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	06/15/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on clinical record review, review of select facility documents, and staff interviews, it was determined that the facility failed to provide adequate supervision and interventions to prevent accidents for one of 10 residents reviewed (Resident 5). Findings Include: Review of Resident 5's clinical record revealed diagnoses that included hypertension (high blood pressure) and depression. Review of Resident 5's fall care plan revealed a care plan, dated May 30, 2026, stating that Resident 5 was a high risk for falls related to impulsiveness. Review of Resident 5's ADL (activities of daily living) care plan revealed an intervention, dated May 30, 2026, stating that Resident 5's transfer status was a two moderate assist related to impulsiveness and unsteadiness. Review of Resident 5's incident report, dated June 9, 2026, revealed that at approximately 4:10 AM, Employee 1 (Nurse Aide) was assisting Resident 5 to the bathroom, after Resident 5 activated her call bell for toileting assistance. The incident report further stated that, per nurse aide report, Resident 5 was transferred to a wheelchair and transported to the bathroom doorway. The bathroom door was partially closed and the nurse aide instructed the Resident to wait while the nurse aide opened the door. The report stated that as soon as the door was opened, Resident 5 attempted to propel herself into the bathroom and immediately fell forward, landing face down with her hands extended. Review of Employee 1's witness statement, dated June 9, 2026, revealed that Resident 5 rang her call bell to use the bathroom. Employee 1 went into the room to help her to the bathroom. The bathroom door was halfway open and Employee 1 stated she told Resident 5 to hold on while Employee 1 opened the door. Further review of the statement revealed that as soon as Employee 1 opened the door, Resident 5 tried to wheel herself into the bathroom and she fell on her face with her hands up. Based on review of the incident report and Employee 1's statement, there was no evidence that Employee 1 had a second assist to help transfer Resident 5 to her wheelchair, per Resident 5's care plan. Review of a witness statement from Employee 2, dated June 12, 2026, revealed that on that day, Employee 2 and another employee assisted Resident 5 to the toilet. As Employee 2 was waiting for Resident 5 to finish, the other employee left to answer call bells. Employee 2 then stated that Resident 5 grabbed the bar and Employee 2 transferred her to her wheelchair. Resident 5 was in her wheelchair as Employee 2 was zeroing the weight chair. Employee 2 stated she observed Resident 5 sliding off of her chair. Employee 2 stated she called for the nurse and they lowered Resident 5 to the floor. Based on review of Employee 2's statement, Employee 2 transferred Resident 5 from the toilet to her wheelchair without a second assist, per Resident 5's care plan. Review of Resident 5's clinical record revealed no documentation of the incident on June 12, 2026. During an interview with the Director of Nursing (DON), on June 15, 2026, at 12:35 PM, she stated that an incident report was not completed for the June 12, 2026, incident. She stated the change of plane was not considered a fall, since Resident 5 slid out of her wheelchair and it did not occur while she was being transferred. In a follow up interview with the DON on June 15, 2026, at 1:57 PM, she stated that Resident 5's care planned assist level should have been followed during her transfers. 28 Pa. Code 201.18(b)(1) Management28 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