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	02/10/2026

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policies, clinical record review and interviews with residents and staff, it was determined that the facility failed to ensure that a resident's representative was informed of a resident's change of status to make treatment decisions, for one of 16 residents reviewed (Resident R16). Findings include: Review of facility policy, Resident Rights dated November 18, 2018, revealed that residents and their families or other representatives have the right to be fully informed by a physician of his/her health and medical condition. The facility shall give the resident and family the opportunity to participate in planning the resident's care and medical treatment. Review of Resident R16's Annual MDS (Minimum Data Set - a mandatory periodic resident assessment tool), dated January 20, 2026, revealed that the resident was admitted to the facility on [DATE], and had diagnoses including respiratory failure (not enough oxygen passes from your lungs to your blood) requiring use of a mechanical ventilator (machines that act as bellows to move air in and out of the lungs), renal failure (a condition in which the kidneys lose the ability to remove waste and balance fluids), hearing loss, seizure disorder (abnormal electrical activity in the brain), paraplegia (paralysis of the legs and lower body) and cerebrovascular accident (damage to the brain from interruption of its blood supply). Continued review revealed that it was very important to the resident to have family involved in discussions about their care. Review of Resident R16's care plan, dated June 12, 2024, revealed that the resident had impaired cognitive function/impaired thought processes with interventions including to assist the resident with decision making regarding care. Interview with Resident R16's representative on February 9, 2026, at 9:30 a.m. revealed that the facility has not been allowing him to participate in making informed treatment decisions regarding the resident's care. Resident R16's representative continued that, the facility has not been informing him of the resident's condition, scheduled appointments, lab or diagnostic results and changes in the resident's treatment plan. Review of progress notes for Resident R16 revealed that on February 4, 2026, the resident went to an ENT (Ears, Nose and Throat) appointment and returned to the facility with recommendations for a different tracheostomy (a surgically created hole in your trachea that allows for breathing) tube size. Continued review of progress notes revealed that on February 8, 2026, at 8:52 p.m. nursing staff informed the nurse practitioner of lab and chest x-ray results. The nurse practitioner gave an order to obtain additional labs and new orders for medications. Further review revealed no evidence that Resident R16's representative was notified or given the opportunity to participate in treatment decisions regarding the resident's ENT appointment, labs and medication changes. Continued interview with Resident R16's representative confirmed that he was not informed or given the opportunity to participate in treatment decisions regarding the resident's ENT appointment, labs and medication changes. Interview with the Director of Nursing on February 9, 2025, at 10:00 a.m. revealed that Resident R16's representative should have been notified of the Resident's appointment, labs and medication changes. 28 Pa Code 201.29(a) Resident rights28 Pa Code 211.10(a) Resident care policies

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of facility policies, clinical record review and interviews with staff, it was determined that the facility failed to ensure that personal privacy was provided during treatment and medication administration for two of 16 residents reviewed (Residents R27 and R28).Finding include: Review of Facility policy on Resident's Rights dated November 18, 2018, revealed that under section Policy Statement: All residents in long term care facilities have rights guaranteed to them under federal and state law. Under section POLICY INTERPRETATION #1. 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. #2. The facility will promote the exercise of rights for each resident including any who face barriers (such as communication problems hearing problems and cognition limits) in the exercise of these rights. #3. The facility will protect and promote the rights of each resident including each of the following rights: exercise his or her rights privacy and confidentiality. The nursing home shall establish and implement written policies and procedures setting forth the rights of residents for the protection and preservations of dignity individuality and to the extent medically feasible. Independent residents and their families or other representatives shall fully informed, and documentation shall be maintained in the resident's file of the following rights #a. privacy in treatment and personal care. Review of Resident R27's clinical record revealed that Resident was admitted to the facility on [DATE], with diagnoses of Chronic Respiratory Failure. Review of physician's order dated January 15, 2026, revealed an order for L (left) Elbow cleanse with NSS (normal saline solution), apply Medi honey, cover with wound dressing one time a day. Observation of Resident R27's bedroom conducted on February 8, 2026, at 11:25 AM revealed that resident R27 was in a single room further Resident R27's bed did not have a privacy curtain around it. Wound care observation with licensed Employee E5 conducted on February 8, 2026, at 11:30 AM revealed that Resident R27 was in bed. Further observation revealed that Employee E5 proceeded to perform wound care on Resident R27's elbow without closing the residence door. Resident R27 was visible from the hallway with resident R27's door open. Interview with Employee E5 conducted at the time of the observation, confirmed that she did not close Resident R 27's door while performing wound care on Resident R27's elbow. Observation on February 8, 2026, at 9:05 a.m. revealed Employee E6, licensed nurse, administer medications to Resident R28 via the resident's feeding tube in his stomach. Resident R28's bed was directly across from Resident R26's bed and there was no privacy curtain between the beds, allowing for full observation of the medication administration by Resident R26. Interview, at the time of the observation, Employee E6, licensed nurse, confirmed that there was no privacy curtain between the residents' beds. 28 Pa Code 201.29(a) Resident rights (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa Code 211.10(a) Resident care policies

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of clinical record, review of facility policy and interview with staff, it was determined that the facility failed ensure that a person-centered care plan was developed for one of sixteen residents reviewed. (Resident R27)Review facility policy on plan of care and interdisciplinary care conference revealed that under section policy the facility will develop a meaningful plan of care and compliance with state and federal regulatory requirements that meets the individual needs of the resident in order to provide quality of care and the components that are necessary for the quality of life of the individual. Review of Resident R27's clinical record revealed that Resident was admitted to the facility on [DATE], with diagnoses of Chronic Respiratory Failure. Review of physician's order dated January 15, 2026, revealed an order for L (left) Elbow cleanse with NSS (normal saline solution), apply Medi honey, cover with wound dressing one time a day. Further review of physician's orders revealed an order dated January 23, 2026, for Left ear: cleanse area with NSS pat dry apply skin prep, leave open to air every shift for Wound Tx (treatment). Further review of Resident R27's physician's orders revealed an order dated December 29, 2025, for: Foley care per protocol Q (every) shift. May change foley PRN (as needed) for blockage or leakage, if Foley flush protocol is unsuccessful. Size:14fr 5-15cc balloon every shift. Review of progress note dated January 21, 2026, revealed Resident R27 was seen by the wound nurse and wound MD during wound rounds for evaluation and treatment of areas of the Left elbow, and left ear. Left elbow unstageable 1.8x2.0x0.1, 100 black necrosis, treatment for Medi honey in place. Left ear stage 2 1.0x0.3x0.1, 100 scab treatment for skin prep in place. Review of wound note dated January 21, 2026, revealed that resident had developed a stage 2 pressure ulcer on her ear and an unstageable pressure ulcer to left elbow. Review of Resident R27's care plans revealed that there was no care plan addressing Resident R27's pressure ulcers. Further review of resident ours 27's care plans revealed that there was no care plan addressing Resident R27's Foley Catheter. Observation of Resident R27 conducted on February 8, 2026, at 11:28AM revealed that Resident R27 was in bed. Further, Resident R27 had a urine bag hanging under her bed. Follow up observation of Resident R 27 conducted with Director of Nursing Employee E2 on February 9, 2026, at 11:15 AM, revealed that resident R27 had a foley catheter connected to a urine bag. Interview with Employee E2 conducted at the time of observation confirmed that resident R27 had a Foley catheter. Interview with Employee E2 conducted on February 10, 2026, at 10:15 AM confirmed that there was no care plan addressing Resident R27's pressure ulcer to the left ear and pressure ulcer to the left elbow. 28 Pa. Code 211.12(d)(1) Nursing services

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of facility policies, clinical record review and interviews with staff, it was determined that the facility failed to ensure that Enhanced Barrier Precautions were followed during treatment and medication administration for three of 16 residents reviewed (Residents R8, R28 and R33).Findings include: Review of facility policy, Enhanced Barrier Precautions dated November 30, 2022, revealed, Enhanced Barrier Precautions expand the use of PPE [Personal Protective Equipment] beyond situations in which exposure to blood and body fluids is anticipated and refer to the use of gown and gloves during specific high contact resident care activities. Continued review revealed, Enhanced Barrier Precautions may be implemented for residents in the facility when the following the following are present . wounds and/or indwelling medical devices are present (e.g. central line, urinary catheter, feeding tube, tracheostomy/ventilator). Further review revealed that high contact care activities include: dressing, bathing, transferring, providing hygiene, changing linens, toileting, device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator), wound care (any skin opening requiring a dressing). Observation on February 8, 2026, at 9:05 a.m. Employee E6, licensed nurse, administered medications to Resident R28 via the feeding tube in the resident's stomach. During the administration, Employee E6 wore gloves and a face mask. Employee E6 then exited the resident's room, changed gloves, and prepared medications for Resident R8. Employee E6 then entered the resident's room and administered medications to Resident R8 via the feeding tube in the resident's stomach. During the administration, Employee E6 wore gloves and a face mask. No hand hygiene was preformed between changing gloves between residents and Employee E6 did not wear a gown while administering medications to either resident. Interview on February 8, 2026, at 9:50 a.m. Employee E6, licensed nurse, revealed that the employee did not know that Residents R28 and R8 required the use of Enhanced Barrier Precautions and stated I was instructed to just wear gloves. Review of R33's clinical records revealed that resident R33 was admitted to the facility on [DATE], with diagnosis of but not limited to Chronic Respiratory Failure. Review of Resident R33's physician orders revealed an order dated September 25, 2025, for: May suction resident every shift and prn every shift AND as needed. Review of resident R33 MDS (minimum data set, a federally required resident assessment completed at a specific interval) dated September 29, 2025, revealed that section O0110. Special Treatments, Procedures, and Programs, D1. Suctioning was marked X indicating that Resident R33 was on suctioning. Observation conducted on February 8, 2026, at 10:23 AM revealed that there was no enhanced by precautions signage observed outside of Resident R 33's room, further there was no enhanced barrier precaution signage observed inside resident R33's room. Observation of Resident R33 conducted on February 8, 2026, at 10:26AM revealed that Resident R33 was in bed. Further, Resident R33 had tracheostomy. Tracheostomy care and suctioning observation conducted on February 8, 2026, at 11:05 AM, with (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employee E3 revealed that Employee E3 performed tracheostomy care and suctioning on Resident R33 wearing only a mask and gloves. Interview with Employee E3 conducted at the time of the observation revealed that she did not have to wear a gown because she did not perform a high-contact procedure. Interview with Director of Nursing Employee E2 conducted on February 8, 2026, at 11:07AM, confirmed that staff must follow the Enhance Barrier Precaution (EBP) signage posted outside of the staff lounge which indicated that staff must wear gloves and gowns When providing tracheostomy care including suctioning. Interview with Infection preventionist Employee E7 conducted on February 9, 2026, at 10:32 AM revealed there are no signage for enhance barrier precaution outside resident's rooms and that enhanced barrier precaution signage are posted on the walls around the facility. Further, Employee E7 revealed that all staff must wear gowns and gloves for residents on enhanced barrier precautions. Further, Employee E7 revealed that respiratory care and suctioning require an enhanced barrier precaution. Review of enhanced bar precaution signage posted outside the staff lounge revealed the following: everyone must clean their hands including before entering and when leaving the room, providers and staff must also wear gloves and gown for the following high-contact resident care activities: device care or use: central line, urinary catheter, feeding tube, tracheostomy, wound care and skin opening requiring a dressing.