

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  396133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/28/2025
NAME OF PROVIDER OR SUPPLIER  Vibra Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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 0607  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft.  (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

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Based on facility policy review, personnel file review, and staff interviews, it was determined that the facility failed to implement their written policies and procedures that prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property by failing to determine residency status in order to perform the accurate criminal history background checks prior to hire for five of five personnel files reviewed (Employees 9, 10, 12, 13, and 14); and failed to validate and verify licensure status for one of two nurse personnel files reviewed (Employee 10). Findings include: Review of facility policy, titled Abuse, Neglect and Exploitation, dated November 1, 2017, with a last review date of September 10, 2024, revealed Background, reference and credentials' checks should be conducted on employees prior to or at the time of employment by the Facility in accordance with applicable state and federal regulations. Review of Employee 9's personnel file revealed her hire date was June 3, 2025, and that a Pennsylvania State Criminal Background check was completed on May 29, 2025. Employee 9's personnel file review failed to reveal that her state residency status was verified in order to determine which criminal background check needed completed. Review of Employee 10's personnel file revealed her hire date was July 29, 2025, and that a Pennsylvania State Criminal Background check was completed on July 11, 2025. Employee 9's personnel file review failed to reveal that her Pennsylvania state residency status was verified in order to determine which criminal background check needed completed. Further review of Employee 10's file revealed that a copy of her Florida compact nursing license was present but failed to include that a license verification was completed to determine that the license was active and in good standing with no allegations of abuse, neglect, and exploitation of residents and misappropriation of resident property against it. Review of Employee 12's personnel file revealed her hire date was August 12, 2025, and that a Pennsylvania State Criminal Background check was completed on August 8, 2025. Employee 12's personnel file review failed to reveal that her state residency status was verified in order to determine which criminal background check needed completed. Review of Employee 13's personnel file revealed her hire date was May 2, 2025, and that a Pennsylvania State Criminal Background check was completed on April 28, 2025. Employee 13's personnel file review failed to reveal that her state residency status was verified in order to determine which criminal background check needed completed. Review of Employee 14's personnel file revealed her hire date was June 10, 2025, and that a Pennsylvania State Criminal Background check was completed on June 9, 2025. Employee 13's personnel file review failed to reveal that her state residency status was verified in order to determine which criminal background check needed completed. During a staff interview with Employee 4 (Human Resources Director) on August 27, 2025, at 11:10 AM, Employee 4 revealed that an applicant enters their information, which includes their addresses for the past 7 years into the database that the facility uses for hiring purposes. Employee 4 confirmed that no one at the facility has knowledge of the addresses that an applicant enters in order to determine whether a state or federal background check should be completed. Employee 4 indicated that she completes a state background check on all new hires. Employee 4 confirmed that she had no additional information to offer for Employees 9, 10, 12, 13, and 14. Employee 4 indicated that the corporate recruiter generally handles the licensure verification process. Employee 4 confirmed that she had no documentation to provide to show that Employee 10's nursing license had been validated or the status verified. During a staff interview with Employee 3 (Executive Director) and the Director of Nursing on August 27, 2025, at 1:37 PM, Employee 3 confirmed that the facility had no other information to offer for Employees 9, 10, 12, 13, and 14. Employee 3 indicated that the facility would review their processes. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1) Management. 28 Pa. Code 201.19(3) Personnel policies and procedures.</p>		

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<p>F 0637</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assess the resident when there is a significant change in condition</p> <p>Based on clinical record review and staff interviews, it was determined the facility failed to complete a comprehensive assessment after a significant change in condition for one of 13 residents reviewed (Resident 23). Findings include: Review of Resident 23's clinical record revealed diagnoses that included cerebrovascular disease (disease affecting blood flow to the brain), atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), and hypertension (high blood pressure). Further review of Resident 23's clinical record revealed that he was admitted to hospice services on July 7, 2025. Review of Resident 23's Minimum Data Set's (MDS- an assessment tool to review all care areas specific to the resident such as a resident's physical, mental or psychosocial needs) with the assessment reference date (last day of the assessment period) of July 21, 2025, revealed that the assessment was still in progress with three sections lacking completion. During a staff interview with Employee 5 (the Registered Nurse Assessment Coordinator) on August 27, 2025, at 2:12 PM, Employee 5 confirmed that the significant change MDS had not been completed timely. She indicated that she had just completed and submitted it that day. During a staff interview with the Director of Nursing on August 27, 2025, at 2:25 PM, she confirmed that the MDS should have been completed timely. 28 Pa Code 211.12(d)(1)(5) Nursing services</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on facility policy review, clinical record review, observations, and resident and staff interviews, it was determined that the facility failed to ensure care and services were provided in accordance with professional standards of practice that met each resident's physical, mental, and psychosocial needs for one of 13 residents reviewed (Resident 49). Findings include: Review of facility policy, titled Negative Pressure Wound Therapy [wound vac], last reviewed on September 10, 2024, revealed, in part, Change dressings per physician orders and manufacturer guidelines. 13. Turn pump on: a. initiate negative pressure setting on the pump as ordered (-125 mm/HG [milliliters of mercury] is a typical default setting;]. b. Establish negative pressure setting (as ordered). Document the following in the resident's medical record: 1. The wound status at time of application of negative pressure. 2. The number of sponge pieces used in the wound dressing. 3. The negative pressure and time settings on the pump. 4. The resident's tolerance of the procedure. 5. The date and time of the dressing application/change. 6. The date and time negative pressure therapy was started and stopped. 7. The name and initials of the person performing the procedure. Review of facility policy, titled Changing the Needleless Connection Device and Extension Tubing, last reviewed on September 10, 2024, revealed, in part, 4. Change needless connection device with each dressing change and after blood draws as needed. 5. For multi-lumen catheters, change needleless connection device every 7 days for lumens not in use. Documentation 1. Document on treatment kardex when procedure was done. Review of Resident 49's clinical record revealed diagnoses that included acute and subacute endocarditis (a life-threatening inflammation of the inner lining of the heart's chambers and valves usually caused by an infection) and cellulitis (skin infection) of the chest wall. Review of Resident 49's physician orders revealed the following order: Wound vac therapy to left upper chest surgical wound continuous at 75mm/HG every shift document amount of drainage, dated August 17, 2025; and IV [intravenous]site - Change dressing once weekly and PRN [as needed]. Measure extending line and check for displacement. If more than 1 cm, notify physician for further orders dated August 25, 2025. Further review of Resident 49's physician orders failed to reveal an order for the frequency of his wound vac dressing changes or needless connection device changes. Review of Resident 49's progress notes revealed a note dated August 18, 2025, at 8:24 PM, which indicated NPWT (Negative Pressure Wound Therapy) placed at 125, no leaks, currently charging, explained to patient about charging overnight, patient acknowledged that he understood the wound vac. The note failed to include the wound status at time of application of negative pressure, the number of sponge pieces used in the wound dressing, the time setting on the pump, or the resident's tolerance of the procedure. Review of Resident 49's progress notes revealed a note dated August 22, 2025, at 9:38 AM, which indicated Wound vac was changed per orders. Area is 5.0cm L by 2.5cm W. Wound bed is 90% granulation. There is a very light layer of about 10% slough at the very top of the wound. Resident denies pain to the area. Wound vac is currently plugged in, and he was encouraged to take the charger to dialysis with him. Vitals are stable this morning. The note failed to include the number of sponge pieces used in the wound dressing or the negative pressure and time settings on the pump. During an observation of Resident 49 on August 28, 2025, at 10:50 AM, with the Director of Nursing (DON), the DON indicated that the facility practice was to change wound vac dressings on Mondays, Wednesdays, and Fridays. Observation of Resident 49's dressing revealed that the dressing was not dated. During an immediate interview with Resident 49, he indicated that they did not change it last evening. He said, they changed it on Friday and Monday, but not yesterday. He further indicated that he was aware that the dressing was to be changed on Mondays, Wednesdays, and Fridays. Observation of Resident 49's wound vac pump on August 28, 2025, at 1:03 PM, with Employee 6 (Registered Nurse/Assistant Director of Nursing) revealed that Resident 49's wound vac pump was set on 125mm/HG, not the ordered 75 mm/HG. Review of Resident 49's progress notes failed to reveal any other documentation of his wound vac dressing changes or any documentation of the needless connection device changes or baseline measurement of the extending line of the central IV line. Review of Resident 49's August 2025 Medication and Treatment Administration Records failed to reveal any documentation of wound vac dressing changes on August 20, 25, or 27, 2025; any needless connection device changes; or any measurements of the extending line of the central IV line. During a staff interview with Employee 6 on August 28, 2025, at 2:05 PM, Employee 6 indicated that when she researched the setting on Resident 49's wound vac pump, she saw that the DON had addressed the wound vac pump setting that morning with Resident 49's physician because staff cannot change the pump settings as the pumps are pre-programmed.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>Based on observations, staff interview, and facility policy review, it was determined that the facility failed to store drugs and biologicals in accordance with accepted professional standards for one of one medication carts observed (300/400 hall medication cart). Findings include: Review of facility policy, titled Medication Storage; Storage of Medication, last reviewed September 10, 2024, revealed subsection 12 stated, Insulin products should be stored in the refrigerator until opened. Note the date on the label for insulin vials and pens when first used. During observation of the 300/400 medication cart on August 27, 2025, at approximately 10:00 AM, revealed that an insulin pen for Resident 19 had been opened and previously used with no open date written on the pen. During the observation, it was revealed that the medication cart contained a manufacturer's box of single-use polyvinyl alcohol 1.4% eye drop applicators. Review of the single-use eye drop applicators and the box that they were contained in revealed that the lot number (number assigned to a manufactured good to allow for tracking and identification of a specific manufactured good in the case of a recall) on the box did not match the lot number printed on the individual single-use eye drop applicators. The observations above were confirmed in the presence of the Director of Nursing (DON) on August 28, 2025, at approximately 9:30 AM. During a staff interview on August 27, 2025, at approximately 1:20 PM, the DON confirmed that insulin pens should be labeled with a date when they are opened. Further, medications should be stored in their original manufacturer's container and should not be placed in separate containers which have different lot numbers. 211.12(d)(1)(3)(5) Nursing services</p>		

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<p>F 0808</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law.</p> <p>Based on observations, clinical record review, and resident and staff interviews, it was revealed that the facility failed to ensure that five of 20 residents reviewed during meal service received a therapeutic diet per physician order (Residents 17, 19, 22, 40, and 59). Findings include: Clinical record reviews for Residents 17, 19, 22, 40, and 59 revealed diagnoses that included diabetes mellitus (the body's ability to produce or respond to the hormone insulin is impaired, resulting in abnormal metabolism of carbohydrates and elevated levels of glucose in the blood and urine) and physician orders for a no concentrated sweets diet. During an interview with Resident 40 on August 26, 2025, at 9:50 AM it as revealed she is diabetic and feels the meals are carbohydrate heavy. A review of the diet spreadsheet for August 27, 2025, (day 23 of the Spring/Summer menu 2025) lunch meal revealed the no concentrated sweet diet (liberal diabetic diet) were to be served fruit cup in place of the pudding for dessert. Observation of tray line on August 27, 2025, at 12:05 PM, revealed Residents 17, 19, 22, 40, and 59 were ordered a no concentrated sweets diet and were served pudding vice fruit cup. The surveyor confirmed with Employee 2 (Food Service Director) on August 27, 2025, at 12:15 PM, that the Residents that ordered a no concentrated sweets diet were to be served fruit cup in place of the pudding. At that time, the pudding was removed from the aforementioned Resident's trays and a fruit cup was provided. Interview with the Employee 3 (Executive Director) on August 28, 2025, at 2:30 PM, revealed residents should be served the physician ordered diet. Pa code 211.6(a) - Dietary Services</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Based on observations, review of facility policy, and staff interviews, it was determined that the facility failed to store and serve food/beverages in accordance with professional standards for food safety in the kitchen, in one of two nourishment centers (300/400 pantry), and in the creamery (an accessible lounge area). Findings include: Review of facility policy, Food Safety Requirements, not dated, read, in part, keep foods covered or in a tight container; and label, date and monitor foods to ensure they are utilized by the use-by date or frozen or discarded. Review of facility policy, Use and Storage of Food Brought in by Family or Visitors, not dated, read in part, all food items brought into the facility must be labeled with content and dated. Review of facility policy, Ice machines and Portable Ice Carts, revised and implemented August 27, 2025, read, in part, it is the policy of the facility to ensure that ice machines are clean and maintained. Ice machines will be cleaned at a frequency specified by the manufacturer. Review of manufacturer use and care guide, page 10, read, in part, maintenance should be completed on a semi-annual basis or more based on usage and location. Observation in walk-in freezer on August 25, 2025, at 6:17 PM, revealed a tray of muffins and 1/3 tray of marble cake open covered in plastic wrap with no date. Observation in walk-in refrigerator on August 25, 2025, at 6:15 PM, revealed feta cheese and mozzarella cheese open and not dated. Observation in dry storage on August 25, 2025, at 6:18 PM, revealed 1 bag ziti, 1 bag golden raisin, and 1 bag granola open, covered in plastic wrap, not dated; and 1 box chocolate chip gluten free cookies open and not securely closed in a box with other gluten free items dated 6/23. Observation in the main kitchen on August 25, 2025, at 6:23 PM, revealed one bulk bin of onions, not dated. Observation on the shelf above the 3-compartment sink on August 25, 2025, at 6:25 PM, revealed four individually wrapped sugar cookies, not dated. Observation in the creamery on August 25, 2025, at 6:28 PM, revealed a damp white towel with brown liquid marks was visible under the sink. The drip shield inside the ice machine contained a black moist substance along the bottom edge that was able to be wiped away with a paper towel. Observation in the 300 /400 nourishment center refrigerator on August 25, 2025, at 6:30 PM, revealed one vanilla might shake, thawed and not dated, with a thaw or use by date (product is to be utilized within 14 days once thawed); clear liquid on the bottom of the inside of the refrigerator; and 1 Styrofoam container of buffalo wings and celery without a resident identifier and not dated. Interview with Employee 11 (Food service Supervisor) on August 25, 2025, at 6:18 PM, revealed the aforementioned items should be securely closed and date marked when opened. Interview with Employee 2 (Food Service Director) on August 27, 2025, at 11:34 AM, it was revealed the aforementioned items should be securely closed and date marked once opened. Review of the most recent facility provided ice machine service contract documentation dated October 31, 2024, revealed preventive maintenance was completed on the kitchen ice machine. There was no documentation for preventive maintenance on the ice machine in the creamery. Observation and interview with Employee 3 (Executive Director) on August 28, 2025, at 9:36 AM, it was revealed that the ice machine in the creamery is utilized by staff to obtain ice for the residents. The drip shield on the inside of the ice machine contained a moist black substance that was able to be wiped away with a paper towel. Employee 3 confirmed that the ice machine needed to be cleaned. It was also revealed that the contracted service on the ice machine was last completed October 31, 2024, and service should've been performed in April 2025. The contract company was contacted and service was scheduled for September 2, 2025. Employee 3 moved the towel from underneath the sink, a water mark stained the flooring, and stated he would contact maintenance regarding the sink. Observation in the creamery on August 28, 2025, at 10:30 AM, revealed the towel remained under the sink and the ice machine drip shield remained soiled. Interview with the Employee 3 on August 28, 2025, at 2:30 PM, revealed food items should be date marked once opened or pulled from the freezer, resident items should be labeled with a resident identifier and date marked, and ice machines should be cleaned bi-annually or as needed. 28 Pa code 211.6(f) - Dietary Services</p>		

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<p>F 0837</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility.</p> <p>Based on facility documentation review and staff interview, it was determined that the facility failed to ensure that the governing body was responsible and accountable for the facility Quality Assurance Performance Improvement (QAPI) program. Findings include: Review of the facility Quality Assurance Performance Improvement (QAPI) Plan undated indicated the following, in part, VibraLife's governing body is ultimately responsible for overseeing the QAPI committee. The owner/president has direct oversight responsibility for all functions of the QAPI Committee and reports directly to the governing body. The QAPI Committee, which includes the medical director, is ultimately responsible for assuring compliance with federal and state requirements and continuous improvement in quality of care and customer satisfaction. Review of QAPI attendance sign-in sheets for January-March 2025, failed to reveal that the facility Medical Director (MD) or the Nursing Home Administrator (NHA) attended any of the monthly meetings in the quarter. Review of QAPI attendance sign-in sheets for April-June 2025, failed to reveal that the facility MD or NHA attended any of monthly meetings in the quarter. Review of a Memorandum with the Subject of Administrator Coverage dated August 12, 2024, provided by Employee 3, revealed that the designated Administrator of Record (NHA) had appointed Employee 3 as the full-time, permanent administrator on-site. The memorandum further indicated, in part, that the Administrator of Record remains actively engaged with facility operation; his office is located just three miles from the facility, enabling him to be on-site daily as needed; and that the NHA and Employee 3 communicate regularly, ensuring that all operational aspects are aligned with both state regulations and corporate objectives. This memorandum was signed by both the Administrator of Record and Employee 3 on October 17, 2024. During a staff interview with Employee 3 (Executive Director), the Director of Nursing, and Employee 6 (Assistant Director of Nursing) on August 28, 2025, at 2:49 PM, Employee 3 confirmed that although he is not the NHA, he has attended the QAPI meetings. Employee 3 further indicated that the NHA is also the Vice-President of Operations for the company that owns the facility and, in that capacity, also serves as part of the governing body. Employee 3 confirmed that the facility's NHA nor the MD have attended the QAPI meetings January through June 2025. Employee 3 indicated that he communicates via phone with the NHA at least twice a week, and often daily, but confirmed that he does not necessarily discuss or send QAPI minutes to him to review nor does he remind him to read meeting minutes in the facility electronic database even though the NHA also serves as a member of the governing body. Employee 3 was unable to provide any written documentation between him and the NHA/governing body in correlation to QAPI or ensuring that the MD attends the QAPI meetings. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1)(3) Management.</p>		

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<p>F 0868</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Have the Quality Assessment and Assurance group have the required members and meet at least quarterly</p> <p>Based on review of the facility provided attendance sign-in sheets for the facility's Quality Assurance Performance Improvement (QAPI) Committee and staff interview, it was determined that two of the required members failed to attend at least one meeting in two out of three quarters. Findings include: Review of QAPI attendance sign-in sheets for January-March 2025, failed to reveal that the facility Medical Director or the Nursing Home Administrator (NHA) attended any of the monthly meetings in the quarter. Employee 3 (Executive Director) had signed as the NHA. Review of QAPI attendance sign-in sheets for April-June 2025, failed to reveal that the facility Medical Director or the NHA attended any of monthly meetings in the quarter. Employee 3 had signed as the NHA. During a staff interview with Employee 3, the Director of Nursing, and Employee 6 (Assistant Director of Nursing) on August 28, 2025, at 2:49 PM, Employee 3 confirmed that he is not the NHA, and that the facility's NHA nor the Medical Director had attended the QAPI meetings. He further indicated that he communicates via phone with the NHA at least twice a week and most of the time daily, but confirmed that he does not necessarily send QAPI minutes to him to review. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1)(3) Management.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  396133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/28/2025
NAME OF PROVIDER OR SUPPLIER  Vibra Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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.			
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Based on review of facility policy, clinical record review, observations, and resident and staff interviews, it was determined that the facility failed to establish Enhanced Barrier Precautions (EBP) and maintain an infection prevention and control program designed to provide a safe and sanitary environment to help prevent the development and transmission of communicable diseases and infections on two of two nursing units; and failed to maintain an effective infection control program related to the administration of medications for one resident observed during medication administration observation (Resident 63). Findings include: Review of facility policy, Enhanced Barrier Precautions (EBP), effective 2024 and revised 2024, read, in part, EBP are indicated for residents with any of the following: infection or colonization with a CDC [Center for Disease Control] targeted MDRO when Contact Precautions do not otherwise apply; or wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO. Chronic wounds include unhealed surgical wounds, and venous stasis ulcers. Indwelling medical device examples include central lines, urinary catheters, feeding tubes, and tracheostomies. A short-term peripheral intravenous line (PIV) is not considered an indwelling medical device for the purpose of EBP. EBP should be used for any residents who meet the above criteria, wherever they reside in the facility. For residents for whom EBP are indicated, EBP is employed when performing the following high-contact resident care activities: dressing, bathing, transferring, providing hygiene, changing linens, device care or use: central line, urinary catheter, feeding tube, trach/ventilator, wound care: any skin opening requiring a dressing. Review of Resident 40's clinical record review documented diagnoses that included urinary tract infection. Interview with Resident 40 on August 26, 2025, at 9:50 AM revealed she received an intravenous antibiotic for a urinary tract infection, and it finished on August 25th, 2025. Surveyor observed empty medication bags hanging from the intravenous (IV) pole. No enhanced barrier precaution signage or Personal Protective Equipment (PPE- masks, gowns, gloves) were readily visible near Resident 40's room. Further clinical record review documented physician orders that included: place midline (peripheral catheter longer than a standard IV positioned in the vein of the upper arm near the armpit) for IV antibiotic one time, started August 15, 2025; normal saline 10 ml intravenously every shift for midline maintenance, started August 15, 2025, and discontinued August 27th, 2025; Zosyn intravenous 100 ml every 6 hours for 10 days, started August 15, 2025, and discontinued August 25th, 2025, at 2:00 PM. Review of Resident 40's August 2025 medication and treatment administration record documented the aforementioned physician orders were administered. No enhanced barrier precaution signage or Personal Protective Equipment (PPE- masks, gowns, gloves) were readily visible Review of Resident 46's clinical record documented diagnoses that included lumbar spine incision wound care, osteomyelitis (bone infection) of vertebra. Further clinical record review documented physician orders that included: Cefepime 2 gram intravenously every 8 hours, started August 19, 2025, discontinued September 26, 2025; heparin injection 5000 units subcutaneously two times a day for clot prevention, started August 25, 2025; IV Site - Change dressing once weekly and as needed every Tuesday on day shift and measure extending line and check for displacement - if more than 1 cm notify physician for further orders, started August 26, 2025; lumbar spine incision - keep dressing in place and monitor for increase redness, swelling, drainage daily on day shift - notify provider, started August 20, 2025. Progress note dated August 19, 2025, at 5:33 PM, read, in part, PICC line right upper extremity. Further review of progress notes documented the weekly sterile PICC dressing change was completed on August 26th, 2025, at 6:35 PM. Review of Resident 46's August 2025 medication and treatment administration record documented the aforementioned physician orders were administered. No enhanced barrier precaution signage or Personal Protective Equipment (PPE- masks, gowns, gloves) were readily visible. Review of Resident 47's clinical record documented diagnoses that included fracture right ulna (thin bone in the forearm) and retention of urine. Further clinical record review documented physician orders that included: Foley Catheter 16 FR 10 ml balloon for (urine retention), revised August 20, 2025; foley catheter care every shift and as needed- soap and water cleanse at meatus and down catheter tubing every shift, started August 24, 2025; foley catheter and drainage bag change as needed for infection, obstruction, or when the closed system is compromised as needed, started August 24, 2025. Review of Resident 47's August 2025 medication and treatment administration record documented catheter care was documented as completed August 20th through 27th, and the catheter was changed on August 24th. No enhanced barrier precaution signage or Personal Protective Equipment (PPE- masks, gowns, gloves) were readily visible Review of</p>		

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NAME OF PROVIDER OR SUPPLIER  Vibra Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  707 Sheperdstown Rd Mechanicsburg, PA 17055	
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<p>F 0947</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.</p> <p>Based on review of personnel training records and staff interviews, it was determined that the facility failed to ensure each nurse aide was provided with the required in-service training consisting of no less than 12 hours per year for one of five employee records reviewed (Employee 7); and failed to provide annual training that included dementia management for one of five employee records reviewed (Employee 8). Findings include: Review of personnel information revealed Employee 7's hire date was March 5, 2024. Review of her training record from August 29, 2024, through August 28, 2025, revealed that she had only completed 9.5 hours of annual training. Review of personnel information revealed Employee 8's hire date was May 21, 2024. Review of her training record from August 29, 2024, through August 28, 2025, revealed that she had not completed any dementia management training. During a staff interview with Employee 4 (Human Resources Director) on August 27, 2025, at 10:59 AM, she confirmed that Employee 7 did not complete the required training hours and that Employee 8 did not complete dementia training. During a staff interview with the Employee 3 (Executive Director), the Director of Nursing (DON), and Employee 6 (Assistant Director of Nursing) on August 28, 2025, at 2:18 PM, the DON confirmed that she would expect nurse aides to complete required training topics and to obtain a minimum of 12 hours of training per year. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1)(3) Management. 28 Pa. Code 201.19(7) Personnel policies and procedures. 28 Pa. Code 201.20(a)(d) Staff development.</p>		