STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396133	A. BLDG: 00 B. WING:	01/30/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
VIBRA REHABILITATION CENTER STATE LICENSE NUMBER: **22170201**	**707 SHEPHERDSTOWN ROAD** **MECHANICSBURG, PA 17055**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT Findings of an abbreviated survey completed on January 30, 2025, at Vibra Rehabilitation Center identified that the facility was not in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care and the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0000		
F 0600 SS=G		F 0600		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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F 0600 SS=G	Continued from page 1 483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by:	F 0600	1. The facility implemented quick and decisive action in accordance to our abuse policy upon abuse allegations from Resident 1 regarding Employee 1. Employee 1 was immediately suspended, and RN performed a skin check on Resident 1, the provider was notified, and statements were obtained. Within 24 hours the Department of Health was notified, the police department was notified and intent to press charges occurred; the Cumberland County Office of Aging was notified as well as the Pennsylvania Department of Aging. Resident 1 was immediately tended to by staff regarding his skin tears and first aide was administered appropriately. 2. The facility will continue to perform weekly skin checks on remaining residents, observe the grievance policy, and conduct routine care plan meetings in order to determine any other residents who may be at risk for similar issues. We did interview other residents on Employee 1 assignment and no other residents had complaints.	Completion Date: **02/10/2025** Status: **APPROVED** Date: **02/12/2025**

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F 0600 SS=G	Continued from page 2	F 0600	3. The facility provides annual mandatory abuse training to all staff with the most recent training having been completed in October of 2024. The facility conducted immediate retraining of all staff upon receiving the complaint of abuse and will increase the abuse training from annual to quarterly x 12 months to ensure all staff receive the appropriate training and understand such training. 4. The facility will continue to follow the abuse policy, will continue to perform background checks prior to hire, will continue to perform reference checks prior to hire, will continue to perform annual performance evaluations for all staff, will continue to monitor grievances submitted by residents and family for the potential for abuse, will continue to perform weekly skin checks of all residents, and will continue with routine care plan meetings with residents and family to ensure any indication of potential abuse is investigated and handled appropriately. The Director of	

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F 0600 SS=G	Continued from page 3	F 0600	Nursing or designee will review all grievances submitted to ensure appropriate investigation and follow up continue. The audits will include 5 random grievances weekly x 4 weeks then 5 random grievances monthly x 2 months. Findings will be discussed at QAPI. 5. Date of Compliance: 2/10/25.	

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F 0600 SS=G	Continued from page 4 Based on clinical record review, facility policy review, review of investigation documentation, as well and resident and staff interviews, it was determined that the facility failed to ensure that residents were free from abuse, resulting in actual harm as evidenced by skin tears, bruising, and mental anguish caused by rough treatment, for one of four residents reviewed (Resident 1). Findings include: Review of facility policy, "Abuse, Neglect and Exploitation", effective November 1, 2017, revealed, "Each resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation... Residents must not be subject to abuse by anyone, including, but not limited to; Facility staff, other residents, consultants, contractors, volunteers, or staff of other agencies, family members, legal guardians, friends or other individuals...The facility and its staff will:...not use verbal, mental, sexual or physical abuse, corporal punishment, or involuntary seclusion."	F 0600		

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F 0600 SS=G	Continued from page 5 Review of Resident 1's clinical record revealed diagnoses that included chronic congestive heart failure (weakness of the heart that leads to buildup of fluid in the lungs and surrounding body tissues) and B-cell lymphoma (a type of blood cancer that affects your lymphatic system). Review of Resident 1's care plan revealed that he had a self-care deficit and needed assistance with toileting. Further review of his care plan revealed that he had potential for bleeding complications related to use of anticoagulants (blood thinners), and that he was to be handled gently during care, positioning and transfers. Review of facility "Report Form for Investigation of Alleged Abuse, Neglect, Misappropriation of Property" revealed "On 1/26/25 [Employee 1], CNA [Certified Nurse Aide], was assigned to care for [Resident 1]. She took him to the bathroom and had difficulty getting him to stand after using the toilet. Per [Resident 1], [Employee 1] was rude to him, aggressive in her language, and kept grabbing	F 0600		

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F 0600 SS=G	Continued from page 6 him by the arm. Eventually [Employee 1] asked another CNA, [Employee 2], to come assist. [Employee 2] witnessed the mistreatment of [Resident 1] including verbal aggression and [Employee 1] grabbing him roughly by the arm. [Employee 2] intervened and asked [Employee 1] to calm down. Upon leaving the room [Employee 2] reported the event to the LPN [Licensed Practical Nurse] and the RN [Registered Nurse] supervisor. [Employee 1] was suspended pending investigation and a skin check was performed on [Resident 1]. He has bruising to his L [left] hand, a skin tear to his L inner forearm, and a skin tear to his L shin. All of this was reported to the MD [doctor] and first aide was administered." Review of Resident 1's witness statement, dated January 27, 2025, revealed, "The day before yesterday I had a lot of strength. Yesterday I had no energy. She [Employee 1] was shoving me around like a rag doll. She said I saw you up yesterday moving around. She jerked me around in the bathroom and said I'm not playing games."	F 0600		

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F 0600 SS=G	Continued from page 7 Review of Employee 2's witness statement, dated January 26, 2025, revealed, "Around 10 [Employee 1] asked me to help [Resident 1] in bathroom. She stated, 'he walked in fine yesterday' but today won't. When I went into the bathroom [Resident 1] was on toilet leaning she grabbed his left arm trying to put hand on rail couple times talking very rude and inappropriate. I told her to stop and tried to help him more gentle." During an interview with Employee 2 on January 30, 2025, at 12:20 PM, she revealed that on January 26, 2025, [Employee 1] asked her assist with getting Resident 1 up off of the toilet. Employee 2 stated that, while in the bathroom, Employee 1 was in front of Resident 1 "aggressively" pulling his left arm to place it on the rail next to the toilet for him to stand, but Resident 1's arm "was not even long enough" to reach the bar. Employee 2 reported that Resident 1 had three wrist bands on his left arm and Employee 1's hand was on top of the wrist bands when she was pulling his arm. Employee 2 stated	F 0600		

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F 0600 SS=G	Continued from page 8 she asked Employee 1 to stop pulling on Resident 1's arm, and repositioned him on the toilet so he was able to reach the rail. Employee 2 reported that Resident 1 was very weak and was having difficulty standing. Employee 2 stated that Employee 1 kept saying that Resident 1 was able to walk the day before, and seemed "really upset" that he couldn't walk to the bathroom when he did it the day before. Employee 2 stated that she felt the way Employee 1 talked to Resident 1 was not appropriate, and it was not the way someone should speak to another person. Employee 2 stated that once Resident 1 was in his wheelchair, they noticed he was bleeding on the underside of his wrist area. Employee 2 reported that the skin tear was approximately the size of one to two quarters, and bleeding was not present on Resident 1's wrist before the incident. Employee 2 stated that she reported the incident to Employee 5 (Licensed Practical Nurse [LPN]). Employee 2 and Employee 5 then put Resident 1 into bed. At that time they noticed blood on Resident 1's pant leg and found he had a skin tear on his left shin. Employee 2 stated that after the	F 0600		

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F 0600 SS=G	Continued from page 9 incident, Resident 1 seemed "scared and shook up." Employee 2 also reported that when she cared for Resident 1 later in the shift, she noticed that the top of his left hand was "black and blue." Review of Employee 5's witness statement dated January 26, 2025, revealed, "At 10 am I observed [Employee 1] walk out of [Resident 1's] room and ask [Employee 2] for help. As [Employee 2] came out of [Resident 1's] room and stood at the nurse's station she was shaking her head, I asked her what happened, [Employee 2] stated, 'She was too much, she was rough with him in the bathroom.' I asked [Employee 2] who. She stated [Resident 1]. I asked [Employee 2] if she asked [Employee 1] to stop. [Employee 2] said 'yes,' but she kept on saying 'you were fine yesterday and now acting like you can't move, I'm not playing these games today.' I went to assess the resident and observed him breathing heavily seated in his wheelchair beside his bed. I observed blood running down his left leg. I asked [Employee 2] to assist me getting the resident in bed, @ that time observed resident had sustained	F 0600		

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F 0600 SS=G	Continued from page 10 a skin tear to his left wrist. [Employee 2] stated, 'That's where she kept grabbing his hand and forcing him to grab the siderail/handrails.' I notified the RN [Registered Nurse] supervisor of the incident." Review of Employee 3's (RN supervisor) witness statement dated January 26, 2025, revealed, "This nurse called to [Resident 1's] room by LPN on duty. Resident stated he had rough care this am. Resident stated he did not feel safe with the accused caregiver caring for him. Resident was seen with a skin tear to L forearm and L shin. Resident's roommate stated accused caregiver was very rude and impatient. 2nd CNA present stated the accused caregiver was physically rough and short tempered with resident during care in the bathroom." During an interview with Employee 3 on January 30, 2025, at 10:38 AM, she reported that she went to assess Resident 1 after it was reported to her that he was mishandled by an employee. She stated that when she saw him, he was "distraught", shaking and could not catch his breath. Resident 1 told her that	F 0600		

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F 0600 SS=G	Continued from page 11 he did not feel safe with Employee 1, and that he felt he was "roughed around." Employee 3 stated that when she assessed Resident 1's skin tears, she found they were bleeding, and were nickel/quarter size (wrist) and dime size (shin). Employee 3 reported that Employee 5 cleaned up Resident 1's skin tears and applied steri-strips (surgical tape strips used to close small wounds). Employee 3 reported the incident to the on-call Assistant Director of Nursing (ADON) and sent Employee 1 home. During an interview with the ADON on January 30, 2025, at 11:11 AM, she reported that she became aware of the incident when it was reported to her on January 26, 2025, by Employee 3. She stated when she assessed Resident 1 on January 27, 2025, she noted the skin tears to his left wrist and shin were scabbed over. She also noted that the back of Resident 1's left hand was reddish-purple in color. She shared that when she questioned Resident 1 about the skin tear on his shin, he initially stated that Employee 1 kicked him, but then indicated that he	F 0600		

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F 0600 SS=G	Continued from page 12 was not sure exactly how it occurred. She noted that Resident 1 was slow and weak on that date, and ended up being sent to the hospital, where he was subsequently admitted, due to a decline in his condition. During an interview with Resident 2, Resident 1's roommate at the time of the incident, on January 30, 2025, at 11:55 AM, he revealed he was in the room at the time Employee 1 was providing care to Resident 1. Resident 2 stated that the curtain was partially pulled between the beds, but that he could hear the exchange and could see arms moving. Resident 2 reported that Employee 1 was "very sassy," and that he told Resident 1 after she left that she should not be working there. Resident 2 stated that he did not recall exactly what was said between Employee 1 and Resident 1 but that it was "hot and heavy", it was an angry exchange, and that in his opinion Employee 1 should be arrested because of the way she was acting and treating Resident 1. Review of Employee 1's witness statement dated	F 0600		

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F 0600 SS=G	Continued from page 13 January 26, 2025, revealed, "When I went to do care on [Resident 1] this morning he stated that he couldn't do anything due to his neck injury. I told him that that's what he told me yesterday as well and he walked to and from the bathroom all day yesterday. He wouldn't sit up in the bed until I did it for him and then stood in the bathroom to get on the toilet. Once on the toilet he kept sliding sideways and trying to put himself on the floor. I told him to sit up numerous times and went and got [Employee 2] to help stand him again and finish his care. We put him back into his w/c [wheelchair]." Review of training documentation revealed that Employee 1 received abuse prevention training on October 2, 2024. During an interview with the Director of Nursing on January 30, 2025, at 9:47 AM, she revealed that Resident 1 was hospitalized with sepsis (potentially life-threatening condition that arises when the body's response to infection causes injury to its own tissues and organs). She also revealed that Resident 1 had	F 0600		

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F 0600 SS=G	Continued from page 14 decided to press charges against Employee 1, Employee 1 was terminated, and that the facility was in the process of conducting abuse training with staff. During an interview with the Nursing Home Administrator on January 30, 2025, at 1:00 PM, he revealed the expectation that Employee 1 should have handled Resident 1 appropriately. The facility failed to ensure Resident 1 was free from abuse, resulting in actual harm as evidenced by skin tears, bruising, and mental anguish caused by rough treatment by Employee 1. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1)(e)(1) Management 28 Pa. Code 201.29(c) Resident rights	F 0600		

Certified End Page

VIBRA REHABILITATION CENTER

STATE LICENSE NUMBER: 22170201

SURVEY EXIT DATE: 01/30/2025

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeanne Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen MD
Debra L. Bogen, MD, FAAP
Secretary of Health

Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY