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	06/04/2026

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 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 clinical record review and staff interview, it was determined that the facility failed to ensure that the care plan was reviewed and revised to reflect the resident's current status for one of seven residents reviewed (Resident 4). Findings Include: Review of Resident 4's clinical record revealed Resident 4 was admitted to the facility on [DATE], with diagnoses that included 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) and hypertension (elevated blood pressure). Review of Resident 4's admission nursing progress note, dated May 13, 2026, revealed the Resident was noted with a stage 2 pressure ulcer to the coccyx (tailbone). Review of Resident 4's facility form titled IDT admission Evaluation with Baseline Care Plan, dated May 13, 2026, revealed the Resident had a stage 2 pressure ulcer to the coccyx. Review of Resident 4's TAR, dated May 2026, revealed a treatment order, dated May 13, 2026, to cleanse the area with soap and water, pat dry, apply zinc oxide, every shift for stage 2 pressure ulcer. On May 24, 2026, the treatment order was changed from every shift to every four hours. Review of Resident 4's current care plan revealed a care plan dated May 17, 2026, stating I have potential/actual impairment to skin integrity of the (SPECIFY location) r/t [related to]. The care plan did not specify that Resident 4 had an actual pressure ulcer nor the location of the pressure ulcer. During an interview with the Director of Nursing on June 3, 2026, at 2:44 PM, the DON was made aware of the care plan concern for Resident 4. No additional information was provided. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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	06/04/2026

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **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 residents receive necessary treatment and services consistent with professional standards of practice for two of 7seven residents reviewed (Residents 1 and 7).Findings include: Review of Resident 1's clinical record revealed she was readmitted to the facility from the hospital on May 19, 2026, with diagnoses that included pressure ulcer of sacral region stage 3 (injury to the skin and underlying tissue caused by prolonged pressure on the skin), hypertension (HTN- persistent high blood pressure), and weakness. Review of Resident 1's IDT admission Evaluation with Baseline Care Plan assessment revealed it was signed by the Director of Nursing (DON) on May 31, 2026. The assessment noted Resident 1 had a pressure ulcer but did not note the measurements of the pressure ulcer. Review of Resident 1's nursing progress notes failed to reveal any notes or assessments related to her being readmitted to the facility or details surrounding her physical status on May 19 or 20, 2026. During an interview with the DON on June 3, 2026, at 11:56 AM, she revealed no one completed the admission assessment for Resident 1 when she returned from the hospital, so she completed it late on May 31, 2026. She further revealed she did assess Resident 1 upon her return from the hospital but did not write a note or complete the assessment at that time, and she did not measure Resident 1's pressure ulcer. She further revealed her expectation that admission assessments would contain wound measurements and be completed timely after admission or readmission. Review of Resident 1's physician orders revealed an order for Wound care- stage 3 sacrum- gently wash with wound cleanser normal saline apply xeroform every shift for impairment to sacrum, with a start date of May 22, 2026. Review of Resident 1's wound note from May 27, 2026, revealed The resident has a wound that has healed today. They will be discharged from wound care services. Please consult the wound care team as needed for alterations in skin. Continue preventative measures: repositioning schedule per protocol, incontinence management. During an interview with the DON on June 3, 2026, at 12:33 PM, she revealed Resident 1's treatment order to her sacrum should have been discontinued when her wound resolved and she was discharged from wound care on May 27, 2026. She further revealed she would expect the wound nurse's recommendations to be followed and treatment orders to be discontinued as indicated. Review of Resident 7's clinical record revealed Resident 7 was admitted to the facility on [DATE], with diagnoses that included Rheumatoid Arthritis (RA-a chronic autoimmune disorder where the immune system mistakenly attacks the lining of the joints) and chronic venous insufficiency (occurs when damaged vein walls and valves in the legs fail to efficiently return blood to the heart). Review of Resident 7's TAR for May 2026, revealed an order dated to start May 9, 2026, for wound VAC therapy (also known as negative pressure wound therapy-a medical device that uses gentle suction to accelerate the healing of complex, large, or slow-to-heal wounds) to right thigh wound, 100 mmHg negative pressure continuous (pressure setting for the wound VAC). Review of Resident 7's clinical record revealed that she went to an outside appointment on May 14, 2026, for a wound VAC dressing change. Resident 7 returned to the facility with orders to continue the wound VAC at 100 mmHg negative pressure continuously and to return on May 21, 2026, for another wound VAC change, and to send wound VAC supplies with for the next appointment. Review of Resident 7's wound center consult dated May 21, 2026, revealed that Resident's wound cannister was not changed appropriately. The consult stated that the cannister should have been changed earlier that morning but wasn't and was not functioning since 5:00 AM. Review of Resident 7's progress notes revealed a note written by Resident 7's provider, on May 22, 2026, copying the wound care note from the wound consult provider from May 21, 2026. The note stated that Resident 7 presented for a wound VAC change. The Resident's canister was full that morning at 5:00 AM and instead of replacing the wound VAC canister at the nursing home, they just disconnected it. Resident then presented at 3:00 PM with suction off for 10 hours. Review of Resident (continued on next page)

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	06/04/2026

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7's progress notes revealed no nursing progress note regarding the wound VAC being turned off or disconnected, and no evidence that the provider was made aware that the wound VAC was turned off or disconnected. Review of Resident 7's TAR dated May 2026, revealed that on day shift on May 21, 2026, the wound VAC was signed off as running continuously at 100 mmHg negative pressure. During an interview with the DON on June 3, 2026, at 11:00 AM, she stated that the replacement canister for the wound VAC was not at the facility, so it wasn't changed. She stated Resident 7's wound VAC was different than what the facility usually uses. She stated that extra canisters were allegedly delivered but stated nobody could find them. The DON provided a medical equipment delivery ticket for Resident 7's wound VAC supplies, with a delivery date of May 21, 2026. The ticket was not timed. During an interview with the DON on June 3, 2026, at 2:48 PM, the DON stated that Resident 7's wound VAC canisters needed to be changed once or twice a day. The surveyor requested the date that the canisters were actually ordered. As of June 4, 2026, at 1:15 PM, no purchase order or other evidence was provided to the surveyor showing when the additional wound VAC canisters and other supplies were actually ordered for Resident 7. 28 Pa. Code 211.12(d)(1)(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	06/04/2026

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 - 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 interviews, it was determined that the facility failed to ensure that residents receive necessary treatment and services, consistent with professional standards of practice, to promote healing of a pressure ulcer for three of four residents reviewed for pressure ulcers (Residents 1, 2 and 4), which resulted in actual harm for Resident 2 as evidenced by increased size and surface area of the pressure ulcer.Findings Include: During an interview with the Director of Nursing (DON) on June 3, 2026, at 2:41 PM, it was revealed that the facility does not have a pressure ulcer policy. Review of Resident 1's clinical record revealed she was readmitted to the facility from the hospital on May 19, 2026, with diagnoses that included pressure ulcer of sacral region stage 3 (injury to the skin and underlying tissue caused by prolonged pressure on the skin), hypertension (HTN- persistent high blood pressure), and weakness. Review of Resident 1's hospital records revealed Pressure Injury Prevention Recommendations: Turn patient every 2 hours when in bed (use pillows or wedges) and every one hour when in the chair, dated May 18, 2026. Review of Resident 1's physician orders revealed that the order for Turn and reposition every 2 hours was not started until June 3, 2026. Review of Resident 1's comprehensive care plan revealed a focus area for her pressure ulcer with an intervention for follow facility protocols for treatment of injury. Review of Resident 1's wound note from May 20, 2026, revealed The patient has the following risk factors that affect wound healing: Advanced age, fecal incontinence, generalized weakness, HTN, inability to position self, reduced mobility, risk of pressure ulcer formation, urinary incontinence. The following plan is in place to address these factors: Frequent education, heel offloading, medical management per the primary team, offload pressure per facility protocol, turn and reposition. Review of Resident 1's wound note from May 27, 2026, revealed The resident has a wound that has healed today. They will be discharged from wound care services. Please consult the wound care team as needed for alterations in skin. Continue preventative measures: repositioning schedule per protocol, incontinence management. During an interview with the DON on June 3, 2026, at 12:33 PM, she revealed the turning and repositioning order should have been entered earlier, consistent with her hospital recommendations, and she would expect the wound nurse's recommendations to be implemented timely. Review of Resident 2's clinical record revealed Resident 2 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 atrial fibrillation (AFib- an irregular and often very rapid heart rhythm). Review of Resident 2's nursing progress notes revealed an admission note on May 15, 2026, stating that Resident 2 has a stage 2 pressure ulcer (partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer) to the left buttock. Further review of the note revealed no nursing assessment of the pressure injury to include measurements, description of the pressure ulcer's characteristics, progress toward healing or identification of potential complications, and no mention if infection was present. Review of Resident 2's facility form titled IDT admission Evaluation with Baseline Care Plan, dated May 15, 2026, revealed Resident 2 was documented as having a stage 2 pressure injury to the sacrum and an unstageable scabbed area to the right buttock. Further review of the form revealed no assessment of the pressure ulcer to include measurements, description of the pressure ulcer's characteristics, progress toward healing or identification of potential complications, and no mention if infection was present. Review of Resident 2's MAR (medication administration record) and TAR (treatment administration record), dated May 2026, revealed no treatment orders were put into place for the pressure ulcer upon admission to the facility. On May 20, 2026, Resident 2 was seen by the facility's wound consultant. Review of the consult revealed Resident 2 had a stage 2 pressure ulcer to the sacral area and it was present on admission to the facility. Measurements of the area were 1 cm (centimeter) x 0.2 cm x 0 cm, with a calculated surface area of 0.2 sq (square) cm. Further review of the consult revealed treatment (continued on next page)

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	06/04/2026

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 - Actual harm Residents Affected - Few	recommendations to cleanse the area with soap and water and pat dry, apply zinc oxide paste to periwound and base of the wound, leave open to air, every shift and as needed. Review of Resident 2's physician orders and MAR and TAR for May 2026, revealed the recommended treatment was not ordered and no other orders were placed for treatment of Resident 2's pressure ulcer. Review of Resident 2's wound consultant note, dated May 27, 2026, revealed the pressure ulcer to the sacral area had increased in size. Measurements were 1.5 cm x 1.1 cm x 0 cm with a calculated area of 1.65 sq cm. Treatment recommendation was the same recommendation from the prior visit on May 20, 2026, which was never implemented. On May 27, 2026, treatment orders were placed for Resident 2, per the recommendations from the wound consultant. During an interview with the DON on June 3, 2026, at 2:41 PM, she stated that she would expect that wound care recommendations be followed and implemented. The facility failed to implement wound care orders for Resident 2's pressure ulcer and failed to implement wound care orders per recommendation from the wound consultant. Resident 2 had no assessment of his pressure ulcer until May 20, 2026, and no treatment orders for the stage 2 pressure ulcer from May 15 through May 27, 2026. Wound assessment on May 27, 2026 revealed the pressure ulcer had grown in size since May 20, 2026, when no treatment was in place. Review of Resident 4's clinical record revealed Resident 4 was admitted to the facility on [DATE], with diagnoses that included 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) and hypertension. Review of Resident 4's admission nursing progress note, dated May 13, 2026, revealed the Resident was noted with a stage 2 pressure ulcer to the coccyx (tailbone). Further review of the note revealed no nursing assessment of the pressure injury to include measurements, description of the pressure ulcer's characteristics, progress toward healing or identification of potential complications, and no mention if infection was present. Review of Resident 4's facility form titled IDT admission Evaluation with Baseline Care Plan, dated May 13, 2026, revealed the Resident had a stage 2 pressure ulcer to the coccyx. Further review of the form revealed no assessment of the pressure ulcer to include measurements, description of the pressure ulcer's characteristics, progress toward healing or identification of potential complications, and no mention if infection was present. Review of Resident 4's TAR, dated May 2026, revealed a treatment order, dated May 13, 2026, to cleanse the area with soap and water, pat dry, apply zinc oxide, every shift for stage 2 pressure ulcer. On May 24, 2026, the treatment order was changed from every shift to every four hours. Review of Resident 4's provider note, dated May 23, 2026, revealed stage 2 pressure ulcer was noted over the sacral area, no drainage or infection noted. The note further stated that the assessment and plan would include wound care monitoring per nursing protocol and monitor for progression or signs of infection. The note did not include wound measurements or description of the pressure ulcer's characteristics. Review of Resident 4's provider note, dated May 26, 2026, revealed the pressure ulcer was not reassessed in detail on this date. Review of Resident 4's provider note, dated June 2, 2026, revealed the pressure ulcer was noted to be improving with ongoing wound care and better nutritional intake and there were no signs of infection. The note did not include measurements of the pressure ulcer or a description of the ulcer's characteristics. Review of Resident 4's clinical record from admission on [DATE] through June 3, 2026, revealed no assessments of the pressure ulcer to include measurements or description of the pressure ulcer's characteristics. In an email correspondence from the DON on June 4, 2026, at 9:48 AM, she stated that Resident 4 was not seen by the outside wound consultant provider. She stated the family was deciding between hospice and further care so the facility held off a week to see if she would rebound. In a follow up email from the DON on June 4, 2026, at 1:06 PM, she stated that Resident 4's treatment order was changed on May 24, 2026, to every four hours because that is what it originally was supposed to be but there was a transcription error and it was put in initially as every shift. No additional information was provided. 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	06/04/2026

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **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 its residents are free of any significant medication errors for two of seven residents reviewed (Residents 2 and 5). Findings include: Review of Resident 2's clinical record revealed Resident 2 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 atrial fibrillation (AFib- an irregular and often very rapid heart rhythm). Resident 2 also had a history of a liver transplant and kidney transplant. Review of Resident 2's physician orders revealed an order, dated to start May 16, 2026, for Tacrolimus (an immunosuppressant medication that prevents the body from rejecting transplanted organs) ER (extended release) oral tablet 4 mg (milligrams), give one tablet in the morning for kidney transplant, give with 2 mg to equal 6 mg. Further review of Resident 2's physician orders revealed an order, dated to start May 16, 2026, for Tacrolimus 1 mg, give 2 mg by mouth in the morning for kidney transplant, give with 4 mg to total 6 mg. Review of Resident 2's MAR (medication administration record), dated May 2026, revealed that on May 17, 18, 19, and 20, the 4 mg Tacrolimus and 2 mg Tacrolimus were signed off as 5, meaning hold/see progress note. Review of the corresponding eMAR progress notes revealed the following: May 17- Medication not available, awaiting pharmacy's delivery; May 18- on order; May 19- on order; May 20- do not have from pharmacy. Review of Resident 2's clinical record revealed no evidence that the provider was made aware that Resident 2 did not receive his Tacrolimus on May 17, 18, or 19, 2026. Review of Resident 2's nursing progress note dated May 20, 2026, at 3:51 PM, revealed the nurse spoke with Resident 2's family member who would bring in his Tacrolimus on May 21, 2026. Review of Resident 2's MAR revealed he received his Tacrolimus on May 21, 2026, and everyday thereafter for the duration of his admission. Review of Resident 2's provider note, dated May 20, 2026, revealed that the provider was informed that the Resident had not received his Tacrolimus since admission due to medication availability issues. The provider note stated that the medication should be resumed as soon as possible to reduce the risk of transplant complications. The provider also contacted Resident 2's transplant team who recommended the medication should be resumed immediately at his previous dose and a Tacrolimus level should be obtained in one week for monitoring. Review of Resident 2's Tacrolimus level on May 26, 2026, was 9.5 (target level is listed as 5-20). During an interview with the Director of Nursing (DON), on June 3, 2026, at 11:05 AM, she stated that the Resident's family was supposed to bring the medication in. The surveyor asked why it wasn't documented that the wife was to provide the medication but was instead documented that it was not available from pharmacy. DON was also asked how the staff would know that the wife was to provide the medication, as it was not ordered that way and there was no documentation in the clinical record to indicate that. No answer was given to those questions. In a follow up interview with the DON on June 3, 2026, at 12:33 PM, she stated that staff told the family to bring in the medication, but facility was unable to provide documentation of that. In a final interview with the DON on June 3, 2026, at 2:42 PM, she confirmed that staff did not promptly notify the provider of Resident 2's missed medication and stated that is why they were given a write up. Review of Resident 5's clinical record revealed diagnoses that included presence of cardiac pacemaker (a medical device that helps regulate the heart's rhythm by sending electrical impulses to the heart muscle, ensuring it beats at a normal rate) and atrial fibrillation (irregular heart rhythm). Review of Resident 5's clinical record revealed a pharmacy recommendation on May 22, 2026, to increase her anticoagulant medication (apixaban) to twice a day and to review the black box warning (warning designed to alert health care providers and patients to serious, life-threatening, or permanently disabling risks associated with the drug's use, should an adverse reaction occur) associated with her heart rhythm disorder medication. The recommendation sheet was signed that the physician reviewed the black box warning and was in agreement with the (continued on next page)

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	06/04/2026

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	recommendation to increase her apixaban on May 25, 2026. Review of Resident 5's physician orders revealed an order for Apixaban Oral Tablet 2.5 MG, Give one tablet by mouth two times a day for blood clot [prevention], with a start date of May 25, 2026. Review of Resident 5's May MAR revealed it was blank for four administrations, indicating the medication was not administered as ordered between May 25-27, 2026. Review of Resident 5's clinical record failed to reveal any indication as to why the medication was not administered as ordered. During an interview with the DON on June 3, 2026, at 12:33 PM, she revealed the apixaban was not administered during those times because there were warnings for interactions with her other medications, but there should have been notation in the clinical record that was the reason why it was held. She further revealed her expectation that staff would indicate in the clinical record that they are holding a medication and why it is being held, and communicate with the physician for clarification. 28 Pa. Code 211.2(d)(3) Medical Director28 Pa Code 211.9(a)(1) Pharmacy Services28 Pa. Code 211.12(d)(3)(5) Nursing services