STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395964	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shippensburg Rehabilitation and Health Care Center	121 Walnut Bottom Road Shippensburg, PA 17257

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care or services that was trauma informed and/or culturally competent. Based on review of facility policy, clinical record review, and staff interviews, it was determined that the facility failed to ensure that the residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice in order to eliminate or mitigate triggers that may cause re-traumatization of the resident for two of two residents reviewed (Residents 3 and 35).Findings Include: Facility policy, titled Trauma Informed Care, reviewed February 2026, read, in part, Policy: .Residents who display or are diagnosed with a mental disorder, psychosocial adjustment difficulty, and/or PTSD will be provided with appropriate treatment and services to attain the highest practicable level of mental and psychosocial wellbeing.Procedure: . 7. When a resident has experienced a traumatic event, the SW (social worder) will interview resident/resident representative regarding: Potential/actual triggers that may cause re-traumatization of the resident. Review of Resident 3's clinical record revealed diagnoses that included Post-Traumatic Stress Disorder (PTSD-a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event with triggers that can bring back memories of the trauma accompanied by intense emotional and physical reactions), anxiety disorder (mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), and major depressive disorder (ongoing feelings of sadness, despair, loss of energy, and difficulty dealing with normal daily life). Review of Resident 3's trauma informed care assessment, dated February 16, 2026, revealed that Resident 3 was able to participate in the interview and had experienced trauma. Further review of the assessment revealed that Resident 3 reported experiencing feeling very upset when something reminded her of the stressful experience and feeling jumpy or easily startled quite a bit. In addition, Resident 3 indicated that she moderately experienced trouble falling or staying asleep. Review of Resident 3's comprehensive care plan revealed a care plan focus for potential to exhibit behaviors that are a result of past trauma due to abuse as a child from a family member, with an initiated date of February 16, 2026, and a revision date of March 2, 2026. Interventions included, but were not limited to, identify potential triggers dated February 16, 2026. Further review of Resident 3's care plan failed to reveal that her resident-specific triggers had been identified. Review of Resident 3's clinical record revealed a physician's order for a psychiatry consult dated February 16, 2026. Review of Resident 3's clinical record progress notes revealed that Resident 3's Representative gave consent for a psychiatry consult on February 17, 2026. Further review of Resident 3's clinical record failed to reveal any documentation that she had received a psychiatry consult since February 17, 2026. During a staff interview with the Director of Nursing (DON) on April 22, 2026, at 10:44 AM, the DONconfirmed that Resident 3 had not received any psychiatry services yet. During a final staff interview with the Nursing Home Administrator (NHA) and DON on April 23, 2026, at 11:17 AM, the DON confirmed that she would expect trauma assessments to be completed in a more thorough manner to identify actual triggers, which should also then be care planned. In addition, she confirmed that she would expect residents to receive psychiatric services in a timely manner. Review of Resident 35's clinical record revealed diagnoses that included PTSD and major depressive disorder. Review of Resident 35's trauma informed care assessment, dated December 17, 2025, revealed that Resident 35 was able to participate in the interview and had (continued on next page)

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

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	experienced trauma. Further review of the document revealed that Resident 35 reported experiencing repeated, disturbing and unwanted memories of the stressful event quite a bit and moderately having repeated, disturbing dreams of the stressful experience. Review of Resident 35's comprehensive plan of care revealed a focus area for a potential to exhibit behaviors that are a result of past trauma with an intervention to identify potential triggers. Further review of Resident 35's comprehensive plan of care failed to reveal Resident 35's specific trauma or any triggers had been identified. Continued review of Resident 35's clinical record failed to reveal that any follow up relating to Resident 35's PTSD had occurred. During an interview on April 23, 2026 at 11:22 AM, with the NHA and DON, it was revealed that the facility had no additional information relating to Resident 35's PTSD. The DON stated it was the expectation of the facility that trauma and triggers be identified and that residents receive trauma informed care. 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 201.18(b)(1) Management.28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interviews, it was determined that the facility failed to ensure that the resident assessment accurately reflected the resident's status for two of 24 residents reviewed (Residents 6 and 35).Findings Include: Review of Resident 6's clinical record revealed diagnoses that included gastro esophageal reflux disease ([GERD] when stomach acid flows back up into the esophagus) and major depressive disorder (a serious, common mood disorder characterized by persistent sadness, loss of interest, and fatigue, lasting at least two weeks and impairing daily life). Review of Resident 6's quarterly MDS (Minimum Data Set is part of federally mandated process for clinical assessment of all Medicare and Medicaid certified nursing homes) dated March 25, 2026, indicated in Section N0415 High-Risk Drug Classes: Use and Indication, section E, indicated that Resident 6 had taken an anticoagulant during the look-back period. Review of Resident 6's clinical record failed to reveal any evidence that Resident 6 had taken any anticoagulant medications. Interview with the Director of Nursing (DON) on April 23, 2026, at 11:45 AM, revealed that it was marked in error and a correction was being completed. Review of Resident 35's clinical record revealed diagnoses that included post-traumatic stress disorder (PTSD - a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event. The condition may last months or years, with triggers that can bring back memories of the trauma, accompanied by intense emotional and physical reactions) and major depressive disorder. Review of Resident 35's admission MDS dated [DATE], and quarterly MDS dated [DATE], revealed Resident 35 was not coded a diagnosis of PTSD. An interview with Employee 7 on April 23, 2026 at 9:50 AM, revealed Resident 35's aforementioned MDS reports were coded incorrectly and that a modification would be done to correct them. During an interview with the Nursing Home Administrator and DON on April 23, 2026 at 11:22 AM, the DON stated that it was the expectation of the facility that MDS reports accurately reflect the resident's status. 28 Pa. Code 211.5(f) Clinical records28 Pa. Code 211.12(d)(3)(5) Nursing services

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, clinical record reviews, and staff interviews, it was determined that the facility failed to ensure the care plan was reviewed and revised for three of 24 residents reviewed (Residents 3, 11, and 28).Findings include: Review of facility policy, titled Care Plans-Comprehensive, with a last review date of February 2026, revealed, in part, The resident's comprehensive care plan is developed within seven days of the completion of the resident's comprehensive assessment (MDS). Assessments of residents are ongoing, and care plans are revised as information about the resident and the resident's condition changes. Review of Resident 3's clinical record revealed that she was admitted to the facility on [DATE], with diagnoses that included Post-Traumatic Stress Disorder (PTSD-a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event with triggers that can bring back memories of the trauma accompanied by intense emotional and physical reactions), anxiety disorder (mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), and depression. Review of Resident 3's care plan revealed a care plan revealed that a care plan was developed initially developed on February 16, 2026, for a focus for potential to exhibit behaviors that are a result of past trauma due to abuse as child from a family member. Interventions included, but were not limited to, identify potential triggers dated February 16, 2026. Review of Resident 3's clinical record revealed that her Representative was made aware of an incident on March 13, 2026, and at that time Resident 3's Representative reported that Resident 3 was timid and gets scared by noises and agreed to a room move to a private room. Further review of Resident 3's care plan failed to reveal that her trigger of being scared by noises was added to her care plan after the facility was made aware on March 13, 2026.Review of Resident 3's clinical record revealed a social services progress note dated March 13, 2026, which indicated that Resident 3's Representative had reported that Resident 3 was timid and gets scared by noises.During a staff interview with the Director of Nursing (DON) on April 23, 2206, at 9:50 AM, the DON confirmed that Resident 3's fear of noise should have been added to her care plan when facility was made aware. A review of the clinical record for Resident 11 revealed diagnoses that included dementia (decline in cognitive status, including memory, language and problem-solving) and anxiety disorder. A review of Resident 11's clinical record revealed an admission date to the facility on January 23, 2025, with a primary admitting diagnosis of Dementia. A review of Resident 11's care plan failed to include a comprehensive, person-centered care plan for the diagnosis of dementia. The nutrition section of the care plan is the only section that included the diagnosis of dementia. During an interview with the DON on April 23, 2026, at approximately 11:00 AM, the DON agreed that Resident 11's care plan should have been revised to include a care plan specific for the diagnosis of Dementia. Review of Resident 28's clinical record revealed diagnoses that included atrial fibrillation (abnormal heart rhythm characterized by rapid and irregular beating of the upper chamber of the heart) and heart failure (condition that develops when your heart doesn't pump enough blood for your body's needs). Review of Resident 28's current physician orders revealed an order for apixaban (Eliquis-a blood thinning medication used to prevent blood clots from forming) 5 milligrams administer one tablet twice a day, dated October 30, 2025. Review of Resident 28's care plan failed to reveal her use of anticoagulant medication. During a staff interview with the DON on April 22, 2026, at 1:42 PM, the DON indicated that anticoagulant therapy had been removed from Resident 28's care plan by accident and that staff were adding it back on Resident 28's care plan. The DON confirmed that she would expect the anticoagulant use to have remained on her care plan. 28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services.