STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396122	A. Building B. Wing	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fox Subacute at Mechanicsburg	120 South Filbert St Mechanicsburg, PA 17055

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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 - Some	Ensure that residents are fully informed and understand their health status, care and treatments. Based on clinical record review and staff interview, it was determined that the facility failed to discuss the risks/benefits and obtain consent for psychotropic medications for two of two resident records reviewed (Residents 48 and 49).Findings include: Review of Resident 48's clinical record revealed diagnoses that included major depressive disorder severe with psychotic features (a severe form of depression characterized by the presence of psychotic symptoms, such as hallucinations or delusions, alongside typical depressive symptoms) and generalized anxiety disorder (a mental health condition that causes fear, a constant feeling of being overwhelmed and excessive worry about everyday things). Review of Resident 48's physician's orders revealed the use of quetiapine (an antipsychotic medication) with an ordered date of April 15, 2025; and lorazepam (an antianxiety medication) with an ordered date of October 17, 2025. Review of Resident 48's physician order history revealed that he had been on these types of medications since January 24, 2025. Review of Resident 48's clinical record revealed a Psychotropic Medication Treatment Consent, which indicated that Resident 48 was being treated for Tracheotomy/Brain Damage and the medications being used line was blank. The consent was signed by Resident 48's Representative on September 9, 2024. Further review of Resident 48's clinical record failed to reveal any documentation of the facility providing education to the Resident or Representative of the risks and benefits associated with the use of the antipsychotic and antianxiety medications, including side effects and other adverse reactions. Review of Resident 49's clinical record revealed diagnoses that included schizoaffective disorder bipolar type (schizoaffective disorder is a mental health condition that is marked by a mix of schizophrenia symptoms, such as hallucinations and delusions, and mood disorder symptoms, such as depression, mania and a milder form of mania called hypomania; bipolar type includes bouts of hypomania or mania and sometimes major depression), generalized anxiety disorder, and major depressive disorder. Review of Resident 49's physician's orders revealed the use of olanzapine (an antipsychotic medication) with an ordered date of March 5, 2024; buspirone (an antianxiety medication) with an ordered date of October 23, 2025; and escitalopram (an antidepressant medication) with an ordered date of July 30, 2025. Review of Resident 49's clinical record revealed a Psychotropic Medication Treatment Consent, which revealed that the condition Resident 49 was being treated for and the medications being used were blank. The consent was signed by Resident 49's Representative on July 16, 2021. Further review of Resident 49's clinical record failed to reveal any documentation of the facility providing education to Resident 49 or his Representative of the risks and benefits associated with the use of the antipsychotic, antianxiety, or antidepressant medications, including side effects and other adverse reactions. During a staff interview with the Nursing Home Administrator (NHA) and the Director of Nursing on January 22, 2026, at 11:20 AM, the NHA indicated that the facility practice was to have the Resident or their Representative sign the Psychotropic Medication Treatment Consent as part of the admission process to the facility. He further indicated that the facility practice was not to get another consent signed. He said (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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	that staff would review with a Resident's Representative any medication changes and would document this discussion in the progress notes. As of January 22, 2026, at 1:15 PM, the facility had not provided any additional information to indicate that Resident 48's and 49's Representatives had been informed of the risks and benefits associated with the use of their ordered psychotropic medications, including side effects and other adverse reactions, at time of admission to the facility or when medication/treatment changes occurred. 28 Pa. Code 201.29 Resident rights.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on facility policy review, clinical record review, observation, and staff interviews, it was determined that the facility failed to ensure that the care plan was reviewed and revised to reflect the resident's current status for two of 12 residents reviewed (Residents 1 and 4).Findings include:Review of facility policy, titled Care Plan and Conference, last reviewed December 31, 2025, read, in part, Purpose: To facilitate communication of all disciplines of pertinent patient information to formulate a useful care plan that will drive patient care and improve outcomes. Procedure: Ongoing communication between nursing and the Registered Nurse Assessment Coordinator will occur with any change in resident condition.Review of Resident 1's clinical record revealed diagnoses that included chronic respiratory failure (lungs cannot get enough oxygen into the blood or remove enough carbon dioxide) and dependence on a respirator (unable to breath independently and relies on a machine for life sustaining respiration).Review of Resident 1's physician orders revealed an order for trach type and size: # 8 Portex, with a start date of March 19, 2025.Review of Resident 1's comprehensive plan of care revealed a care area for ineffective airway clearance related to disease process with vent support as needed and trach. Trach type and size: 7 XLT-D cuffed.Interview on January 22, 2026 at 10:46 AM, with the Nursing Home Administrator and Director of Nursing (DON) revealed Resident 1's trach size and type changed and her care plan was not updated. The DON stated she would expect care plans to be updated timely.Review of Resident 4's clinical record revealed diagnoses that included chronic respiratory failure and hypertension (persistent high blood pressure). Review of Resident 4's clinical record revealed he had an unwitnessed fall on September 24, 2025. Review of Resident 4's fall report from September 24, 2025, revealed an intervention to place bilateral fall mats on either side of his bed. Review of Resident 4's comprehensive care plan revealed a focus area for At risk for falls with an intervention for bilateral fall mats - ensure placement every shift, last revised October 21, 2025. Observation in Resident 4's room on January 20, 2026, at 11:03 AM; and January 21, 2026, at 12:58 PM, failed to reveal bilateral fall mats. Interview with Employee 4 (Housekeeper) on January 21, 2026, at 12:58 PM, revealed she hasn't seen any fall mats in the Resident's room. During an interview with the DON on January 21, 2026, at 1:03 PM, she revealed the fall mats had previously been reviewed and discontinued. Follow up interview with the DON on January 22, 2026, at 11:27 AM, revealed the fall mats were reviewed and discontinued around the time of his most recent hospitalization in November 2025, and she would expect his care plan to be updated. The DON stated she would expect care plans to be updated timely.28 Pa. Code 201.14(a) Responsibility of licensee28 Pa. Code 211.10(d) Resident care policies28 Pa. Code 211.11(d)(3)(5) Nursing services

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on facility policy review, observation, clinical record review, and staff interviews, it was determined that the facility failed to ensure care and services were provided in accordance with professional standards for one of three residents observed during medication administration pass (Resident 46).Findings include: Review of facility policy, titled Medication Administration, dated November 30, 2025, with a last review date of December 31, 2025, revealed, in part, that gastrostomy tube [a flexible feeding tube placed through the abdominal wall and into the stomach which allows nutrition to be placed directly into the stomach] placement will be confirmed by auscultation with air prior to medication administration. Review of Resident 46's clinical record revealed diagnoses that included acute and chronic respiratory failure with hypoxia (the inability of the respiratory system to meet the oxygenation requirements of the body, dependence on a ventilator, and presence of gastrostomy tube. Review of Resident 46's physician orders revealed an order for Confirmation of feeding tube placement to be done prior to every instillation of tube feeding, medications, water, ect. every shift. Confirm placement per policy, dated January 8, 2026. During a medication administration observation for Resident 46 on January 22, 2026, at 8:45 AM, Employee 3 (Registered Nurse) was observed to administer Resident 46's medications through the Resident's gastrostomy. Employee 3 failed to confirm placement of the gastrostomy tube prior to administering the medications. During a staff interview with Employee 3 on January 22, 2026, at 8:55 AM, Employee 3 indicated that the facility used to have a policy in place that indicated gastrostomy tube placement was to be verified before medication administration, but Employee 3 believed that was no longer in effect. During a staff interview with the Nursing Home Administrator and Director of Nursing (DON) on January 22, 2026, at 11:39 AM, the DON confirmed that Employee 3 should have verified Resident 46's gastrostomy tube placement before administering the medications. 28 Pa. Code 201.18(b)(1) Management.28 Pa. Code 211.12(d)(1)(2)(5) Nursing services.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on facility policy review, clinical record review, and staff interview, it was determined that the facility failed to ensure that residents receive necessary treatment and services, consistent with professional standards of practice, to promote healing of a pressure ulcer for one of two residents reviewed for pressure ulcers (Resident 4).Findings include:Review of facility policy, titled Wound Care and Pressure Ulcer Care last reviewed December 31, 2025, read, in part, Purpose: To manage wounds and or pressure ulcers and promote patient comfort. Check the doctor's order for specific wound care and medication instructions.Review of Resident 4's clinical record revealed diagnoses that included pressure ulcer of other site, stage 3 (injury to the skin and underlying tissue caused by prolonged pressure on the skin), chronic respiratory failure (lungs cannot get enough oxygen into the blood or remove enough carbon dioxide), and hypertension (high blood pressure). Review of facility documents, titled Wound Evaluation & Management Summary dated October 27, 2025; November 7, 2025; November 10, 2025; December 1, 2025; December 8, 2025; December 19, 2025; December 22, 2025; January 5, 2026; January 12, 2026; and January 19, 2026; note Specific to visit recommendations: Dietician consult, vitamin C 500 mg BID (twice daily).Review of dietitian notes, titled Weekly Wound Meeting dated October 28, 2025; November 13, 2025; December 2, 2025; December 9, 2025; December 19, 2025; December 23, 2025; January 6, 2026; and January 13, 2026; note Resident 4 is taking vitamin C as an intervention for wound healing.Review of Resident 4's physician orders revealed an order for Ascorbic Acid (Vitamin C) Oral Tablet 500 MG, Give 500 mg two times a day for wounds, with a start date of September 18, 2025, and a discontinued date of October 6, 2025.During an interview with the Director of Nursing on January 22, 2026, at 12:26 PM, she revealed the vitamin C order for Resident 4 was discontinued when he went to the hospital on October 5, 2025, and never got reentered when he returned. She further revealed the order should have been reinstated when he returned from the hospital as it was still recommended by the wound doctor, and she would expect physician recommendations to be implemented. 28 Pa. Code 201.18(b)(1) Management28 Pa. Code 211.10(c)(d) Resident care policies28 Pa. Code 211.11(d)(1)(3)(5) Nursing services

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on clinical record review, facility policy review, and staff interview, it was determined that the facility failed to ensure Medication Regimen Reviews were reviewed and responded to by the attending physician or prescriber for three of six residents reviewed (Residents 3, 6, and 15).Findings include:Review of facility policy, titled Medication Regimen Review (Monthly Report), without revision date, revealed, Recommendations are acted upon and documented by the facility staff and or the prescriber.Review of Resident 3's clinical record revealed diagnoses that included heart failure (the heart can't pump enough oxygen-rich blood to meet the body's needs, causing symptoms like shortness of breath, fatigue, and swelling; often from underlying issues like high blood pressure or coronary artery disease) and respiratory failure (a serious condition where the lungs can't adequately oxygenate the blood or remove carbon dioxide).Review of Resident 3's medical record revealed a recommendation made on December 10, 2025, by the consultant pharmacist to add additional monitoring for Resident 3's anticonvulsant medication. Further review of the document revealed that it was signed by a nurse along with the statement, added to order, with no physician signature. Further review of the record failed to reveal that the physician had reviewed or taken action to address the irregularity. Review of Resident 6's clinical record revealed diagnoses that included heart failure and respiratory failure.Review of Resident 6's medical record revealed a recommendation made on October 17, 2025, by the consultant pharmacist to either add limit of 14 days to Resident 6's PRN (as needed) antianxiety medication or provide a rationale for extending the order and indicate a duration for the order. Further review of the document revealed that it was signed by a nurse along with the statement, 14-day added to order, with no physician signature. Further review of the record failed to reveal that the physician had reviewed or taken action to address the irregularity. Review of Resident 15's clinical record revealed diagnoses that included fracture of first thoracic vertebra (a break in the first thoracic vertebra, located at the top of the mid-back, often caused by significant trauma like car accidents or falls, and can lead to severe neck/back pain, potential spinal cord injury, hand weakness/numbness, and even quadriplegia if nerves are damaged) and respiratory failure.Review of Resident 15's medical record revealed a recommendation made on December 10, 2025, by the consultant pharmacist to add additional monitoring for Resident 15's antipsychotic medication. Further review of the document revealed that it was signed by a nurse along with the statement, AIMS (Abnormal Involuntary Movement Scale- a scale to assess severity of involuntary facial movements in patients taking certain medications), with no physician signature. Further review of the record failed to reveal that the physician had reviewed or taken action to address the irregularity. Interview with the Director of Nursing on January 22, 2026, at 10:45 AM, revealed that they would expect the regulation to be followed. 28 Pa. Code 211.10(c) Resident care policies.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on facility policy review, observations, and staff interviews, it was determined that the facility failed to label medications properly and failed to discard expired medications in one of two medication rooms observed (First Floor Medication Room).Findings include: Review of facility policy, titled Pharmacy Services, dated November 28, 2018, with a last review date of December 31, 2025, revealed, in part, All opened multi-dose vials will be dated at the time that they are opened. Review of tuberculin skin testing solution information revealed that tuberculin skin testing solution expires 30 days after the initial puncture into the vial. Observation of the First Floor Medication Room with Employee 1 on January 21, 2026, at 8:54 AM, revealed two opened vials of tuberculin skin testing solution. One bottle had no open date noted and the other vial was dated December 4, 2025. During a staff interview with the Director of Nursing (DON) and the Assistant Director of Nursing on January 21, 2026, at 9:20 AM, the DON acknowledged multi-dose vials should be dated when opened and confirmed that the tuberculin skin testing solution vial dated with an open date of December 4, 2025, was expired and should have been discarded. 28 Pa. Code 201.14(a) Responsibility of licensee.28 Pa. Code 201.18(b)(1) Management.28 Pa. Code 211.9(a)(1) Pharmacy services.28 Pa. Code 211.12(d)(1)(2)(3) 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. Based on observation and staff interviews, it was determined that the facility failed to maintain an effective infection control program related to the administration of medications for one of three residents observed during medication administration observation (Resident 33).Findings include: Observation of Resident 33's medication administration by Employee 2 on January 21, 2026, at 10:05 AM, revealed Employee 2 donned her gown and gloves upon entering Resident 33's room. Employee 2 sat Resident 33's cups of prepared medications down on the heating unit. Employee 2 was then observed to use both of her gloved hands to pick the fall mat up off the floor on the left side of the bed and lean it against the wall. Employee 2 then placed Resident 33's cups of prepared medications on top of the upright fall mat that she had placed against the wall. Employee 2 then proceeded to administer Resident 33's medications via her gastrostomy tube (a flexible feeding tube placed through the abdominal wall and into the stomach, which allows nutrition to be placed directly into the stomach). During the continued process of administering Resident 33's medications, Employee 2 was also noted to be holding the end of the tube feeding administration tubing that connects directly to the gastrostomy tube inside her left gloved hand. During an immediate staff interview with Employee 2 on January 21, 2026, at approximately 10:20 AM, Employee 2 confirmed that she had used her gloves to touch the fall mat that was on the floor and proceeded to administer the medications. Employee 2 acknowledged that she should have removed her gloves, cleansed her hands, and applied clean gloves. During a staff interview with the Nursing Home Administrator and Director of Nursing on January 21, 2026, at 1:24 PM, they both confirmed that Employee 2 should have removed her gloves, cleansed her hands, and applied clean gloves prior to administering Resident 33's medications through the gastrostomy tube. 28 Pa. Code 201.18(b)(1) Management.28 Pa. Code 211.12(d)(1)(2)(5) Nursing services.