STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396141	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/04/2026
NAME OF PROVIDER OR SUPPLIER Fox Subacute at South Philadelphia		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review and interviews with staff, it was determined the facility failed to ensure Resident R1 was kept safe from accidents related to exposed bedframe parts for one of 10 residents reviewed. This failure resulted in actual harm to Resident R1 who sustained lacerations to the forehead and inside of the mouth as well as bruising to the left eye when the resident's face came into contact with the bed frame during care. Resident R1 required transfer to the hospital. This deficiency is cited as past non-compliance. (Resident R1) Findings Include:Review of Resident R1's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses including, acute and Chronic Respiratory Failure, Anoxic (resulting from lack of oxygen) brain damage, tracheostomy status (a tube placed into the airway through the neck and into the trachea to assist with breathing), and generalized muscle weakness. Review of Resident R1's most recent Minimum Data Set (MDS- assessment of care needs), dated December 10, 2025, section GG, Functional Abilities and Goals, revealed that the resident was dependent on staff for bed mobility. Review of the resident's care plan dated May 16, 2023, revealed that Resident R1 required a one person assist for bed mobility. Review of documentation submitted to the State Survey Agency on February 24, 2026, revealed [Resident R1] is a tracheostomy dependent, bed bound, alert but not oriented young [gentleman/lady]. [Resident R1] requires 1 person to assist (her/his) with bed mobility and incontinence care. At approximately 0500am on 2/20/2026 the CNA (nurse aide) was providing incontinent care to [the resident] and as he rolled (her/him) onto (her/his) left side (her/his) face hit in the corner of the metal bed frame where the circumferential rail meets the rail for the headboard. He turned (her/his) back he noticed blood on (her/his) face and immediately called for the nurse who promptly responded to the room to access the resident. The nurse asked the respiratory therapist to get the house supervisor as she assessed the resident and dressed the lacerations on (her/his) forehead. The supervisor assessed [Resident R1] to be at (her/his) baseline neurological condition and noted two lacerations to (her/his) forehead, swelling and bruising to (her/his) left eye and a small cut in (her/his) mouth. The medical team was notified and 911 (EMS - Emergency Medical Service) was called. [The resident]'s son and responsible party was notified of the incident and her transfer to the hospital.Review of the incident investigation revealed nurse aide, Employee E3 was assisting the resident with continence care on February 20, 2026. The witness statement from nurse aide, Employee E3 stated As I was providing care to [Resident R1], I turned (her/him) over onto (her/his) left side.for just about 30-40 seconds. When I finished and turned (her/him) back, I noticed blood streaming down (her/his) face coming from (her/his) eyebrow.I saw drops of blood on the wooden and metal part of the headboard.All I could guess was (she/he) might have cut (her/his) eyebrow against the headboard .911 was called. An unsigned statement identified by the DON as being from Licensed nurse, Employee E4, stated LPN entered room and observed bleeding from supraorbital (region immediately over the eye socket) area. 2 lacerations observed, blood in oral cavity noted, discoloration and inflammation to left eye note[d] .MD made aware, order given to send to emergency department .Resident exited the facility at 0559 via stretcher.Review of statement from Licensed (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 0689 Level of Harm - Actual harm Residents Affected - Few	nurse, Employee E5, revealed Pt (patient) has 2 cuts on (her/his) forehead, above the [right] & [left] eyes, a bump in between the cuts, & a black eye. Mouth was bleeding too, I wiped the blood and noticed that the patient has a small cut insider (her/his) [right] upper mouth .I checked the side of the bed & noticed that there was blood on the [right] corner side of the bed frame .EMS came to pick up the [patient] . Review of the timeline compiled and provided by the DON (Director of Nursing) revealed, at 6:30 a.m. on February 20, 2026, I was informed that [resident R1] sustained an injury during care and needed to go to the hospital and at 10:15 a.m. she spoke to resident [physician] at [hospital] emergency department. I thoroughly explained what caused (his/her) injuries. During an interview on March 4, 2026, at 1:45 p.m., the Director of Nursing (DON), Employee E2, revealed that she believed the resident's facial injuries were sustained when the resident's face made contact with an exposed pin used to secure two pieces of the bedframe to each other. She stated that she believed that the pin was sticking up and the two sharp ends made contact with the skin above the resident's eyebrows, causing the lacerations when the resident was repositioned onto (his/her) back, dragging the pin over the skin. Employee E2 stated that she believed the black eye and swelling of the forehead were caused by the resident's face making contact with an exposed knob on the frame. Further review of the incident report revealed nurse aide, Employee E3 was evaluated for repositioning competency following the incident. Review of facility performance evaluation worksheet titled Turning and Positioning completed on February 27, 2026, revealed the following standards were to be met: 12. To bring the resident towards you (to turn away), slide arms under resident's shoulders, and.move the resident's shoulders toward you on top of your arms.13. Slide both arms under the resident's upper thighs and lower back and. move the resident's buttocks toward you on the bed.14. Slide both arms under the resident's lower legs and.move the resident's legs toward you on the bed.15, Cross the resident's arms across his/her chest.16. To turn the resident away from you, cross the leg nearest to you over the far leg at the ankle, or bend the knee up with foot on bed.17. Place one hand on the resident's shoulder nearest you and your other hand on the hip nearest you.18. Turn the resident gently to his/her side facing away from you. Make sure resident will not be lying too close to either side rail as resident should be in the center of the bed. All expectations evaluated were documented as met by the nurse aide, Employee E3. Observation conducted on March 4, 2026, in the presence of the Director of Nursing, Employee E2 of the bedframe used by resident had at the time of the incident revealed that there was an exposed [NAME] pin (a bent wire piece resembling a large [NAME] pin) securing the connection between the base of the bedframe and the headboard. This area was observed to sit approximately two inches below the top of the deflated air mattress. DON confirmed that the mattress was inflated while the resident was using it. When asked how the resident's face came into contact with this part which was well below the surface of the mattress, the DON stated that the resident was boomerang shaped due to contractures which did not allow the resident to straighten out fully. She stated that this caused the resident's head and feet to overlap the edge of the mattress when repositioned onto (her/his) side during care. DON confirmed that the resident's spine had not been aligned with the edge of the bed nearest to the nurse aide when repositioned at the time of the incident. This deficiency was identified as actual harm past non-compliance for failure the failure of the facility to provide a safe bedframe for Resident R1. On March 4, 2026, the Director of Nursing presented documentation, indicating that the facility initiated a plan of correction on February 20, 2026, to address the failure of the facility to provide a safe bedframe which resulted in actual harm to Resident R1 who sustained lacerations to the forehead and inside the resident's mouth. The facility's plan of correction included the following: The facility alleged a date of compliance of February 27, 2026. The plan of correction stated the following:Resident's bed was replaced. A thorough investigation was conducted into the incident ruling out neglect. The CNA caring for [Resident R1] at the time of the incident was taken off the schedule until his competency and technique were evaluated by the DON and a direct education regarding safety during turning and positioning was provided on 2/27/26.All residents that are on the (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	same model bed were identified. Therapy secured foam padding to the corners of the bedframes immediately mitigating the risk for injury on 2/20/26.Acquired a new bed vendor to replace all beds of the same make and model. Staff were educated on the use of the new bed. In-servicing on turning and positioning safety was completed by all CNAs on 2/27/26.Maintenance will conduct monthly audits to ensure safety and proper function of beds. DON or designee will verify that proper positioning during care is being maintained weekly during clinical rounds. Results from audits will be reported at monthly QAPI and Safety meetings overseen by the Administrator x 3 months. Facility education record and subsequent audits were verified for completion. Staff were interviewed to verify education of appropriate turning and positioning procedure. Random staff and resident interviews were conducted to verify compliance with the plan of correction. QAPI (Quality Assurance Improvement Plan) records reviewed to verify ongoing monitoring. Resident beds were verified to be padded for safety. Invoices were reviewed to confirm new frames were ordered. No continuing concerns were identified through record review, interview or observation. This deficiency was cited as past non-compliance. 28 Pa. Code 201.14. (a) Responsibility of licensee 28 Pa Code 201.18(b)(1) Management