

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396141	(X2) MULTIPLE CONSTRUCTION: A. BLDG: __-_____ B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/13/2025
NAME OF PROVIDER OR SUPPLIER: FOX SUBACUTE AT SOUTH PHILADELPHIA		STREET ADDRESS, CITY, STATE, ZIP CODE: 1930 S. BROAD ST. 5TH FLOOR NORTH PHILADELPHIA, PA 19145		
STATE LICENSE NUMBER: 24460201				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
E 0000	INITIAL COMMENT Based on an Emergency Preparedness Survey completed on February 13, 2025, at Fox Subacute At South Philadelphia, it was determined there were no deficiencies identified with the requirements of 42 CFR 483.73.	E 0000		

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.



Certified End Page

FOX SUBACUTE AT SOUTH PHILADELPHIA

STATE LICENSE NUMBER: 24460201

SURVEY EXIT DATE: 02/13/2025

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, 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396141	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>02</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/13/2025
--	---	---	--

NAME OF PROVIDER OR SUPPLIER: FOX SUBACUTE AT SOUTH PHILADELPHIA STATE LICENSE NUMBER: 24460201	STREET ADDRESS, CITY, STATE, ZIP CODE: 1930 S. BROAD ST. 5TH FLOOR NORTH PHILADELPHIA, PA 19145
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
K 0000	INITIAL COMMENT	K 0000		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396141	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>02</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/13/2025	
NAME OF PROVIDER OR SUPPLIER: FOX SUBACUTE AT SOUTH PHILADELPHIA STATE LICENSE NUMBER: 24460201		STREET ADDRESS, CITY, STATE, ZIP CODE: 1930 S. BROAD ST. 5TH FLOOR NORTH PHILADELPHIA, PA 19145		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
K 0000	Continued from page 1 Facility ID# 24460201 Building 02 Main & North Building, Fifth Floor Based on a Medicare/Medicaid Recertification Survey completed on February 13, 2025, it was determined that Fox Subacute At South Philadelphia was not in compliance with the following requirements of the Life Safety Code for a new Nursing health care occupancy. Compliance with the National Fire Protection Association's Life Safety Code is required by 42 CFR 483.90(a). This is a six-story, Type II (222), fire resistive building, with a basement, sub-basement, ground, first through fifth floors, that is fully sprinklered.	K 0000		
K 0374 SS=E		K 0374		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396141	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>02</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/13/2025
NAME OF PROVIDER OR SUPPLIER: FOX SUBACUTE AT SOUTH PHILADELPHIA		STREET ADDRESS, CITY, STATE, ZIP CODE: 1930 S. BROAD ST. 5TH FLOOR NORTH PHILADELPHIA, PA 19145		
STATE LICENSE NUMBER: 24460201				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
K 0374 SS=E	Continued from page 2 NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 NEW Doors in smoke barriers have at least a 20 minute fire protection rating or are at least 1-3/4 inch thick solid bonded core wood. Required clear widths are provided per 18.3.7.6(4) and (5). Nonrated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal-sliding doors comply with 7.2.1.14. Swinging doors shall be arranged so that each door swings in an opposite direction. Doors shall be self-closing and rabbets, bevels, or astragals are required at the meeting edges. Positive latching is not required. 18.3.7.6, 18.3.7.7, 18.3.7.8 This REQUIREMENT is not met as evidenced by:	K 0374	1. No Residents were affected by this practice. 2. All other smoke doors were approved and functional. 3. Locksmith repaired the smoke door by room 505. Voids were closed up with steel fasteners by room 526 on 2/24/25. 4. Maintenance Dept will continue to monitor during weekly Preventative Maintenance rounds, and will bring findings to monthly Safety & QAPI Meetings overseen by the Administrator, x3 months.	Completion Date: 03/03/2025 Status: APPROVED Date: 03/06/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396141	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>02</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/13/2025	
NAME OF PROVIDER OR SUPPLIER: FOX SUBACUTE AT SOUTH PHILADELPHIA STATE LICENSE NUMBER: 24460201		STREET ADDRESS, CITY, STATE, ZIP CODE: 1930 S. BROAD ST. 5TH FLOOR NORTH PHILADELPHIA, PA 19145		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
K 0374 SS=E	Continued from page 3 Based on observation and interview, it was determined the facility failed to ensure doors in smoke barrier walls were maintained to resist the passage of smoke, affecting one of six levels within the component. Findings include: Observation on February 13, 2025, revealed: a) 11:10 a.m., Double smoke doors, next to room 505 failed to close smoke tight. b) 11:40 a.m., Double smoke doors, next to room 526 had door frame voids where hardware was removed. Interview at the exit conference with the Chief Operating Officer, Administrator, and Maintenance Director, on February 13, 2025, at 12:15 p.m., confirmed the above smoke door issues.	K 0374		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396141	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>02</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/13/2025
NAME OF PROVIDER OR SUPPLIER: FOX SUBACUTE AT SOUTH PHILADELPHIA		STREET ADDRESS, CITY, STATE, ZIP CODE: 1930 S. BROAD ST. 5TH FLOOR NORTH PHILADELPHIA, PA 19145		
STATE LICENSE NUMBER: 24460201				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
K 0374 SS=E	Continued from page 4	K 0374		
K 0923 SS=E	<p>NFPA 101 Gas Equipment - Cylinder and Container Storage</p> <p>Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3.</p> <p>>300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating.</p> <p>Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING."</p> <p>Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs</p>	K 0923	<p>1. No Residents were affected by this practice.</p> <p>2. All other O2 storage was in compliance.</p> <p>3. Back O2 Storage will now be labeled and store only Full tanks. Front O2 storage room will now be labeled and store only Empty tanks. Staff will be in-serviced on the new practice by 3/8/25.</p> <p>4. Lead RT will audit for compliance weekly and will bring results of audits to monthly Safety & QAPI meetings overseen by the Administrator.</p>	<p>Completion Date: 03/03/2025 Status: APPROVED Date: 03/05/2025</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396141	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>02</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/13/2025
--	---	---	--

NAME OF PROVIDER OR SUPPLIER: FOX SUBACUTE AT SOUTH PHILADELPHIA STATE LICENSE NUMBER: 24460201	STREET ADDRESS, CITY, STATE, ZIP CODE: 1930 S. BROAD ST. 5TH FLOOR NORTH PHILADELPHIA, PA 19145
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
K 0923 SS=E	Continued from page 5 cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by:	K 0923		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396141	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>02</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/13/2025	
NAME OF PROVIDER OR SUPPLIER: FOX SUBACUTE AT SOUTH PHILADELPHIA STATE LICENSE NUMBER: 24460201		STREET ADDRESS, CITY, STATE, ZIP CODE: 1930 S. BROAD ST. 5TH FLOOR NORTH PHILADELPHIA, PA 19145		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
K 0923 SS=E	Continued from page 6 Based on observation and interview, it was determined the facility failed to properly store and identify medical gas cylinders, affecting one of six levels within the component. Findings include: Observation on February 13, 2025, at 11:30 a.m., revealed on the fifth floor, inside the portable oxygen storage room, the full versus empty cylinders were mixed into the full and empty racks. Interview at the exit conference with the Chief Operating Officer, Administrator, and Maintenance Director, on February 13, 2025, at 12:15 p.m., confirmed the mixed oxygen cylinders.	K 0923		



Certified End Page

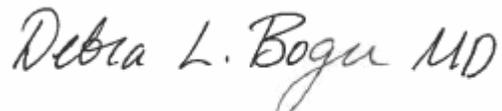
FOX SUBACUTE AT SOUTH PHILADELPHIA

STATE LICENSE NUMBER: 24460201

SURVEY EXIT DATE: 02/13/2025

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, 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