate and make sure everybody knew what was going on and make sure all the vehicles were safe and see if there was anything that was missing or needed to happen. When asked how many vehicles the facility uses for transport Director of Maintenance, Employee E5 revealed, there's three vans that could be used and a car that could be used but that's for ambulatory people. Director of Maintenance, Employee E5 was asked, how did you do an evaluation of the vans to make sure everything was still working properly and then how did you come up with the training that you were using to retrain the staff? When asked if anything was changed or modified in the vans Director of Maintenance, Employee E5 stated, I didn't want to modify I just went straight to all new equipment basically new everything, as far as like lap belts or well I noticed that the handicapped van is set up with a use of the existing cross strap and the van has been modified for handicapped. they put the (continued on next page)</p>		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	brackets in the floor and it's got the bracket the receiving actually and but it's primarily mounted so you use the seat belt that's in there. Because of the way it goes on some of the chairs I said we needed to get a different kind of an additional lap belt for chairs that don't that have the armrests attached to the back; you would have to go under and across, thus losing the cross strap if you're going to lose the chest strap let's put it down where it's better so we got the lap belt that attaches to the anchor points. I ordered those for the handicapped van and I installed them, for training there is a manufacturer nineteen minute video we'll make the staff/drivers watch the video and we take them to the van we show them how it's done and then we make the drivers actually do it. Continued interview with the Director of Maintenance, Employee E5 on March 12, 2026, revealed the facility van driver was still employed and was re-in serviced and re-trained with a hands-on training on how to proper secure individuals in facility vans. The training included reviewing a 19-minute video and hands on skills testing. Interview held on March 12, 2026, with Nursing Home Administrator, Employee E1 and Director of Nursing, Employee E2 at 2:20 p.m. confirmed the facility van driver did not properly secure Resident R1 in the transportation van. The facility failed to ensure that Resident R1 was adequately secured in the transportation van. This failure resulted in actual harm for Resident R1 who fell while being transported in the van and sustained a fracture of the left distal femur and fracture of the right distal tibia and required a transfer to the hospital. 28 Pa. Code 201.14(a) Responsibility of Licensee 28 Pa. Code 201.18(b)(1)(e)(1) Management		