STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396122	A. BLDG: 00 B. WING:	01/09/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
FOX SUBACUTE AT MECHANICSBURG STATE LICENSE NUMBER: **22220201**	**120 SOUTH FILBERT STREET** **MECHANICSBURG, PA 17055**

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F 0000	INITIAL COMMENT Based on a Medicare/Medicaid Recertification, State Licensure and Civil Rights Compliance survey completed on January 9, 2025, it was determined that Fox Subacute of Mechanicsburg was not in compliance with the following requirements of 42 CFR Part 483 Subpart B, Requirements for Long Term Care Facilities and the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0000		
F 0583 SS=D		F 0583		

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.

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F 0583 SS=D	Continued from page 1 483.10(h)(1)-(3)(i)(ii) Personal Privacy/Confidentiality of Records §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in	F 0583	Preparation and submission of this plan of correction is required by state and federal law. This plan of correction does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding. One: actions taken for situation identified: 1) The Facility recognizes that it cannot retroactively correct the situation for resident R18. 2) The Facility immediately removed the written paper on January 7, 2025. 3) All resident rooms were inspected for any personal identifying information outside of their rooms Two: system changes and measures that will be taken: 1) All staff will be educated on the privacy of our residents. 2) Any privacy concerns will be addressed by Nursing Administration Three: monitoring mechanism to assure compliance: 1) The Director of Nursing or her designee will conduct audits on 5	Completion Date: **02/28/2025** Status: **APPROVED** Date: **01/22/2025**

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F 0583 SS=D	Continued from page 2 accordance with State law. This REQUIREMENT is not met as evidenced by:	F 0583	random residents 3x a week for 4 weeks for compliance with privacy outside of their rooms, then five (5) random residents 1x a week for 2 months. 2) The Director of Nursing will report findings at Continuous Quality Improvement Committee meetings	

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F 0583 SS=D	Continued from page 3 Based on observation, clinical record review, and staff interview, it was determined that the facility failed to ensure residents were afforded the right to secure and confidential personal and medical records for one of 14 residents reviewed (Resident 18). Findings include: Review of Resident 18's clinical record revealed diagnoses that included quadriplegia (paralysis of both arms and both legs) and tracheostomy status (artificial opening to the trachea [aka windpipe] through which a machine provides breathing assistance). During observations on January 7, 2025, it was observed, from the hallway, that a paper was taped to the wall outside Resident 18's room to the left of the room number sign. It was observed that written on the paper was Resident 18's first name and clinical assessment	F 0583		

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F 0583 SS=D	Continued from page 4 findings, along with other statements. Written on the paper was the date of January 4, 202[5]. During a staff interview on January 8, 2025, at approximately 1:20 PM, Nursing Home Administrator (NHA) revealed that the paper contained notes written to communicate information for Resident 18's treatment in regard to suctioning Resident 18's tracheostomy. During the interview, NHA revealed it should have been placed on the back of the Resident's door where it would not have been in plain sight from the hallway. 28 Pa code 201.18(b)(2)(3) Management	F 0583		
F 0657 SS=E		F 0657		

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F 0657 SS=E	Continued from page 5 483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by:	F 0657	Preparation and submission of this plan of correction is required by state and federal law. This plan of correction does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding. One: actions taken for situation identified: 1) The Facility recognizes that it cannot retroactively correct the situation for resident R2, R26, R29, R37. 2) The Facility updated R2, R26, R29, R37 care plans to reflect current resident orders and plan of care. 3) All resident care plans were reviewed to ensure that care plans to reflect current resident orders and plan of care. Two: system changes and measures that will be taken: 1) All Licensed and IDC staff will be in-serviced on initiating, updating and resolving care plan items. 2) Care plans will be monitored at Daily Clinical meetings and updated as necessary	Completion Date: **02/28/2025** Status: **APPROVED** Date: **01/22/2025**

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F 0657 SS=E	Continued from page 6	F 0657	Three: monitoring mechanism to assure compliance: 1) The Director of Nursing or her designee will conduct audits on 5 (5) random residents 3x week for 4 weeks for compliance with careplans, then five (5) random residents 1x week for 2 months. 2) The Director of Nursing will report findings at Continuous Quality Improvement Committee meetings	

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F 0657 SS=E	Continued from page 7 Based on facility policy review, observations, clinical record review, and staff interviews, it was determined the facility failed to review and revise the resident's care plan for four of 14 residents reviewed (Residents 2, 26, 29, and 37). Findings include: Review of facility policy, titled "Care Plan and Conference", last revised November 30, 2018, 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. Ongoing communication will occur between nursing and RNAC (Registered Nurse Assessment Coordinator) will occur with any change in resident condition." Review of Resident 2's clinical record revealed diagnoses that included dependence on respirator (ventilator) status (when a patient is unable to wean off a ventilator and breathe independently, they	F 0657		

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F 0657 SS=E	Continued from page 8 become ventilator dependent), congestive heart failure (a chronic condition in which the heart doesn't pump blood as well as it should), and muscle weakness. Observation of Resident 2 on January 7, 2025, at 10:31 AM, revealed she was lying in bed and had fall mats on both sides of her bed. Observation of Resident 2 on January 8, 2025, at 12:46 PM, revealed she was lying in bed and had fall mats on both sides of her bed. Review of Resident 2's care plan revealed a focus area of "The resident is at risk for falls related to medication side effects and history of fall", last revised May 15, 2024, with an intervention for "Fall mat to floor on right (door) side of bed", last revised January 21, 2024. Review of Resident 2's clinical record revealed she had an unwitnessed fall on July 13, 2024, with an intervention for bilateral fall mats.	F 0657		

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F 0657 SS=E	Continued from page 9 Interview with Employee 1 (RNAC) on January 9, 2025, at 10:09 AM, revealed Resident 2's physician order did not get revised to reflect the new order for bilateral floor mats, therefore, the new order did not make it to the care plan to be updated. Interview with the Director of Nursing (DON) on January 9, 2025, at 12:03 PM, revealed she would expect Resident 2's care plan to be updated with her fall intervention from July 13, 2024. Review of Resident 26's clinical record on January 7, 2025, revealed diagnoses included hypertension (elevated/high blood pressure) and bipolar disorder (mental health disorder that causes extreme shifts in mood from depression to manic hyperactivity). Review of Resident 26's comprehensive plan of care revealed a care plan with a focus of, "Potential for adverse reaction to prescribed psychotropic medications: CNS [central nervous system] Stimulants- Amphetamine-Dextroamphet[amine] ..."	F 0657		

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F 0657 SS=E	Continued from page 10 which had an initiation date of March 4, 2024. Review of the "Goal" section of the care plan revealed the goal of, "Resident will be free of adverse reaction to CNS stimulates administered", which had a revision date of November 26, 2024. Review of Resident 26's clinical record revealed that Resident 26's order for Amphetamine-Dextroamphetamine was discontinued on September 20, 2024. During an electronic communication on January 9, 2025, at 12:37 PM, Nursing Home Administrator revealed Resident 26 had a care plan meeting (interdisciplinary meeting utilized to review the plan of care to adjust according to the residents' needs) on November 19, 2024. During a staff interview on January 9, 2025, at approximately 12:50 PM, DON revealed that Resident 26's care plan for CNS stimulants should have been discontinued, at least, during the care plan meeting.	F 0657		

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F 0657 SS=E	Continued from page 11 Review of Resident 26's physician's orders revealed an order for clonazepam (schedule IV controlled medication used to treat anxiety disorders) 3 mg as-needed every 24 hours for restlessness; clonazepam 1 mg twice a day for anxiety disorder; lorazepam (schedule IV controlled medication used to treat anxiety disorders) 1 mg every six hours as needed for anxiety. Review of Resident 26's comprehensive plan of care revealed a care plan with a focus of, "Potential for adverse reaction to prescribed psychotropic medications: Anti-Anxiety Medications", with an initiation date of February 7, 2024. Review of the "Interventions" section of the care plan revealed only one intervention, which stated, "Notify physician for adverse effects of medication", which had an initiation date of February 7, 2024. Resident 26's care plan for anti-anxiety medications did not include additional information such as, but not limited to, target symptoms to monitor, possible non-pharmacological interventions to attempt prior	F 0657		

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F 0657 SS=E	Continued from page 12 to administration of an as-needed anti-anxiety medication, nor on-going consultation with psychiatric health services. Resident 26 also had a physician order for Seroquel 25 mg (antipsychotic medication used to treat mental health disorders) one time a day for bipolar disorder. Review of Resident 26's comprehensive plan of care revealed a care plan with a focus of, "Potential for adverse reaction to prescribed psychotropic medications: Anti-Psychotic medication", with an initiated date of March 11, 2021. Review of the "Interventions" section of the care plan revealed only one intervention, which stated, "Notify physician for adverse effects of medications", which was initiated March 11, 2021. During a staff interview on January 9, 2025, at approximately 12:50 PM, Nursing Home Administrator revealed that Resident 26's care plan did not appear to be individualized.	F 0657		

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F 0657 SS=E	Continued from page 13 Review of Resident 29's clinical record revealed diagnoses that included chronic respiratory failure (a long-term condition that prevents the body from exchanging oxygen and carbon dioxide properly) and quadriplegia (paralysis that affects all a person's limbs). Observation of Resident 29 on January 7, 2025, at 10:48 AM, revealed bilateral thick fall mats on both sides of the bed. Review of Resident 29's care plan on January 7, 2025, revealed a care plan for falls related to seizure disorder, with an initiation date of May 9, 2024. Resident 29's care plan failed to include bilateral thick fall mats. Review of Resident 29's physician's orders revealed an order for bilateral thick fall mats, with an active date of January 8, 2025. Review of Resident 29's care plan on January 8,	F 0657		

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F 0657 SS=E	Continued from page 14 2025, revealed bilateral thick fall mats were added to the fall care plan, with an initiation date of January 8, 2025. During an interview with the DON on January 9, 2025, at 12:04 PM, revealed they would have expected Resident 29 to have had an order for the fall mats and would have expected them to have been added to their care plan afterward. DON revealed Resident 29 has had bilateral thick fall mats since the Resident was admitted to the facility in May 2024. Review of Resident 37's clinical record revealed diagnoses that included obstructive uropathy (when urine can't flow normally through your urinary tract due to a blockage), congestive heart failure, and muscle weakness. Review of Resident 37's care plan revealed a focus area of "Resident has impaired skin integrity related to blister right lateral heel", last revised March 8, 2024.	F 0657		

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F 0657 SS=E	Continued from page 15 During an interview with the DON on January 9, 2025, at 12:06 PM, she revealed Resident 37's blister wound has been resolved since March 2024, and she would expect her wound care plan to be revised. 28 Pa. Code 211.11 (d) Resident care plan 28 Pa. Code 211.12(d)(3) Nursing services	F 0657		
F 0684 SS=E		F 0684		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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
F 0684 SS=E	Continued from page 16 483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 0684	Preparation and submission of this plan of correction is required by state and federal law. This plan of correction does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding. One: actions taken for situation identified: 1) The Facility recognizes that it cannot retroactively correct the situation for resident R9, R14, R17. 2) The Facility reviewed R9, and had a new skin assessment completed, site has been healed and treatment d/cd. R14 was assessed and is still receiving treatment to her open areas. R17 chart was reviewed for missing documentation and medication administration. 3) All current residents were reviewed for vital signs, incomplete documentation and correct skin assessments and orders relating to those skin assessments. Two: system changes and measures that will be taken: 1) All Licensed staff will be	Completion Date: **02/28/2025** Status: **APPROVED** Date: **01/22/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396122	A. BLDG: __00_____ B. WING: _____	01/09/2025

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F 0684 SS=E	Continued from page 17	F 0684	in-serviced on documentation accuracy, including vital signs, notifying physician on follow up and on lab values and abnormal lab values, accurate skin assessments and treatment orders 2) Documentation will be monitored at Daily Clinical meetings and staff will be notified as necessary for corrections Three: monitoring mechanism to assure compliance: 1) The Director of Nursing or her designee will conduct audits on five (5) random residents 3x a week for 4 weeks for compliance with documentation accuracy, including vital signs, notifying physician on follow up and on lab values and abnormal lab values, accurate skin assessments and treatment orders, and careplans, then five (5) random residents 1 x a week for 2 months. 2) The Director of Nursing will report findings at Continuous Quality Improvement Committee meetings	

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F 0684 SS=E	Continued from page 18 Based on facility policy review, clinical record review, and staff interviews, it was determined that the facility failed to ensure care and services are provided in accordance with professional standards of practice that will meet each resident's physical, mental, and psychosocial needs for three of 14 residents reviewed (Residents 9, 14, and 17). Findings include: Review of facility policy, titled "Medication Administration", with a last review date of December 31, 2024, revealed "Medications are given at the time ordered or within 60 minutes before or after the time for bid [twice a day], tid [three times a day], or qid [four times a day] passes." Review of Resident 9's clinical record revealed diagnoses that included cerebral palsy (a congenital disorder of movement, muscle tone, or posture), chronic respiratory failure (long term condition in which the respiratory system is unable to adequately	F 0684		

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F 0684 SS=E	Continued from page 19 exchange oxygen and carbon dioxide in the body), tracheostomy (an opening or incision in the windpipe to relieve an obstruction to breathing), and dependence on a ventilator (a machine or device used medically to support or replace the breathing of a person who is ill, injured, unable to breathe on their own, or under anesthesia). Review of Resident 9's physician orders on January 7, 2024, revealed an order to apply triple antibiotic ointment to moisture associated skin damage (MASD) at tracheostomy stoma site every shift, dated September 24, 2024. Review of Resident 9's clinical record failed to reveal any progress notes, weekly skin assessments, nursing assessments, or respiratory assessments between September 24, 2024, and January 8, 2025, that included any identified skin damage to their tracheostomy site or otherwise. During a staff interview with the Director of Nursing (DON), Employee 1, and Employee 2 on January	F 0684		

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F 0684 SS=E	Continued from page 20 9, 2025, at 10:38 AM, the DON confirmed that she could not find any clinical documentation indicating that Resident 9 had any MASD at their tracheostomy site. She further indicated that Resident 9's physician had assessed their tracheostomy site on January 8, 2025, and noted there was no skin damage noted and discontinued the antibiotic ointment. The DON also indicated that, if a resident had skin issues, that she would expect staff to document them accordingly. Review of Resident 14's clinical record revealed diagnoses that included chronic obstructive pulmonary disease (COPD - a common lung disease that makes it difficult to breathe) and hypertension (high blood pressure). Review of Resident 14's December 2024 treatment administration record (TAR) revealed the following treatment orders: cleanse pressure area to left buttock cleanse with normal saline solution (NSS) cover with calcium alginate and foam border gauze daily, every night shift for pressure area, with a start	F 0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0684 SS=E	Continued from page 21 date of July 5, 2024; treatment for left buttock - cleanse with NSS, apply Medi honey to area and cover with foam dressing daily and as needed every night shift for wound care, with a start date of December 2, 2024; and treatment to left superior thigh - cleanse with NSS, apply Medi honey to area and cover with foam dressing daily and as needed every night for wound care, with a start date of November 13, 2024. Further review of Resident 14's December 2024 TAR revealed the treatment orders above were blank on December 14 and 18, 2024, indicating they were not completed. Review of Resident 14's November 2024 TAR revealed the following treatment orders: treatment to left superior thigh - cleanse with NSS, apply Medi honey to area and cover with foam dressing daily and as needed every night shift for wound care, with a start date of November 13, 2024; and treatment to left thigh - cleanse with NSS, apply Medi honey to area and cover with foam dressing daily and as	F 0684		

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F 0684 SS=E	Continued from page 22 needed every night shift for wound care, with a start date of September 9, 2024. Further review of Resident 14's November 2024 TAR revealed the treatment orders above were blank on November 16, 2024, indicating they were not completed. Review of Resident 14's October 2024 TAR revealed a treatment order to cleanse pressure area to left buttock, cleanse with NSS, cover with calcium alginate and foam border gauze daily every night shift for pressure area, with a start date of July 5, 2024. Further review of Resident 14's October 2024 TAR revealed the treatment order above was blank on October 25, 2024, indicating the treatment was not completed. Review of Resident 14's October 2024 TAR revealed a treatment order for the left thigh, to cleanse with NSS, apply Medi honey to area and	F 0684		

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F 0684 SS=E	Continued from page 23 cover with foam dressing daily and as needed every night shift for wound care, with a start date of September 9, 2024. Further review of Resident 14's October 2024 TAR revealed the treatment order above was blank on October 16 and 25, 2024, indicating the treatment was not completed. During a staff interview with the DON on January 9, 2025, at 12:51 PM, revealed that she believed Resident 14's treatment was completed on the dates above, but had careless documentation. DON revealed if the treatment was completed, it should have been documented on the TAR. Review of Resident 17's clinical record revealed diagnoses that included Type 2 Diabetes Mellitus (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), cerebral palsy (a congenital disorder of movement, muscle tone, or posture), hypotension (low blood pressure), and end stage renal disease (ESRD -	F 0684		

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F 0684 SS=E	Continued from page 24 condition in which a person's kidneys cease functioning on a permanent basis) with dependence on dialysis(external filtering of the blood performed by a machine by removing the blood and replacing it). Review of Resident 17's physician orders revealed orders for Midodrine HCl Oral Tablet 5 MG [milligram] give three tablets by mouth three times a day related to hypotension. Hold for SBP [systolic blood pressure] greater than 120, dated October 29, 2024; and Insulin Aspartame Injection Solution 100 units/ml [milliliter] Inject as per sliding scale: if 151 - 200 = 1; 201 - 250 = 2; 251 - 300 = 3; 301 - 350 = 4; 351 - 400= 5; 401+ = Call Physician, subcutaneously before meals related to Type 2 Diabetes Mellitus, dated October 29, 2024. Review of Resident 17's October 2024 Medication Administration Record revealed that on October 30 and 31, 2024, that there were no documented blood sugars for 6:00 AM, 11:00 AM, or 4:00 PM. All boxes were marked with an "X."	F 0684		

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F 0684 SS=E	Continued from page 25 Review of Resident 17's progress notes revealed a medication administration note on October 30, 2024, at 5:16 PM, related to their ordered 4:00 PM blood sugar check, that indicated Resident 17 was "sleeping, not woken at this time. verbally abusive to staff prior to falling asleep will check blood sugar when she wakes up." Further review of Resident 17's progress notes and Medication Administration record failed to reveal that this occurred. In addition, the review failed to reveal any other nursing progress notes as to why Resident 17's blood sugars were marked with an "X" on the aforementioned dates and times. Review of Resident 17's November 2024 Medication Administration Record revealed their 6:00 AM ordered blood sugar was blank on November 1, 2024. Review of Resident 17's November 2024 nursing progress notes failed to reveal any documentation as	F 0684		

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F 0684 SS=E	Continued from page 26 to why their ordered blood sugar was not completed. Review of Resident 17's December 2024 Medication Administration Record revealed their 6:00 AM ordered blood sugar was blank on December 6, 16, 17, 18, and 20, 2024; their 11:00 AM ordered blood sugar was blank on December 15, 16, and 17, 2024; and their 4:00 PM ordered blood sugar was blank on December 15 and 17, 2024. In addition, their blood sugar was documented on December 23, 2024, at 4:00 PM, as being 471. Review of Resident 17's December nursing progress notes failed to reveal any documentation as to why their ordered blood sugars were not completed on the aforementioned dates and times, or that Resident 17's physician was notified of the blood sugar being greater than 401 on December 23, 2024, as ordered. Review of Resident 17's January 2025 Medication	F 0684		

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F 0684 SS=E	Continued from page 27 Administration Record revealed that on January 3, 2025, at 6:00 AM, their ordered blood sugar test was blank; and that on January 7, 2025, at 9:00 PM, Resident 17's blood pressure was recorded as 134/84 and their dose of Midodrine was administered. Review of Resident 17's January nursing progress notes failed to reveal any documentation as to why their ordered blood sugar was not completed or why the Midodrine was not held as ordered. During a staff interview with the DON, Employee 1, and Employee 2 on January 9, 2025, at approximately 10:16 AM, the DON indicated that she called the nurse who documented Resident 17's blood sugar as being 471 on December 23, 2024, and the nurse said they did not recall Resident 17's blood sugar ever being that high, that they know they would have called the physician, but that they could not clearly recall for sure. The DON indicated that she had no additional information regarding Resident 17's blood sugars not being obtained as	F 0684		

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F 0684 SS=E	Continued from page 28 per physician orders on the dates and times identified. The DON confirmed that Resident 17 was documented as receiving their Midodrine on January 7, 2025, when it should have been held. The DON said she would expect nursing staff to administer resident medications as ordered or to document why medications were not given as ordered and include all necessary follow-up communication with the physician. 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.10(c)(d) Resident Care Policies 28 Pa. Code 211.12(c)(d)(1)(2)(3)(5) Nursing Services	F 0684		
F 0690 SS=E		F 0690		

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F 0690 SS=E	Continued from page 29 483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.	F 0690	Preparation and submission of this plan of correction is required by state and federal law. This plan of correction does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding. One: actions taken for situation identified: 1) The Facility recognizes that it cannot retroactively correct the situation for resident R37. 2) The Facility reviewed R37, for missing documentation 3) All current residents with Catheters were reviewed for incomplete documentation, Foley care, output, and Foley Flush Kit changes Two: system changes and measures that will be taken: 1) All Licensed staff will be in-serviced on documentation accuracy, Foley care, documentation of output and Foley Flush Kit changes 2) Documentation will be monitored at Daily Clinical meetings and staff	Completion Date: **02/28/2025** Status: **APPROVED** Date: **01/23/2025**

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F 0690 SS=E	Continued from page 30 This REQUIREMENT is not met as evidenced by:	F 0690	will be notified as necessary for corrections Three: monitoring mechanism to assure compliance: 1) The Director of Nursing or her designee will conduct audits on 5 random residents 3x a week for 4 weeks for compliance with Foley care, documentation, output and direct observation of residents that have orders for Foley Flush Kits were done, then five (5) random residents 1x week for 2 months. 2) The Director of Nursing will report findings at Continuous Quality Improvement Committee meetings	

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F 0690 SS=E	Continued from page 31 Based on facility policy review, clinical record review, and staff interview, it was determined that the facility failed to ensure a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections, consistent with physician orders and the resident's person-centered care plan, for one of five residents reviewed for catheter care (Resident 37). Findings include: Review of facility policy, titled "Catheter-Indwelling", last revised November 30, 2021, read, in part, "Purpose: To maintain constant urinary drainage, facilitate bladder irrigation, and monitor renal function and contain urinary drainage in seriously ill residents while maintaining a closed system. Criteria: must be documented for strict (foley- catheter) output if ordered by the physician." Review of Resident 37's clinical record revealed diagnoses that included obstructive uropathy (when urine can't flow normally through your urinary tract	F 0690		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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
F 0690 SS=E	Continued from page 32 due to a blockage), congestive heart failure (a chronic condition in which the heart doesn't pump blood as well as it should), and muscle weakness. Review of Resident 37's physician orders revealed orders for the following: Document foley output every shift, with a start date of July 5, 2023. Foley catheter care every shift per policy, with a start date of July 5, 2023. Change foley flush kit every night shift, with a start date of July 18, 2023. Review of Resident 37's care plan revealed a focus area: "The resident has the potential for infection related to indwelling catheter. Diagnosis: Obstructive Uropathy" with an intervention for, "Empty foley catheter and document output every shift", initiated July 4, 2023; "Foley catheter care every shift per facility policy", initiated July 4, 2023; and "Change	F 0690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396122	A. BLDG: 00 B. WING:	01/09/2025

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F 0690 SS=E	Continued from page 33 foley flush kit every night shift", initiated February 26, 2024. Review of Resident 37's TAR (Medication Administration Record- documentation for treatments/medication administered or monitored) from April 2024 through December 2024, revealed the order to document foley output every shift was not documented as completed 18 times during day shift and 14 times during night shift. Further review of Resident 37's TAR from April 2024 through December 2024 revealed the order for foley catheter care was not documented as completed on April 15 during night shift; May 10 during night shift; June 5 during day shift; August 23 during day shift; August 6, 14, 27, and 28 during night shift; and December 17 and 18 during night shift. Further review of Resident 37's TAR from April 2024 through December 2024 revealed the order to change the foley flush kit was not documented as	F 0690		

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F 0690 SS=E	Continued from page 34 completed on April 15; August 6, 14, 27, and 28; and December 17 and 18. Review of Resident 37's clinical record revealed she received antibiotic treatment for urinary tract infections from July 15-22, 2024; and November 3-15, 2024. Interview with the Director of Nursing on January 9, 2025, at 12:03 PM, revealed she would expect foley output, catheter care, and changing of the foley flush kit to be completed per facility process and physician order. 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services	F 0690		
F 0757 SS=E		F 0757		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0757 SS=E	Continued from page 35 483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by:	F 0757	Preparation and submission of this plan of correction is required by state and federal law. This plan of correction does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding. One: actions taken for situation identified: 1) The Facility recognizes that it cannot retroactively correct the situation for resident R9. 2) The Facility reviewed R9, and had a new skin assessment completed, site has been healed and treatment d/cd. 3) All current residents were reviewed for correct skin assessments and orders relating to those skin assessments. Two: system changes and measures that will be taken: 1) All Licensed staff will be in-serviced on documentation accurate skin assessments and treatment orders 2) Documentation will be monitored at Daily Clinical meetings and staff	Completion Date: **02/28/2025** Status: **APPROVED** Date: **01/23/2025**

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F 0757 SS=E	Continued from page 36	F 0757	will be notified as necessary for corrections 3) Education will be provided to consultant pharmacist re: reviewing all medications to include ointments and treatment medications and Pharmacy Recommendations will be reviewed to ensure that ointments and treatment medications are reviewed by the Pharmacist Three: monitoring mechanism to assure compliance: 1) The Director of Nursing or her designee will conduct audits on 5 random residents 3x a week for 4 weeks for compliance with treatments for skin assessments then five (5) random residents 1x week for 2 months. 2) The Director of Nursing or her designee will conduct random audits for ointments and treatment medications to compare Physician orders against Pharmacy Reviews and will review 5 random residents pharmacy recommendations monthly for compliance with treatments for skin assessments and pharmacy recommendations, then five (5)	

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F 0757 SS=E	Continued from page 37	F 0757	random residents for 2 months. Pharmacy recommendations are received monthly 3) The Director of Nursing will report findings at Continuous Quality Improvement Committee meetings	

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F 0757 SS=E	Continued from page 38 Based on facility policy review, clinical record review, and staff interview, it was determined that the facility failed to ensure that residents were free of unnecessary medications for one of one resident reviewed for antibiotic use (Resident 9). Findings include: Review of facility policy, titled "Medication Regimen Review and Reporting", with a last review date of December 31, 2024, indicated that a "Medication Regimen Review (MRR) is a thorough evaluation of the drug regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication" and the "consultant pharmacist reviews the medication regimen and medical chart of each resident at least monthly to appropriately monitor the medication regimen and ensure that the medications each resident receives are clinically indicated." Review of Resident 9's clinical record revealed	F 0757		

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F 0757 SS=E	Continued from page 39 diagnoses that included cerebral palsy (a congenital disorder of movement, muscle tone, or posture), chronic respiratory failure (long term condition in which the respiratory system is unable to adequately exchange oxygen and carbon dioxide in the body), tracheostomy (an opening or incision in the windpipe to relieve an obstruction to breathing), and dependence on a ventilator (a machine or device used medically to support or replace the breathing of a person who is ill, injured, unable to breathe on their own, or under anesthesia). Review of Resident 9's physician orders on January 7, 2025, revealed an order to apply triple antibiotic ointment to moisture associated skin damage (MASD) at tracheostomy stoma site every shift, dated September 24, 2024. Review of Resident 9's clinical record failed to reveal documentation or assessment of any identified skin damage on September 24, 2024, through January 8, 2025.	F 0757		

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F 0757 SS=E	Continued from page 40 Review of Resident 9's clinical record revealed that the facility's consultant pharmacist had reviewed Resident 9's medication regimen on October 15, 2024; November 12, 2024; and again between December 1-15, 2024, with no recommendations made regarding the ongoing use of the triple antibiotic ointment. During a staff interview with the Director of Nursing (DON), Employee 1, and Employee 2 on January 9, 2025, at 10:38 AM, the DON confirmed that she could not find any clinical documentation identifying that Resident 9 had any MASD at their tracheostomy site, that they should have caught the ongoing antibiotic cream order prior to yesterday, and that it should not have been utilized for this long. She further indicated that Resident 9's physician had assessed their tracheostomy site on January 8, 2025, and noted there was no skin damage noted and discontinued the antibiotic ointment. The DON also confirmed that the monthly consultant pharmacist reviews failed to identify the lack of clinical documentation to support the use of the	F 0757		

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F 0757 SS=E	Continued from page 41 ongoing antibiotic cream or the overall ongoing use of the antibiotic cream as a concern. 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)(5) Nursing services	F 0757		
F 0758 SS=E		F 0758		

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F 0758 SS=E	Continued from page 42 483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and	F 0758	Preparation and submission of this plan of correction is required by state and federal law. This plan of correction does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding. One: actions taken for situation identified: 1) The Facility recognizes that it cannot retroactively correct the situation for resident R26. 2) The Facility reviewed R26, but resident has since discharged and no longer resides at the facility 3) All current residents were reviewed for duplicate therapy and Physician documentation for Risk/Benefit and orders and signed Physician orders 4) All current residents were reviewed for Medication Administration and Controlled drug record for correct administration times frames as prescribed and for missing documentation Two: system changes and measures that will be taken:	Completion Date: **02/28/2025** Status: **APPROVED** Date: **01/22/2025**

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F 0758 SS=E	Continued from page 43 §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by:	F 0758	1) All Licensed staff and Medical Director and Medical Providers will be in-serviced on documentation Psychotropic drug use, Duplicate Therapy, correct administration times frames as prescribed and for missing documentation. 2) Documentation will be monitored at Daily Clinical meetings for accuracy 3) Pharmacy Consultant to review for accuracy and discrepancies 4) Medical Director and his staff will be in-serviced on documentation for Risk/Benefits of use Three: monitoring mechanism to assure compliance: 1) The Director of Nursing or her designee will conduct audits on 5 random residents 3x a week for 4 weeks for compliance with Psychotropic drug use, then five (5) random residents 1x week for 2 months. 2) The Director of Nursing will report findings at Continuous Quality Improvement Committee meetings	

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F 0758 SS=E	Continued from page 44 Based on clinical record review and staff interviews, it was determined that the facility failed to ensure the resident was free of unnecessary psychotropic medications for one of five residents reviewed for unnecessary medications (Resident 26). Findings include: Review of Resident 26's clinical record on January 7, 2025, revealed diagnoses that included hypertension (elevated/high blood pressure) and bipolar disorder (mental health disorder that causes extreme shifts in mood from depression to manic hyperactivity). Review of Resident 26's physician orders revealed orders for clonazepam (schedule IV controlled medication in the drug class of benzodiazepine) 3 milligrams (mg - metric unit of measure) every 24 hours as needed for restlessness for 14 days, with a start date of December 30, 2024, and end date of January 13, 2024.	F 0758		

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F 0758 SS=E	Continued from page 45 Review of Resident 26's clinical record revealed the as needed clonazepam had been continuously reordered every 14 days over the course of the prior year and beyond. Resident 26 also had a separate, standing order for clonazepam 1 mg two times a day for anxiety disorder (mental health disorder characterized by excessive worry or fear), which was dated September 13, 2024. Review of Resident 26's physician orders revealed that Resident 26 had an order for lorazepam (schedule IV controlled medication in the drug class of benzodiazepine) 1 mg every six hours as needed for anxiety for 14 days, with a start date of December 30, 2024, and end date of January 13, 2024. Review of Resident 26's clinical record revealed the as needed lorazepam had been continuously reordered since October, 2022. Review of available documentation revealed no clinical rationale was documented as to why	F 0758		

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F 0758 SS=E	Continued from page 46 Resident 26 was receiving duplicative medications of the same drug class with duplicative therapeutic effect. Further, review of a pharmacy recommendation dated November 12, 2024, revealed the consultant pharmacist identified that Resident 26 was receiving "Duplicate PRN [as-needed] anxiolytics [anti-anxiety medications]" and recommended, "Please evaluate and consider consolidating to one." To which the provider checked, "Disagree - Perceived risks are outweighed by benefits. Order to remain as is." The response was dated November 19, 2024. Review of Resident 26's clinical record revealed no documented review of the risks and/or benefits of Resident 26 receiving duplicative medications of the same medication class and therapeutic effect. During a staff interview on January 9, 2025, Director of Nursing (DON) revealed the facility was unable to locate a documented rationale for the	F 0758		

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F 0758 SS=E	Continued from page 47 duplicative medication use at that time. Review of Resident 26's order for lorazepam 1 mg revealed it was to be provided every six hours as needed. Review of the "Controlled Drug Record" (documentation tool utilized to record the amount of medication, amount administered, and date and time the medication is administered) for Resident 26's lorazepam revealed staff documented administering one tablet of lorazepam on September 25, 2024, at 1:00 PM, then a second administration at 4:00 PM, less than six hours between administration. Review of the electronic medication administration record (MAR - document tool utilized to record when medications or treatments are administered) revealed neither administration recorded on the "Controlled Drug Record" was recorded in Resident 26's electronic MAR. Further review of the "Controlled Drug Record"	F 0758		

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F 0758 SS=E	Continued from page 48 revealed staff documented administering one tablet of lorazepam on October 19, 2024, at 4:30 PM, and then a second administration was documented at 8:00 PM, less than six hours in between doses. Review of the electronic MAR revealed staff did not record the 8:00 PM lorazepam administration. Finally, on October 20, 2024, staff recorded on the "Controlled Drug Record" administration of the lorazepam at 3:45 PM, then another administration was recorded at 8:00 PM, less than 6 hours between doses. Review of the electronic MAR revealed the 8:00 PM administration was not documented. During a staff interview on January 9, 2024, at approximately 11:30 AM, DON revealed it was the facility's expectation that staff follow the as needed time frame as prescribed by the physician when administering as needed medications.	F 0758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396122	A. BLDG: 00 B. WING:	01/09/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
FOX SUBACUTE AT MECHANICSBURG STATE LICENSE NUMBER: **22220201**	**120 SOUTH FILBERT STREET MECHANICSBURG, PA 17055**

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F 0758 SS=E	Continued from page 49 During review of the aforementioned "Controlled Drug Record" for Resident 26's lorazepam 1 mg tablet, the following was identified: Between the dates of September 14 and 26, 2024, 19 tablets were recorded on the "Controlled Drug Record" as being administered but not recorded in Resident 26's Medication Administration Record. Between the dates of October 11 and 28, 2024, 11 tablets were recorded on the "Controlled Drug Record" as being administered but not recorded in Resident 26's Medication Administration Record. Between the dates of November 13, 2024, and December 6, 2024, 16 tablets were recorded on the "Controlled Drug Record" as being administered but not recorded in Resident 26's Medication Administration Record. Between the dates of December 7 and 25, 2024, 17 tablets were recorded on the "Controlled Drug Record" as being administered but not recorded in	F 0758		

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F 0758 SS=E	Continued from page 50 Resident 26's Medication Administration Record. Between the dates of December 29, 2024, and January 8, 2025, nine tablets were recorded on the "Controlled Drug Record" as being administered but not recorded in Resident 26's Medication Administration Record. During the staff interview on January 9, 2025, at approximately 11:30 AM, DON revealed it was the facility's expectation that staff document on the electronic MAR when medications are administered. Review of Resident 26's clinical record revealed that between November 27, 2024, and December 1, 2024, Resident 26 did not have an active order for lorazepam; however, staff administered lorazepam 1 mg tablet on the following dates and time: November 29, 2024, at 12:00 AM November 29, 2024, at 8:00 PM December 1, 2024, at 1:27 AM During the staff interview on January 9, 2025, at	F 0758		

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F 0758 SS=E	Continued from page 51 approximately 11:30 AM, DON revealed that staff should only administer medication when there is an order by a physician. 28 Pa code 211.9(d)(j.1) Pharmacy services 28 Pa code 211.12(d)(1)(3)(5) Nursing services	F 0758		

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P 1690		P 1690		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: | (X6) DATE:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 1690	Continued from page 1 Prevention, control and surveillance of tuber (a) The facility shall have a written TB infection control plan with established protocols which address risk assessment and management, screening and surveillance methods, identification, evaluation, and treatment of residents and employees who have a possible TB infection or active TB. This REGULATION is not met as evidenced by:	P 1690	Preparation and submission of this plan of correction is required by state and federal law. This plan of correction does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding. One: actions taken for situation identified: 1) The Facility recognizes that it cannot retroactively correct the situation for Employee 3 and 7 2) The Facility removed both employees from the schedule until their TB screening was completed and reviewed 3) All current employees were reviewed for accurate TB screening requirements Two: system changes and measures that will be taken: 1) HRA, DON, ADON, Department Heads and Infection Preventionist will be in-serviced on Facility TB policy 2) Infection Preventionist will review all new employees for correct and accurate TB screening before new	Completion Date: **02/28/2025** Status: **APPROVED** Date: **01/22/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 1690	Continued from page 2	P 1690	employees are allowed to start Three: monitoring mechanism to assure compliance: 1) The Director of Nursing or her designee will conduct audits weekly audits of all new hires for 4 weeks and then monthly for 2 months for accuracy 2) The Director of Nursing will report findings at Continuous Quality Improvement Committee meetings	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 1690	Continued from page 3 Based on facility policy review, review of personnel records, and staff interview, it was determined that the facility failed to complete tuberculosis screening for two of five employees reviewed (Employees 3 and 7). Findings include: Review of facility policy, titled "Employee Tuberculosis Screening and Control Program", with a last review date of December 31, 2024, revealed, in part, "A. Human Resources uses the TB [tuberculosis] Algorithm and other information contained in this policy for initial guidance on what constitutes a cleared baseline status for new employees at the time of hire; C. The Infection Preventionist (or Designee) guides Human Resources with complex clinical decision making in the process of determining an employee's risk, signs, symptoms, and ability to determine a safe TB baseline status; A. The following are acceptable as cleared baseline status under which a newly hired employee may start: Two negative TST's [tuberculin	P 1690		

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P 1690	Continued from page 4 skin tests] administered not more than 3 weeks apart according to policy and a completed Baseline TB Individual Risk Assessment for Healthcare Providers; or a negative TB Blood Assay test not more than one year old plus a completed Baseline TB Individual Risk Assessment for Healthcare Providers plus a completed Symptoms Questionnaire." Review of personnel file for Employee 3, date of hire November 6, 2024, failed to reveal that Employee 3 had received any tuberculin skin tests or a tuberculin assay blood test completed prior to hire. Review of personnel file for Employee 7, date of hire December 17, 2024, revealed that Employee 7 had received one tuberculin skin test completed on April 3, 2024, at a prior employer, which was documented as negative. There was not other documentation regarding any additional tuberculin skin tests or a tuberculin assay blood test completed prior to hire.	P 1690		

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P 1690	Continued from page 5 During a staff interview with the Nursing Home Administrator on January 9, 2025, at 10:32 AM, he confirmed that he had no additional information to provide for Employees 3 and 7. He indicated that Employees 3 and 7 have both been removed from the floor, have been sent to have a tuberculin blood assay test completed, and will not be allowed to return to work until a negative test result is received. He confirmed that he would expect the facility to follow their policy and that all new hire employees would be screened appropriately for tuberculosis prior to starting employment.	P 1690		
P 4740		P 4740		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 4740	Continued from page 6 Verbal and telephone orders. (c) Verbal and telephone orders for medications shall be dated and countersigned by the prescribing physician, or physician ' s delegee authorized under 42 CFR 483.80(e), within 48 hours. This REGULATION is not met as evidenced by:	P 4740	Preparation and submission of this plan of correction is required by state and federal law. This plan of correction does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding. One: actions taken for situation identified: 1) The Facility recognizes that it cannot retroactively correct the situation for resident R26. 2) The Facility reviewed R26, but resident has since discharged and no longer resides at the facility 3) All current residents were reviewed to ensure that all verbal orders are being countersigned by the physician Two: system changes and measures that will be taken: 1) All Licensed staff and Physician and Medical Providers will be in-serviced on Physician verbal orders and Physician countersigning orders 2) Documentation will be monitored at Daily Clinical meetings and staff	Completion Date: **02/28/2025** Status: **APPROVED** Date: **01/22/2025**

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P 4740	Continued from page 7	P 4740	will be notified as necessary for corrections Three: monitoring mechanism to assure compliance: 1) The Director of Nursing or her designee will conduct audits on 5 random residents 3x week for 4 weeks for compliance with verbal orders then five (5) random residents 1x week for 2 months. 2) The Director of Nursing will report findings at Continuous Quality Improvement Committee meetings	

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P 4740	Continued from page 8 Based on clinical record review, facility policy review, and staff interview, it was determined that the facility failed to ensure verbal orders for medications are countersigned by the prescribing physician within 48 hours for one of 14 residents reviewed (Resident 26). Findings include: Review of the facility policy, titled "Verbal Orders, Physician Orders and Diagnostic/Lab Results", last reviewed December, 2024, revealed it did not include language regarding requirement of the physician to sign the verbal order. Review of Resident 26's clinical record on January 7, 2025, revealed diagnoses that included hypertension (elevated/high blood pressure) and bipolar disorder (mental health disorder that causes extreme shifts in mood from depression to manic hyperactivity). Review of Resident 26's physician orders revealed	P 4740		

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P 4740	Continued from page 9 an order was entered on December 30, 2024, for lorazepam (schedule IV controlled medication in the drug class of benzodiazepine) 1 mg, one tablet by mouth every six hours as needed for 14 days. Review of the order revealed it was entered as a "verbal" order. Review of Resident 26's clinical record revealed that the verbal order did not have a counter-signature by the prescribing physician. Resident 26's electronic health record also had a verbal order documented on December 30, 2024, for clonazepam (schedule IV controlled medication in the drug class of benzodiazepine) 2 mg, give one and a half tablets every 24 hours as-needed for 14 days. Review of Resident 26's clinical record revealed that the verbal order had no counter-signature by the prescribing physician. During a staff interview on January 9, 2024, at	P 4740		

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P 4740	Continued from page 10 approximately 11:30 AM, Director of Nursing revealed it was the facility's expectation that verbal orders are signed by the physician as required by State regulation.	P 4740		

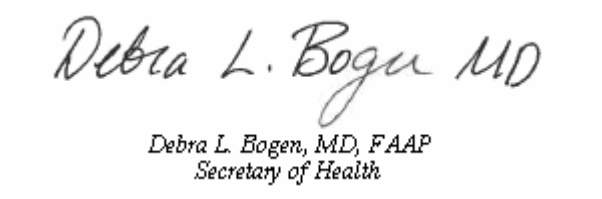
Certified End Page

FOX SUBACUTE AT MECHANICSBURG

STATE LICENSE NUMBER: 22220201

SURVEY EXIT DATE: 01/09/2025

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



Pennsylvania
Department of Health

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