STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396133	A. Building B. Wing	05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vibra Rehabilitation Center	707 Sheperdstown Rd Mechanicsburg, PA 17055

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **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 care and services were provided for a resident with hypoglycemia (low blood sugar) in accordance with professional standards of practice that meet each resident's physical, mental, and psychosocial needs, for one of 18 residents reviewed (Resident 1), which resulted in actual harm as evidenced by Resident 1 becoming unresponsive and requiring hospitalization. Findings Include: Review of Resident 1's clinical record revealed she was admitted to the facility on [DATE], with diagnoses that included Type 2 Diabetes Mellitus (a chronic condition where the body either resists the effects of insulin or doesn't produce enough of it) and congestive heart failure (CHF-when the heart muscle doesn't pump blood as well as it should, leading to a backup of fluid in the lungs and body tissues). Review of Resident 1's Medication Administration Record (MAR) dated May 2026, revealed an order, with a start date of May 1, 2026, to check Resident 1's blood glucose level at 6:00 AM and 9:00 PM. Further review of Resident 1's MAR revealed PRN (as needed) orders, with a start date of April 19, 2026, for Glucose Gel 40%, give 15 grams by mouth as needed for blood glucose less than 60, administer if blood glucose is less than 60 and resident is alert enough to swallow; and an order for Glucagon 1 mg (milligram), inject 1 mg intramuscularly as needed for blood glucose less than 60, administer if blood glucose is less than 60 and Resident is NOT alert enough to swallow. Review of Resident 1's MAR revealed that on May 9, 2026, at 9:00 PM, Resident 1's blood glucose was documented as being 57. Further review of the MAR revealed that neither the glucose gel nor the glucagon were given at that time, per PRN order to be given for blood glucose less than 60. Review of Resident 1's clinical record revealed no nursing progress note about Resident 1's blood glucose level of 57, no evidence of any assessment of Resident 1, no evidence that the provider was made aware, and no evidence that a follow up blood glucose level was checked. Review of Resident 1's MAR revealed that on May 10, 2026, at 6:00 AM, Resident 1's blood glucose was documented as being 44. Further review of the MAR revealed that neither the glucose gel nor the glucagon were given at that time, per PRN order to be given for blood glucose less than 60. Review of Resident 1's clinical record revealed no nursing progress note about Resident 1's blood glucose level of 44, no evidence of any assessment of Resident 1, no evidence that the provider was made aware, and no evidence that a follow up blood glucose level was checked. Review of Resident 1's nursing progress note, dated May 10, 2026, revealed that the nurse entered Resident 1's room at around 10:10 AM and Resident 1 appeared to be sleeping. Blood glucose level was checked and it was 47. PRN glucagon was administered and the RN supervisor was notified and arrived to Resident 1's room. When staff attempted to put the Resident's head of the bed down to reposition the Resident, she became unresponsive and had projectile vomited. The note further stated that the PRN glucagon was not effective as the blood glucose level was rechecked and it was 37. A second PRN glucagon was administered and 911 was notified. Prior to leaving the facility, Resident 1's blood glucose level was checked and it was 89. Review of Resident 1's MAR revealed she received PRN glucagon at 10:11 AM for a blood glucose level of 47 and again at 10:22 AM for a blood glucose level of 37. During an interview with the Director of Nursing (DON) on May 19, 2026, at 10:48 AM, she stated that the facility does not have policies on insulin (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396133	A. Building B. Wing	05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vibra Rehabilitation Center	707 Sheperdstown Rd Mechanicsburg, PA 17055

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 0684 Level of Harm - Actual harm Residents Affected - Few	administration, blood glucose monitoring, or hypoglycemia. On May 19, 2026, at 12:20 PM, the DON stated that per Employee 2, she was aware of the blood glucose level of 44, but the Resident was talking so they didn't recheck the blood glucose until she went unresponsive. She further confirmed that there is no documentation of anything that Employee 1 did regarding the blood glucose levels of 57 and 44. The DON provided a statement from Employee 2, undated, which stated that Resident 1 was in her room, awake and talking, eating breakfast. The aides were talking to the Resident and tried to take her tray away twice and she said she was still eating. At about 9:00 AM, they took her tray. At about 10:00 AM is when Employee 2 found Resident 1 in her room unresponsive, gave two doses of glucagon and transferred her to the hospital. The DON provided a form titled Employee Corrective Action Form for Employee 1, that was dated May 14, 2026. Under the section Statement of the Issues revealed Blood sugar of 44- [Employee 1] said she gave glucose tabs/nothing documented-no call to provider. The form further revealed, under Employee Comments, Employee 1 stated that it was the end of her shift, she gave in report all interventions and requested the oncoming nurse to follow up. Employee 1 signed the form on May 14, 2026. During an interview with the DON on May 19, 2026, at 2:01 PM, the DON stated that glucose gel is kept in the medication cart so there is no record of when the medication is removed from the cart to be administered. She stated that there is no documentation that Employee 1 gave Resident 1 glucose gel or glucagon, per PRN order to be given for blood glucose less than 60. The facility failed to provide interventions to Resident 1 for blood glucose levels of 57 and 44, resulting in Resident 1 becoming unresponsive and requiring hospitalization. 28 Pa. Code 201.14(a) Responsibility of licensee.28 Pa. Code 201.18(b)(1) Management.28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396133	A. Building B. Wing	05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vibra Rehabilitation Center	707 Sheperdstown Rd Mechanicsburg, PA 17055

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, it was determined that the facility failed to ensure that the resident received care, consistent with professional standards of practice, to treat pressure ulcers for one of 18 residents reviewed (Resident 1). Findings Include: Review of Resident 1's clinical record revealed she was admitted to the facility on [DATE], with diagnoses that included Type 2 Diabetes Mellitus (a chronic condition where the body either resists the effects of insulin or doesn't produce enough of it) and congestive heart failure (CHF-when the heart muscle doesn't pump blood as well as it should, leading to a backup of fluid in the lungs and body tissues). Review of Resident 1's nursing progress notes revealed an eMAR note on April 23, 2026, at 5:03 AM, stating that Resident 1 was reporting a 4/10 buttock pain, concern for stage 2 pressure injury. Zinc oxice paste was applied, which provided relief. Review of Resident 1's nursing progress note on April 23, 2026, at 6:00 AM, revealed that zinc oxide was applied, but does not specify where. The note further stated that the Resident had a foam dressing on her buttock prior to finding the pressure injury. Skin inspection completed and refer to evaluation for details. Review of Resident 1's facility form titled Skin Inspection Daily on admission x 72 hours, dated April 23, 2026, revealed Resident 1 has a stage 2 pressure ulcer (partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer) to the sacrum. Under comments, it was documented that zinc oxide was applied and that the Resident had a foam dressing on her buttock prior to finding the pressure injury. Further review of the form revealed no measurements, no description of the pressure ulcer's characteristics, no progress toward healing or identification of potential complications, and no mention if infection was present. Review of Resident 1's TAR (treatment administration record), dated April 2026, revealed that on April 23, 2026, zinc oxide paste was ordered to be applied to buttocks every shift for stage 2 pressure injury. Review of Resident 1's admission MDS (Minimum Data Set- an assessment tool to review all care areas specific to the resident such as a resident's physical, mental or psychosocial needs), dated April 26, 2026, revealed in Section M, Resident 1 was coded as having one stage 2 pressure ulcer, that was not present on admission. Review of Resident 1's nursing progress note on April 28, 2026, revealed zinc oxide applied, but does not state where it was applied. The note further states that the Resident had a foam dressing on her buttock prior to finding the pressure injury. Skin inspection as completed and refer to evaluation for details. Review of Resident 1's facility form titled Skin Inspection Daily on admission x 72 hours, dated April 28, 2026, revealed Resident 1 has a stage 2 pressure ulcer to the sacrum. Under comments, it was documented that zinc oxide was applied and that the Resident had a foam dressing on her buttock prior to finding the pressure injury. Further review of the form revealed no measurements, no description of the pressure ulcer's characteristics, no progress toward healing or identification of potential complications, no mention if infection was present, and no pain assessment. Review of Resident 1's clinical record revealed no pressure ulcer assessments were completed after April 28, 2026. On May 22, 2026, at 8:44 AM, the Director of Nursing (DON) stated that the facility does not have a pressure ulcer policy. She further stated that the nursing progress note on April 23, 2026 says suspected stage 2 and there were no measurements because there was no pressure found, they were just applying zinc as preventative. On May 22, 2026, at 8:57 AM, the surveyor questioned the DON regarding her statement of no pressure ulcer found and that the zinc was just preventative. Surveyor referenced the treatment order of the Zinc, that was ordered for a stage 2 pressure ulcer, the two skin inspection forms that state Resident 1 has a stage 2 pressure ulcer and the MDS being coded that Resident 1 has a stage 2 pressure ulcer. No additional information was provided by the DON. In a follow up interview with the DON on May 22, 2026, at 10:42 AM, the surveyor again made the DON aware of the concern that Resident 1's pressure ulcer assessments did not include measurements, wound characteristics, identification of potential complications and no mention of possible infection. No additional information was provided. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396133	A. Building B. Wing	05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vibra Rehabilitation Center	707 Sheperdstown Rd Mechanicsburg, PA 17055

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, it was determined that the facility failed to maintain complete clinical records for one of 18 residents reviewed (Resident 1). Findings Include: Review of Resident 1's clinical record revealed she was admitted to the facility on [DATE], with diagnoses that included Type 2 Diabetes Mellitus (a chronic condition where the body either resists the effects of insulin or doesn't produce enough of it) and congestive heart failure (CHF-when the heart muscle doesn't pump blood as well as it should, leading to a backup of fluid in the lungs and body tissues). Review of Resident 1's TAR (treatment administration record) dated April 2026, revealed that on April 24, 2026, a treatment order was received for Resident 1's left elbow skin tear. The order stated to cleanse the left elbow skin tear with normal saline solution and then apply bordered gauze, every day shift. Review of Resident 1's clinical record, including progress notes, revealed no mention of how Resident 1 obtained the left elbow skin tear. Review of Resident 1's TAR dated May 2026, revealed that the treatment order to the left elbow skin tear was signed off as 5, meaning hold/see nurses note on the following days: May 3, 5, 6, 7, 8, and 9. On May 4, there was no documentation that the treatment was completed. Review of the corresponding eTAR progress notes revealed that on May 3, 5, 6, 7, 8 and 9, 2026, it was documented that Steri-Strips were in place. Review of Resident 1's clinical record revealed no documentation regarding when the Steri-Strips were placed and by whom. On May 21, 2026, at 4:21 PM, the facility provided a statement from the Nurse Practitioner, which stated that they put Steri-Strips on Resident 1's elbow. The statement further stated that Resident 1 had very fragile skin, and she told the Nurse Practitioner that she bumped it against the side table. Review of Resident 1's clinical record revealed no documentation that the Nurse Practitioner applied the Steri-Strips and when, and no documentation on how Resident 1 stated she obtained the skin tear. During an interview with the Director of Nursing on May 22, 2026, at 10:42 AM, no additional information was provided. 28 Pa Code 211.5(f)(ii)(iv)(ix) Medical records28 Pa Code 211.12(d)(1)(3)(5) Nursing services