STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385280	A. Building B. Wing	09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lebanon Veterans Home	600 North 5th Street Lebanon, OR 97355

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview it was determined the facility failed to ensure medications were not expired for 2 of 4 sampled houses reviewed for medication storage. This placed residents at risk for altered medication effectiveness. Findings include: 1. On 9/5/25 at 3:03 PM, an open bottle of Prednisolone 1% eye drops was observed with Staff 19 (LPN) in the medication storage in room [ROOM NUMBER]. The bottle of Prednisolone had an open date which was unreadable and was dispensed on 6/13/25. Staff 19 stated eye drops were expired after being open for 30 days. On 9/5/25 at 3:05 PM, an open bottle of acetaminophen was observed with Staff 19 in the medication storage in room [ROOM NUMBER] which expired in 2/2025. Staff 19 stated medications were to be destroyed when they were expired. On 9/5/25 at 3:14 PM, two open insulin pens (an injection device that allows you to deliver preloaded insulin into the body) were observed with Staff 19 in the medication storage in room [ROOM NUMBER]. Both pens did not have an open date on them and were dispensed on 7/1/25. Staff 29 stated insulin pens were expired after being open for 28 days. On 9/5/25 3:19 PM, Staff 20 (RNCM) stated medications needed to be removed from medication storage when expired. Staff 20 stated eye drops were to be labeled when opened and discarded after 30 days. Staff 20 stated insulin pens were to be labeled when opened and discarded after 30 days. 2. During an observation of the resident medication storage cabinets in the [NAME] House 100 unit on 9/5/25 at 6:05 PM, the following was found in room [ROOM NUMBER]: - One box of Ondansetron 4mg tablets with an expiration date of 8/2025. On 9/5/25 at 6:05 PM, Staff 34 (LPN) acknowledged the expired medication and stated the expectation for resident medications was for nursing staff to remove and replace medications before they expired. On 9/8/25 at 5:28 PM, Staff 2 (DNS) acknowledged the expired medications and stated the expectation for resident medications in the medication cabinets was they were not expired while in use. 3. During an observation of the resident medication storage cabinets in the [NAME] House 200 unit on 9/5/25 at 6:25 PM, the following was found in room [ROOM NUMBER]: (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
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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- One tube of triple antibiotic ointment with an expiration date of 7/2025. On 9/5/25 at 6:25 PM, Staff 35 (LPN) acknowledged the expired medication and stated the expectation was for all expired medications to be removed from resident storage cabinets. On 9/8/25 at 5:28 PM, Staff 2 (DNS) acknowledged the expired medications and stated the expectation for resident medications in the medication cabinets was they were not expired while in use.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview it was determined the facility failed to ensure proper food temperatures were maintained for meals served from 2 of 12 facility kitchens reviewed for food service. This placed residents at risk for unpalatable and unpleasant meals. Findings include:1. On 9/2/25 at 11:55 AM, Resident 130 stated the ground up food was completely unpleasant. On 9/3/25 at 8:12 AM, Resident 15 stated the food was tasteless, and always cold. On 9/3/25 at 10:09 AM, Resident 2 stated the food was not palatable and she/he did not like to eat it. During an observation of the lunch meal service on 9/5/25 at 12:24 PM, a meal of lemon pepper tuna, rice pilaf, and broccoli was served to residents of the [NAME] 200 house. The meal service also included an alternate texture option for the lemon pepper tuna. The temperatures of the meal components when delivered from the kitchen were as follows: - Lemon pepper tuna: 160 degrees F. - [NAME] pilaf: 149 degrees F. - Broccoli: 135 degrees F. The broccoli was reheated in the microwave multiple times until it reached a temperature of 165 degrees F. - Mechanical soft texture (ground up) lemon pepper tuna: 125 degrees F. This tuna was placed in an oven set to 200 degrees F until served. Throughout the meal service the following were observed: - The lemon pepper tuna, rice pilaf, and broccoli were kept in separate foil covered metal containers on the kitchen counter and were opened repeatedly while being served. - All plates of food were reheated in the microwave prior to serving them to the residents. On 9/5/25 at 12:45 PM, Staff 37 (CNA) stated the residents' plates were microwaved nearly every lunch and dinner service to get the food warm enough to serve. The surveyor test meal was served at 12:47 PM directly after the last resident meal. The texture of the lemon pepper tuna was rubbery, the mechanical soft texture tuna was dry, the rice pilaf was dry and crunchy, and the broccoli was mushy and unpalatable. The lemon pepper tuna, the mechanical soft texture tuna, and the rice pilaf were lukewarm to touch, and the broccoli was cold. The following temperatures were noted: - Lemon pepper tuna: 121 degrees F. - Mechanical soft texture lemon pepper tuna: 136 degrees F. - [NAME] pilaf: 123 degrees Fahrenheit. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Broccoli: 87 degrees Fahrenheit. On 9/5/25 at 3:20 PM, Staff 6 (Dietary Manager) stated the drop in temperatures for resident meals was a known issue, and the facility administration was working on a plan of correction. Further education was forthcoming for staff. She stated the required holding temperature for most foods was 140 degrees F, and staff were instructed to use the oven set to 200 degrees F or the microwave to bring resident food up to the proper temperature before serving. On 9/5/25 at 5:06 PM, Staff 1 (Administrator) acknowledged the drop in temperatures and the unpleasantness of the surveyor test tray. He stated the drop in resident meal temperatures was a known issue, and the administrative team was working on a correction plan. 2. On 9/5/25 at 11:39 AM, the posted lunch menu included lemon pepper tuna. On 9/5/25 at 11:49 AM, the meal cart was delivered to the Alpha 200 house. The tuna was placed in the oven. Staff 7 (CNA) removed the tuna from the oven, and it was observed at a temperature of 131 F. Staff 7 referenced a temperature guide for the food and stated it was close to the required temperature for other meats. On 9/5/25 at 12:16 PM, after all other meals were delivered to residents a test tray was sampled, and the tuna was lukewarm. On 9/5/25 at 12:28 PM, Staff 6 (Dietary Manager) stated the required holding temperature was 140 F. Staff were instructed to return food to the oven uncovered or use a microwave if temperatures were below the threshold.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review it was determined the facility failed to ensure infection control standards were followed in 1 of 4 houses reviewed for infection control. This placed residents at risk for spread of infection. Findings include: During an observation of the COVID precautions in the [NAME] House 100 unit on 9/3/25 at 10:25 AM, it was noted the frosted glass door to the unit did not have signage, PPE (Personal Protective Equipment), trash cans, or hand sanitization supplies on either side of the door. On 9/4/25 at 11:26 AM, Staff 5 (Infection Control RN) stated units with active COVID outbreaks were to have signage, PPE, trash cans, and hand sanitization supplies for staff and visitors on all doors to the unit. During an observation of the COVID precautions in the [NAME] House 100 unit on 9/4/25 at 12:57 PM, two visitors were seen exiting the unit through the frosted glass door. The two visitors removed their masks after exiting, put the masks in their pockets, and opened multiple doors with their hands while exiting the building. During an observation of the COVID precautions in the [NAME] House 100 unit on 9/5/25 at 6:55 PM, a staff member was observed to exit the unit through the frosted glass door, take off their mask, walk across the lobby to throw the mask away, and then sanitize their hands. On 9/8/25 at 3:21 PM, Staff 5 stated staff and visitors were not supposed to use the frosted glass door to the [NAME] House 100 unit. He stated he did not put any signage, PPE, trash cans, or hand sanitization supplies by that door because it was not supposed to be used by anyone. On 9/8/25 at 5:28 PM, Staff 2 (DNS) acknowledged the lack of COVID precautions for the frosted glass door on the [NAME] House 100 unit. She stated the expectation for any unit during a COVID outbreak was for signage, PPE, trashcans, and hand sanitization supplies to be at every door for that unit.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on interview and record review it was determined the facility failed to obtain copies of advanced directives for 1 of 3 sampled residents (#13) reviewed for advanced directives. This placed residents at risk for not having their health care decisions honored. Findings include: Resident 13 was admitted to the facility in 2023 with diagnoses including anxiety and heart failure. From 7/23/23 through 7/9/25, Interdisciplinary Care Conference notes revealed Resident 13 would look for a copy of her/his advance directive.The 10/15/24 care conference reflected Resident 13 would look for a copy of the document and expressed interest in receiving assistance with completing it.A review of Resident 13's medical record revealed no indication staff assisted Resident 13 with completing an advance directive. On 9/8/25 at 11:33 AM, Staff 22 (Social Service Designee) acknowledged no one followed up on Resident 13's request to complete an advance directive.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview it was determined the facility failed to ensure carpeting was clean for 1 of 3 houses (Delta 3). This placed residents at risk for an unhomelike environment. Findings include: On 9/3/25 at 10:41 AM on Delta 3 the following were observed: -The carpet between the fireplace and the dining room had three large brown stains that were approximately one foot in diameter. -The carpet in front of the recliners located by the television had dark brown stains that were approximately four feet long by one foot wide. -The carpet between the dining room and room [ROOM NUMBER] had a dark brown stain approximately one- and one-half feet in diameter. On 9/3/25 at 10:45 AM Staff 8 (CNA) stated the carpets were cleaned approximately two weeks prior but the brown spots resurfaced a few days later. On 9/8/25 at 10:10 AM Staff 9 (Housekeeping Manager) stated the stains surrounded the dining room for at least two years. The carpet was cleaned at least every two weeks, but the stains were not able to be removed.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on interview and record review it was determined the facility failed to protect a resident's right to be free from physical abuse by a resident for 1 of 1 sampled resident (#68) reviewed for abuse. This placed residents at risk for injury. Findings include: Resident 68 was admitted to the facility in 9/2025 with a diagnosis of dementia. Resident 68's care plan initiated 12/12/24 revealed she/he had a history of wandering into other residents' rooms. Staff were to attempt to redirect Resident 68 before she/he entered another resident's room and offer food. Resident 135 was admitted to the facility in 4/2023 with a diagnosis of dementia. Resident 135's care plan initiated 12/28/23 revealed she/he had verbal and physical aggression. Interventions included to not invade Resident 135's space and staff were to monitor her/him when in close proximity of other residents. An 8/28/25 Resident to Resident /Staff Assessment form revealed on 8/28/25 at 5:10 PM CNAs witnessed Resident 68 walk into Resident 135's room while Resident 135 was in the dining room eating. Resident 135 stood up from the dining table, went into her/his room, and started to speak to Resident 68. Resident 135 then looked toward the dining room at staff, pushed Resident 68 hard which caused Resident 68 to fall. Resident 68 did not hit her/his head when she/he fell and did not sustain an injury. On 9/5/25 at 4:27 PM Staff 10 (CNA) stated Resident 68 wandered into other residents' rooms and did not have boundaries. Staff usually redirected her/him out of other residents' rooms. On 8/28/25 Resident 135 was eating dinner in the dining room when Resident 68 walked into Resident 135's room. Resident 135 finished eating and walked into her/his room and started to talk to Resident 68. The conversation was in normal tones and did not appear to be a concern. Resident 135 looked toward the dining room, then looked back at Resident 68 and pushed Resident 68 causing her/hm to fall. Staff 10 stated it was difficult to read Resident 135's mood. Some days Resident 135 was happy and other days she/he woke up upset. Staff 10 stated she did not intervene and initially just observed the interaction. Staff 10 stated the care plan indicated staff were to monitor Resident 135 from a distance because she/he did not like when people were in her/his bubble.On 9/8/25 at 8:40 AM Staff 36 (CNA) stated Resident 135 was usually very sweet and friendly but over the last few months she/he became very angry and unpredictable. Resident 135 could be in a normal interaction with a resident and in just a second would change into a different person. Staff had to distract Resident 135 when she/he became aggressive. Staff 36 stated you never knew what Resident 135 would do, at times she/he allowed residents in her/his room and other times it upsets her/him. Staff 36 stated on 8/28/25 initially Resident 135 did not seem to be upset Resident 68 was in her/his room, but all of a sudden her/his voice changed. Staff 36 stated when she/he heard Resident 135's voice change she/he headed to Resident 135's room but it was too late, and Resident 135 pushed Resident 68. Resident 68 was not upset and was not hurt. On 9/5/25 at 1:08 PM Staff 11(LPN Resident Care Coordinator) stated Resident 68 wandered, and on 8/28/25 she/he wandered into Resident 135's room. Staff 11 acknowledged the care plan directed staff to be in close proximity when Resident 135 was with other residents.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on observation, interview, and record review it was determined the facility failed to ensure a resident was not started on a psychotropic medication without indication for use and failed to monitor a resident for side effects of psychotropic medications for 1 of 5 sampled residents (#123) reviewed for mood and unnecessary medications. This placed residents at risk for adverse medication reactions. Findings include: Resident 123 was admitted to the facility in 2/2024 with a diagnosis of dementia and stroke.a. A Behavioral Management Program Policy and Procedure last updated 8/2014 revealed all non-pharmacological interventions were to be exhausted and acute medical conditions including pain and environmental factors were to be ruled out prior to obtaining any orders for psychoactive medications. Resident 123's 9/16/24 physician visit note revealed she/he was sitting at the exit door waiting to visit her/his spouse. Resident 123 appeared to be in good spirits. Staff did not report concerns. Staff previously reported on 8/19/24 Resident 123 kicked a staff when she/he was unable to leave the facility. Resident 123's Interdisciplinary Care Conference forms revealed:-10/2/24 Resident 123 visited her/his spouse on campus and enjoyed eating meals with her/him.-12/26/24 staff reported Resident 123 was agitated and hit staff. Resident 123 was frustrated from her/his inability to visit her/his spouse.Resident 123's 3/10/25 External Visit indicated Resident 123 had worsening behaviors. Staff reported after Resident 123 visited her/his spouse, she/he appeared to be calm and content. The note indicated Resident 123 was on daily oxycodone (narcotic pain medication) for pain. The use of Seroquel (antipsychotic medication) was discussed with family and agreed with implementation. Resident 123's physician orders dated 3/10/25 revealed Seroquel was to be administered at bedtime.Resident 123's 3/2025 MAR revealed she/he was administered Seroquel at bedtime from 3/11/25 for agitation/behaviors.Resident 123's clinical record revealed laboratory tests were not obtained prior to the initiation of Seroquel on 3/11/25. On 9/9/25 at 9:47 AM Staff 11 (LPN Resident Care Coordinator) stated Resident 123 was angry and depressed because she/he was not able to visit her/his spouse. Staff 12 (LPN Resident Care Coordinator) stated the antipsychotic was not appropriate for use and her/his behaviors did not improve. On 9/8/25 at 2:40 PM Staff 2 (DNS) stated Resident 123 sat by the door and wanted to see her/his spouse. The staff tried to assist the resident, but she/he hit and banged on the door. Resident 123 and her/his spouse were on different sleep schedules, and it was difficult for Resident 123 to understand the reason she/he could not visit her/his spouse. Staff 2 acknowledged labs were not obtained until 3/27/25, after the Seroquel was started. Staff 2 also indicated the Seroquel did not work.b. Resident 123's 6/24/25 Psychotropic Pharmacy Review form revealed she/he was on Seroquel (antipsychotic).Resident 123's care plan initiated on 2/29/24 was not updated to include the use of Seroquel and to monitor for side effects of the medication. Resident 123's clinical record did not indicate she/he was monitored for side effects of Seroquel. On 9/5/25 at 1:22 PM Staff 11 (LPN Resident Care Coordinator) stated a care plan for Seroquel was not developed and there was no monitoring for the side effects of the antipsychotic.

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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. Based on observation, interview, and record review it was determined the facility failed to update resident care plans for 2 of 3 sampled residents (#s 9 and 74) reviewed for ROM and infection control. This placed residents at risk for skin break down and inaccurate records. Findings include: 1. Resident 9 was admitted to the facility in 10/2020 with a diagnosis of dementia. Resident 9's 4/11/25 Annual MDS revealed she/he had decreased ROM and a left-hand contracture. On 9/8/25 at 9:47 AM Resident 9 was observed in the dining area with a soft lamb wool Velcro wrap to the left hand. Resident 9's Care Plan initiated 10/2020 did not have a Velcro wrap on the care plan. On 9/4/25 at 9:18 AM Staff 28 (CNA) stated Resident 9 had a contracture and her/his fingers were hard to bend at times, and she/he had her/his wrap for quite a while. On 9/8/25 at 12:04 PM Staff 12 (LPN Resident Care Coordinator) stated staff used to place a towel in her/his hand to prevent her/his hand from forming a tight grip due to her/his contracture but she/he pulled the towel out. Staff 12 stated she ordered a new soft splint approximately one month ago but did not update the care plan. 2. Resident 74 was admitted to the facility in 1/2025 with diagnoses including urinary tract infection and cancer. Review of physician orders revealed Resident 74 was placed on Enhanced Barrier Precautions (EBP) on 4/23/25 due to chronic ulcers on the right ankle and heel. No end date was documented. On 9/2/25 at 1:52 PM, Resident 74 stated her/his shoulder wound was basically healed, but she/he still had wounds on her/his leg. On 9/3/25 at 11:30 AM, a nurses note indicated there was no wound on Resident 74's right lateral foot so no wound care was provided; the wound was resolved. From 9/2/25 through 9/5/25 observations revealed staff were not implementing EBP for Resident 74. On 9/8/25 at 7:06 AM, Resident 74's care plan was reviewed and EBP was listed on the care plan. On 9/8/2025 10:55 AM, Staff 5 (Infection Control RN) reported Resident 74's catheter was removed and her/his wounds were resolved. Staff 5 stated Resident 74's pressure ulcer resolved on 8/19/25 and the care plan was not updated. On 9/9/25 at 8:20 AM, Staff 2 (DNS) confirmed Resident 74 was placed on EBP for wounds which since resolved, and confirmed the care plan was not updated.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on interview and record review it was determined the facility failed to ensure residents' neurological assessments were completed for 1 of 7 sampled residents (#135) reviewed for falls and rehabilitation. This placed residents at risk for unidentified head injuries. Findings include: Resident 135 was admitted to the facility in 4/2023 with diagnoses including dementia.An 4/27/25 incident report indicated Resident 135 was found on the floor in the activity room. According to the incident report, Resident 135 took 10 minutes to fully arouse, was unable to follow simple commands, and her/his right pupil was not responding to light at first. The on-call doctor was notified as well as the resident's Power of Attorney (POA) and it was decided to keep Resident 135 in the facility and monitor her/his neurological status closely.The 4/27/25 Neurological Flow Sheet indicated checks were to be completed every 15 minutes for an hour, every 30 minutes for two hours, every hour for four hours, every four hours for 16 hours, and every eight hours for 48 hours. The 4/27/25 Neurological Flow Sheet for Resident 135 was incomplete with missing assessment areas and stopped after three hours.On 9/8/25 at 3:11 PM, Staff 21 (LPN) stated on 4/27/25 Resident 135 was found in the activity room laying on the ground with a pillow under her/his head. Staff 21 stated it took approximately an hour for Resident 135 to get back to baseline neurologically after the fall.On 9/8/25 at 3:11 PM, Staff 11 (RNCM) stated neurological checks were to be initiated after an unwitnessed fall or a head injury. Staff 11 stated neurological checks were to be completed every 15 minutes for an hour, every 30 minutes for two hours, every hour for four hours, every four hours for 16 hours, and every eight hours for 48 hours. Staff 11 acknowledged Resident 135's neurological checks were incomplete with missing assessment areas. Staff 11 acknowledged the neurological checks stopped after every 30-minute checks and was to be continued until completed.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review it was determined the facility failed to ensure residents received services to prevent accidents for 2 of 5 sampled residents (#s 9 and 74) reviewed for falls and rehabilitation. This placed residents at risk for injury. Findings include: 1. Resident 9 was admitted to the facility in 10/2020 with a diagnosis of dementia. Resident 9's 4/13/25 Post Fall Assessment revealed on 4/13/25 at 6:25 PM she/he had a witnessed fall in the dining room. Resident 9 was in her/his wheelchair, was wiggling her/his legs, leaned to the left, fell to the floor, and sustained a forehead laceration. The assessment indicated the armrest was not properly latched after staff transferred her/him into the chair with a mechanical lift. On 9/8/25 at 10:25 Staff 12 (LPN Resident Care Coordinator) verified staff did not latch Resident 9's wheelchair armrest correctly and her/his movement and lack of trunk control, caused her/him to fall out of the wheelchair when she/he leaned to the left. 2. Resident 74 was admitted in 1/2025 with diagnoses including stroke, cognitive communication deficit, and a history of repeated falls. A fall risk assessment dated [DATE] identified Resident 74 as confused, with multiple diagnoses and medications, and a history of falls. The 5/13/25 revised care plan required Resident 74 to have two-person assistance with a mechanical sit-to-stand lift for transfers. On 9/5/25 at 6:42 AM, Staff 7 (CNA) entered Resident 74's room with a sit-to-stand lift with the resident observed in bed. At 6:55 AM, Staff 7 exited the room with the sit-to-stand lift. No other staff were observed in the room during the transfer. Resident 74 was in her/his electric wheelchair. At 8:30 AM, Staff 7 stated if a resident was care planned for two staff, she should have another staff member present during the transfer, and she did not have another staff present during Resident 74's transfer. Staff 7 stated she was confused about whether all sit-to-stand transfers required two staff or only some. On 9/9/25 at 8:20 AM, Staff 2 (DNS) stated she expected staff to follow residents' care plans. Staff 2 confirmed all sit-to-stand lift transfers required two staff.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385280	A. Building B. Wing	09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lebanon Veterans Home	600 North 5th Street Lebanon, OR 97355

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. Based on interview and record review it was determined the facility failed to complete a trauma assessment for residents with post-traumatic stress disorder (PTSD) for 2 of 7 sampled residents (#s 3 and 11) reviewed for psychotropic medications and unnecessary medications. This placed residents at risk for triggers related to PTSD. Findings include: 1. Resident 3 was admitted to the facility in 11/2019 with diagnoses including post-traumatic stress disorder (PTSD).A 11/19/19 care plan indicated Resident 3 had a history of trauma related to childhood deprivation and abuse. The goal indicated Resident 3 would identify individual strengths by the review date. An intervention indicated Resident 3 needed assistance, supervision, and support to identify precipitating factors and stressors.A review of Resident 3's medical record revealed no indication of a completed trauma screen.On 9/9/25 at 8:21 AM, Staff 30 (Social Service Designee) stated usually upon admission she completed a trauma screen to identify specific types of trauma and triggers for the trauma. With that information she put the type of trauma and triggers in the residents' care plan. Staff 30 stated she was unaware Resident 3 did not have a trauma screen to identify triggers of her/his diagnosis of PTSD and the triggers for Resident 3's PTSD were not on the care plan.On 9/9/25 at 10:46 AM Staff 2 (DNS) stated every resident was to have a trauma screen completed to identify types of trauma and triggers. Staff 2 stated the information obtained in the trauma screen was to be placed on the residents' care plan, so staff were aware of the type of trauma and triggers to watch for.2. Resident 11 was admitted to the facility in 1/2020 with diagnoses including post-traumatic stress disorder (PTSD).On 9/5/25 at 1:54 PM, Staff 31 (CNA) stated Resident 11 was aggravated at times and just wanted to be left alone sometimes.On 9/5/25 at 2:00 PM, Staff 32 (LPN) stated Resident 11 got aggravated at times and she was unsure what made her/him get aggravated.On 9/9/25 at 9:51 AM, Staff 33 (Social Service Designee) stated he was unable to locate a completed trauma screen for Resident 11.A review of Resident 11's medical record revealed no indication of a completed trauma screen or a PTSD care plan.On 9/9/25 at 10:46 AM Staff 2 (DNS) stated every resident was to have a trauma screen completed to identify types of trauma and triggers. Staff 2 stated the information obtained in the trauma screen was to be placed on the residents' care plan, so staff were aware of the type of trauma and triggers to watch for.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385280	A. Building B. Wing	09/09/2025

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. Based on interview and record review it was determined the facility failed to monitor medications for 2 of 10 sampled residents (#s 3 and 4) reviewed for nutrition and unnecessary medications. This placed residents at risk for adverse medication side effects. Findings include: 1. Resident 3 was admitted to the facility in 11/2019 with diagnoses including arterial fibrillation (an irregular heartbeat).A review of Physician Orders revealed an 8/29/25 order for warfarin (a blood thinning medication).A review of Resident 3's care plan revealed no evidence of a blood thinning medication care plan or monitoring for adverse side effects of blood thinning medications.On 9/9/25 at 8:40 AM Staff 14 (RCM) stated adverse side effects for warfarin should be listed in a warfarin care plan. Staff 14 acknowledged Resident 3 had no care plan for blood thinning medications and no monitors in place to monitor for adverse side effects of blood thinning medications.On 9/9/25 at 10:52 AM Staff 2 (DNS) acknowledged Resident 3 was not care planned for blood thinners and had no monitors in place to monitor for adverse side effects of blood thinners.2. Resident 4 was admitted to the facility in 2/2025 with diagnoses including heart failure.A review of Physician Orders revealed an 4/10/25 order for furosemide (a diuretic medication used to treat heart failure by removing excess fluid from the body).A review of Resident 4's weights revealed the following: 7/19/25 218 lbs. 8/28/25 229 lbs. 8/30/25 228.2 lbs. 9/7/25 229.2 lbs.A review of Resident 4's care plan revealed no evidence of a diuretic medication care plan.On 9/8/25 at 2:33 PM, Staff 17 (CNA) stated Resident 4 had a little weight gain but was unsure how much. Staff 17 stated Resident 4 had some edema (swelling) in her/his feet and used compression socks for the edema.On 9/8/25 at 2:48 PM, Staff 19 (LPN) stated she was unsure if Resident 4 had any weight gain or if Resident 4 took any diuretics. Staff 19 stated Resident 4 had edema to both legs, and the physician was to be notified for a weight gain of five pounds or more in three days.On 9/9/25 at 9:07 AM, Staff 20 (RNCM) stated Resident 4's weight gain was not identified until this interview. Staff 20 acknowledged Resident 4 did not have a care plan for diuretic medications and was not being monitored for weight gain.On 9/9/25 at 10:42 AM, Staff 2 (DNS) stated a resident diagnosed with heart failure and taking a diuretic was to be monitored for weight gain and the doctor was to be notified for a gain of two to three pounds. Staff 2 stated Resident 4 should have had a head-to-toe assessment to see if the weight gain was related to heart failure and fluid retention. Staff 2 stated Resident 4 needed to be monitored for weight gain.

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	385280	A. Building B. Wing	09/09/2025

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation and interview it was determined the facility failed to post complete staffing information for 1 of 1 facility reviewed for staffing. This placed residents at risk for incomplete and inaccurate staffing information. Findings include:Observations of the Direct Care Staff Daily Reports (DCSDR) from 9/2/25 through 9/8/25:-On 9/3/25 at 7:00 AM, the DCSDR posted was dated 9/2/25. It did not include evening or night shift staff numbers or hours,-On 9/4/25 at 7:11 AM, the DCSDR posted was dated 9/3/25. It did not include evening or night shift staff numbers or hours,-On 9/5/25 at 6:07 AM, the DCSDR posted was dated 9/4/25. It did not include evening or night shift staff numbers or hours,-On 9/8/25 at 6:45 AM, the DCSDR posted was dated 9/7/25. It did not include evening or night shift staff numbers or hours, On 9/9/25 at 8:16 AM, 10:34 AM and 11:04 AM Staff 2 (DNS) stated they needed to improve the timing of documenting evening shift and night shift information on the DCSDR.