STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396141	A. Building B. Wing	01/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fox Subacute at South Philadelphia	1930 South Broad Street Philadelphia, PA 19145

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical documentation and staff interviews, it was determined the facility failed to ensure adequate supervision during care by not ensuring two staff members were present for one of five residents reviewed (Resident R1). This failure constituted neglect and resulted in actual harm to Resident R1, who fell during the provision of incontinence care and sustained a fracture of the right humeral head (upper arm bone at the shoulder). This deficiency was identified as past noncompliance.Findings include:Review of Resident R1's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses of Sequelae of Cerebral Infarction (area of brain tissue that has died) due to thrombosis of left middle cerebral artery, acute infarction of intestine, obstructive fluid, Subdural Hematoma, cognitive communication deficit, muscle weakness, Pulmonary Embolism without acute heart pulmonale, need for assistance with personal care, tracheostomy status, Chronic Respiratory Failure unspecified whether with hypoxia or hypercapnia, pain. Review of Resident R1's quarterly MDS (Minimum Data Set, periodic assessment of resident care needs), section G, Functional Status, dated [DATE], revealed the resident required extensive assistance of two or more staff members for bed mobility (how resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture).Review of Resident R1's annual Minimum Data Set (MDS), dated [DATE], indicated a Brief Interview for Mental Status (BIMS) score of 15, reflecting cognitive intact. Review of Resident R1's physician orders dated [DATE], revealed an order indicating, bed mobility, two-person assist, and transfer with Hoyer lift, two-person assist.Review of Resident R1's care plan dated [DATE], revealed the following intervention: bed mobility, two-person assist, and transfer with Hoyer lift, two-person assist.Review of facility documentation submitted to the State Survey Agency on [DATE], alleged that Resident R1 was alert and oriented x3 but severely Aphasic (disorder that affects language abilities due to brain damage). Resident R1 was flaccid on (his/her) right side and had minimal use of (his/her) left side. On [DATE], at approximately 5:30 p.m., Certified Nursing Assistant (CNA) Employee E3 positioned Resident R1 on (his/her) left side to complete incontinence care. During care, Resident R1 kicked (his/her) left leg out of the bed, followed by (his/her) right leg, and began to slide out of the bed feet first. Employee E3 yelled for help while attempting to hold Resident R1 in the bed but was unable to do so. Employee E3 assisted Resident R1 to the floor while protecting (his/her) head. The nurse responded to the room and observed Resident R1 on the floor with Employee E3 kneeling behind (resident), supporting (his/her) head and upper body. Resident R1 was immediately assessed and transferred back to bed via Hoyer lift. Neurological checks were completed. Resident R1 reported no pain, and (his/her) vital signs were stable. Bilateral fall mats were placed for safety. On [DATE], Resident R1 reported pain in (his/her) right arm, which (resident) had reported in the past; however, due to the recent fall, the medical team ordered an X-ray of (his/her) arm and administration of PRN pain medication. On [DATE], the X-ray (continued on next page)

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 0600 Level of Harm - Actual harm Residents Affected - Few	revealed a fracture of the right humeral head. The medical team was immediately notified and ordered Resident R1 be sent to the emergency room for further evaluation and treatment. Resident R1 was sent to the ER (emergency room) by orthopedics and underwent a body CT (type of imaging that uses X-ray techniques to create detailed images of the body) scan for additional injuries. Resident R1 returned to the facility on [DATE], with a follow-up orthopedic appointment scheduled for [DATE]. Employee E3 was terminated for failure to follow safety policies and procedures, as Resident R1 required a two-person assist. Facility-wide re-education and in-service training were initiated.Review of the facility's internal investigation, completed by the facility, revealed on [DATE], an interview was conducted with Certified Nursing Assistant (CNA) Employee E3, who had a language barrier and provided the following written statement: I was changing (Resident R1), and when I turned (him/her), (he/she) fell. (Resident) was not hurt because I caught (him/her) before (he/she) fell.Review of the facility's internal investigation statement conducted on [DATE], by the Director of Nursing (Employee E2), revealed that due to Employee E3's language barrier, with English as a second language, a follow-up interview was also conducted. Employee E2 reported that Employee E3 stated she positioned Resident R1 on resident's left side to complete incontinence care when Resident R1 placed (his/her) leg off the side of the bed and began to slip. Employee E3 yelled for help and attempted to hold Resident R1 in the bed by grabbing (resident) around the trunk. Employee E3 was unable to keep Resident R1 in the bed and supported the resident's head and upper body while assisting (him/her) to the floor.Further review of facility's interval investigation revealed an incident report progress noted dated, on [DATE], by Licensed Nurse Employee E4, which stated: During care, CNA Employee E3 lowered the resident to the floor as (he/she) was sliding out of the bed. Resident R1 denied pain or discomfort.Review of the radiology results report dated [DATE], revealed the following findings: Views of the right humerus demonstrate a comminuted fracture of the humeral head with dislocation of the humeral head from the glenoid in an anteroinferior position. Mild degenerative changes of the shoulder and minimal cortical irregularity were noted. No joint effusion was present. Generalized soft tissue swelling was observed. Conclusion: Fracture-dislocation of the right humeral head.Review of timeline created by the Director of Nursing revealed a statement dated [DATE], from an interview conducted with Employee E3 by the Director of Nursing, Employee E2. The statement revealed: E3 reported that she positioned Resident R1 on (resident's) left side to complete incontinence care when Resident R1 put (his/her) legs off the side of the bed and began to slide off. I (E3) yelled for help and tried to hold Resident R1 in the bed. When I was unable to hold (him/her), I assisted (resident) to the floor. Employee E2 asked Employee E3 if she was aware that Resident R1 required a two-person assist. E3 responded, Yes, but (he/she) can help with (his/her) left hand, so I thought it would be okay. Employee E2 asked if Employee E3 had asked anyone for help, to which Employee E3 replied, No. Employee E2 informed Employee E3 of Resident R1's injury to (his/her) right arm and asked if the arm was caught or hit on anything. E3 replied, No. When asked how she assisted Resident R1 to the floor, Employee E3 stated that she held Resident R1 around the waist and slid (him/her) to the floor. The bed was at Employee E3's waist height. Employee E2 asked if Resident R1 had hit (his/her) head, and Employee E3 replied, No.Further review of facility timeline included a statement dated [DATE], of an interview attempted with Resident R1 by the Director of Nursing, Employee E2. Employee E2 reported: Attempted to interview Resident R1. Resident R1 was in great spirits and smiled when (he/she) saw me. I asked if (he/she) had any pain, and Resident R1 said no. I asked if (Resident R1) remembered falling, and (he/she) said yes. I asked if (he/she) remembered how it happened, and Resident R1 said no. I asked again, and Resident R1 said yes. I asked if (he/she) had slid (his/her) legs out of the bed during care, and (continued on next page)

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