STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395472	A. Building B. Wing	04/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lebanon Skilled Nursing and Rehabilitation Center	900 Tuck Street Lebanon, PA 17042

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on facility policy review and observation, it was determined that the facility failed to store food in a sanitary manner in the dietary department.Findings include: Review of the facility's policy entitled, Personal Hygiene, dated February 2, 2026, revealed that all staff must wear hair restraints to effectively keep hair from contacting exposed food. Observation during the lunch meal service tray line on April 15, 2026, from 11:30 a.m., to 12:03 p.m., revealed Dietary Employee (DE) 1 and DE 2 were observed working the meal tray line directly over uncovered food with mustaches that were not covered. The window frame above the shelf where a large mixer with an uncovered bowl, the Robot-coupe mixer, and a blender were stored had paint peeling off of it. The Robot-coupe mixer and blender were being used to prepare resident food at that time. The blind in this window frame had dried food debris along the length of it. There was another window frame above a storage rack of trays used for resident meals with paint peeling off of it. CFR 483.60(i) Food Safety RequirementPreviously cited 3/26/25 28 Pa. Code 201.14(a) Responsibility of licensee.

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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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on clinical record review and staff interview, it was determined the facility failed to notify the resident and/or resident's representative(s) of transfer(s), and failed to notify a representative of the Office of the Long-Term Care Ombudsman, including the reasons for the moves, in writing upon transfer for six of six residents who were transferred out of the facility. (Residents 2, 7, 14, 42, 149, and 151) Findings include: Clinical record review revealed that Resident 2 was transferred to the hospital on December 26, 2025, after a change in condition. There was no documented evidence to support that the resident and/or the resident's responsible party or legal representative was provided with written information regarding the transfer to the hospital and that the facility sent a copy of the transfer notice to a representative of the Office of the State Long-Term Care Ombudsman. Clinical record review revealed that Resident 7 was transferred to the hospital on January 9, 2026, after a change in condition. There was no documented evidence that notification of the transfer was provided to a representative of the Office of the State Long-Term Care Ombudsman. Clinical record review revealed that Resident 14 was transferred to the hospital on March 30, 2026, after a change in condition. There was no documented evidence that the resident and/or the resident's responsible party or legal representative was provided with written information regarding the transfer to the hospital or that notification of the transfer was provided to a representative of the Office of the State Long-Term Care Ombudsman. Clinical record review revealed that Resident 42 was transferred to the hospital on March 12, 2026, after a change in condition. There was no documented evidence that the resident and/or the resident's responsible party or legal representative was provided with written information regarding the transfer to the hospital or that notification of the transfer was provided to a representative of the Office of the State Long-Term Care Ombudsman. Clinical record review revealed that Resident 151 left the facility against medical advice on February 3, 2026. There was no documented evidence that notification of the transfer was provided to a representative of the Office of the State Long-Term Care Ombudsman. In an interview on April 17, 2026, at 10:22 a.m., the Administrator confirmed that the notifications of transfers were not sent to the residents and/or resident representatives and that written notices of the transfers and discharge were not sent to the Office of the State Long-Term Care Ombudsman. 28 Pa. Code 201.14(a) Responsibility of licensee.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on facility policy review, resident group interview, a review of facility resident council meeting minutes and grievances, and staff interview, it was determined that the facility failed to address grievances voiced by residents.Findings include:Review of the facility policy entitled, Grievance Policy, last reviewed February 24, 2026, revealed that grievances may include a formal, written grievance process or a resident's verbalized complaint to facility staff. The facility was to acknowledge complaints/grievances and actively work toward resolution of the complaint/grievance.During a confidential group interview conducted on April 14, 2026, at 10:00 a.m., four of four residents reported that resident call bells were answered slowly, often taking more than 30 minutes. A review of resident council minutes dated from September 8, 2025, through December 11, 2025 revealed complaints of slow call bell responses on September 8, 2025, October 9, 2025, November 13, 2025, and December 11, 2025. No evidence was provided that resident council minutes were recorded in 2026.A review of resident grievances dated from October 31, 2025, through March 23, 2026, revealed several complaints of slow call bell responses on October 30 and 31, 2025, November 18 and 28, 2025, December 2, 2025, and January 19 and 22, 2026. In an interview on April 17, 2026, at 10:22 a.m., the Director of Nursing and Nursing Home Administrator confirmed that the facility had a pattern of complaints about slow call bell responses and had failed to respond to those grievances. 28 Pa. Code 201.14(a) Responsibility of licensee.

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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, it was determined that the facility failed to provide a safe, clean, and comfortable environment on two of five nursing units. ([NAME] and [NAME] units)Findings include:Observations on April 13, 2026, from 10:01 a.m. through 1:10 p.m. and on April 16, 2026 from 9:40 a.m. through 12:00 p.m. revealed the following: The clear, plastic fire extinguisher cover in the hallway between rooms 135 & 137 was shattered. There were holes on left and right walls of the bathroom in room [ROOM NUMBER].The doorframe of the entrance to room [ROOM NUMBER] was dented and misshaped near the floor.There was a hole in the wall between the beds in room [ROOM NUMBER]. The wallboard at the bottom of the wall on the right of the entrance to the bathroom in room [ROOM NUMBER] was dented and crumbling. 28 Pa. Code 201.14(a) Responsibility of licensee.28 Pa. Code 201.18(e)(2.1) Management.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, it was determined that the facility failed to ensure that the Minimum Data Set (MDS) assessment was completed to accurately reflect the current status of one of 31 sampled residents. (Resident 139)Findings include: Clinical record review revealed that Resident 139 had diagnoses that included diabetes mellitus and a history of falling and required glasses to correct her vision. Resident 139's care plan revealed a problem with impaired vision and that the resident required glasses starting on March 8, 2022. The MDS assessment dated [DATE], incorrectly indicated in Section B (Hearing, Speech, and Vision) that the resident did not require corrective lens during the previous seven days. Observation on April 14, 2026, at 11:00 a.m., revealed that Resident 139 was wearing her glasses. In an interview on April 17, 2026, at 1:00 p.m., the Administrator confirmed that Resident 139's MDS assessment was inaccurate.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on clinical record review and staff interview, it was determined that the facility failed to develop a comprehensive care plan that addressed the individual resident's needs as identified in the comprehensive assessment for one of 31 sampled residents. (Resident 13) Findings include:Clinical record review revealed that Resident 13 had diagnoses that included chronic kidney disease and diabetes mellitus. The Minimum Data Set completed on February 20, 2026, indicated that the resident was alert and frequently incontinent of urine. The Care Area Assessment summary dated February 20, 2026, noted that the resident's urinary incontinence was to be addressed in the care plan. There was no evidence that interventions to address Resident 13's urinary incontinence were included in the current care plan.In an interview on April 17, 2026, at 10:25 a.m., the Director of Nursing confirmed that there was no documented evidence that the identified care area was addressed in the care plan.CFR 483.21(b)(1) Comprehensive Care PlansPreviously cited 3/26/25 and 2/4/2628 Pa. Code 211.12(d)(1)(5) Nursing services.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, resident interview, and staff interview, it was determined that the facility failed to provide care and services to maintain activities of daily living (showering) for one of 31 sampled residents. (Resident 1)Findings include: Clinical record review revealed that Resident 1 was admitted to the facility March 12, 2026, with diagnoses that included chronic kidney disease, polyneuropathies (nerve damage), and muscle weakness. Review of the Minimum Data Set assessment dated [DATE], revealed that the resident had no cognitive impairment, required substantial assistance from staff for showers, and was totally dependent on staff for transfers. Review of facility documentation revealed that the resident was to receive a shower on Wednesdays and Saturdays on the evening shift. In an interview on April 14, 2026, at 11:47 a.m., Resident 1 stated, I haven't had a shower since I got here. Review of the clinical record revealed no documented evidence that Resident 1 received, was offered, or refused a shower during the previous 30 days. In an interview on April 16, 2026, at 10:22 a.m., the Director of Nursing confirmed that there was no documented evidence that showers were offered or provided to Resident 1. 28 Pa. Code 211.12(d)(1)(5) Nursing services.

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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 clinical record review and staff interview, it was determined that the facility failed to ensure physicians' orders were implemented for three of 31 sampled residents. (Residents 4, 8, and 139) Findings include: Clinical record review revealed that Resident 4 had a diagnosis of diabetes mellitus. A physician's order dated November 25, 2025, ordered staff to inject eight units subcutaneously of a diabetic medication, Novolog Injection Solution 100 unit/milliliter (insulin) in the morning prior to breakfast. Staff were to hold the insulin if the resident's blood sugar was less than 80 milligrams per deciliter (mg/dL). Review of Resident 4's April 2026 medication administration records (MAR) revealed that staff administered the medication three times in April when the resident's blood sugar was less than 80mg/dL. Clinical record review revealed that Resident 8 had diagnoses that included cerebral palsy, diabetes mellitus, and heart failure. A physician's ordered dated January 27, 2026, directed staff to weigh the resident every night shift and notify the physician if the resident gained more than two pounds (lbs.) in 24 hours or five pounds in one week. Review of clinical records revealed no evidence that the physician was notified when the resident gained 4.7 lbs. between December 31, 2025, and January 1, 2026, 3.4 lbs. between January 5 and 6, 2026, 6 lbs. between January 6 and 7, 2026, 2.3 lbs. between March 9 and 10, 2026, 5.8 lbs. between March 19 and 20, 2026, 4 lbs. between March 31, 2026 and April 1, 2026, 2.4 lbs. between April 5 and 6, 2026, and 3.3 lbs. between April 13 and 14, 2026. Clinical record review revealed that Resident 139 had diagnoses that included anemia and chronic kidney disease. A physician's order dated February 13, 2026, directed staff to obtain two blood tests (a Complete Blood Count and a Comprehensive Metabolic Panel). A review of Resident 139's clinical record revealed there was no documented evidence to support that the blood tests were obtained as ordered. In an interview on April 17, 2026, at 10:25 a.m., Director of Nursing confirmed there was no documented evidence that the facility had provided care or services in accordance with the aforementioned physicians' orders. CFR 483.25 Quality of CarePreviously cited 3/26/25 28 Pa. Code 211.12(d)(1)(5) Nursing services.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on facility policy review and clinical record review it was determined that the facility failed to attempt and document non-pharmacological interventions to alleviate pain prior to the administration of pain medication prescribed on an as needed basis for two of 31 sampled residents. (Resident 6, 96)Findings include:Review of the facility policy entitled, Pain Management, last reviewed February 24, 2026, revealed that staff would document non-pharmacological interventions (NPI's) and their effectiveness for patients receiving interventions for pain.Clinical record review revealed that Resident 6 had diagnoses that included left knee osteoarthritis, pain in the right hip, and diabetes. On March 17, 2026, the physician ordered for staff to document NPI's every shift. On April 6, 2026, the physician ordered staff to administer the narcotic pain medication, oxycodone, every four hours as needed for moderate to severe pain. Review of Medication Administration Records (MAR) revealed that the resident received the as needed narcotic (oxycodone) without documented evidence that NPI's were attempted prior to administration 23 times in April 2026. Clinical record review revealed that Resident 96 had diagnoses that included cerebral infarction (stroke), diabetes, and hemiplegia and hemiparesis (paralysis). On February 7, 2026, the physician ordered for staff to document the NPI's used before administering the as needed pain medication. On April 3, 2026, the physician ordered for staff to administer the narcotic pain medication, oxycodone, every four hours as needed for moderate to severe pain. Review of the MAR revealed that the resident received the as needed narcotic (oxycodone) without documented evidence that NPI's were attempted prior to administration nine times in April 2026.28 Pa. Code 211.9(a)(1) Pharmacy services.28 Pa. Code 211.12(d)(1)(5) Nursing services.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policies, clinical record review, observations, and staff interviews, it was determined the facility failed to provide appropriate dialysis treatment for one of 31 sampled residents (Resident 10).Findings include:A review of the policy, Dialysis: Hemodialysis External Catheter Evaluation and Maintenance, last reviewed February 24, 2026, revealed that facility staff were to avoid taking blood pressure from an arm with a dialysis access device. Clinical record review revealed that Resident 10 had diagnoses that included diabetes mellitus with chronic kidney disease. A review of Resident 10's Minimum Data Set assessment (MDS), dated [DATE], revealed that Resident 10 was mildly cognitively impaired. Review of the care plan initiated November 11, 2021, and last reviewed December 17, 2025, revealed that Resident 10 required ongoing hemodialysis. The care plan directed staff to monitor the fistula (a surgically created connection between an artery and a vein that provides reliable vascular access for dialysis treatments) site located in the left upper extremity (upper arm) for bleeding and to avoid using the upper extremity for any treatment to avoid complications related to dialysis access. A review of the clinical record revealed that the facility had documented use of Resident 10's left arm to measure blood pressure 10 times in January 2026, 10 times in February 2026, 14 times in March 2026, and four times in April 2026. In an interview on April 17, 2026, at 10:22 a.m., the Director of Nursing confirmed that the documentation revealed that Resident 10's blood pressure had been measured on her left arm.28 Pa. Code 211.10 (d) Resident care policies.28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, it was determined that the facility failed to assess residents with a diagnosis of post-traumatic stress disorder (PTSD) and develop and implement an individualized person-centered care plan to render trauma informed care for one of 31 sampled residents. (Resident 1)Findings include: Clinical record review revealed that Resident 1 was admitted to the facility on [DATE] , 2026, with diagnoses that included PTSD, depression, polyneuropathy (nerve damage), and insomnia. Review of the Minimum Data Set assessment dated [DATE], revealed that the resident had no cognitive impairment, required substantial assistance from staff for activities of daily living, and had a diagnosis of PTSD. There was no documentation to support that the resident was assessed for symptoms or triggers related to the diagnosis of PTSD. The care plan for Resident 1 did not include any measures to address the resident's history of trauma or identify triggers. There were no specific interventions to meet the resident's needs for minimizing triggers and/or re-traumatization. In an interview on April 16, 2026, at 10:22 a.m., the Director of Nursing confirmed that Resident 1 had not been assessed or care planned for PTSD. 28 Pa. Code 211.12(d)(3)(5) Nursing services.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on clinical record review and staff interview, it was determined that the facility failed to ensure that the physician acknowledged the pharmacist's recommendations for two of 31 sampled residents. (Residents 6 and 12)Findings include: Clinical record review revealed that on March 20, 2026, the consultant pharmacist made recommendations regarding Resident 6's medication regimen. There was no documented evidence regarding the recommendation or that the attending physician had acknowledged or acted upon this recommendation. Clinical record review revealed that on October 20, 2025, and February 26, 2026, the consultant pharmacist made recommendations regarding Resident 12's medication regimen. There was no documented evidence regarding the recommendations or that the attending physician had acknowledged or acted upon these recommendations. In an interview on April 17, 2026, at 10:22 a.m., the Director of Nursing confirmed that there was no documented evidence that the medication review recommendations for Residents 6 and 12 were addressed by the physician. 28 Pa. Code 201.18(e)(1)(3)(4) Management. 28 Pa. Code 211.12(d)(3)(5) Nursing services.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on a review of employee personnel and education records and staff interview, it was determined that the facility failed to ensure that each nurse aide received 12 hours of in-service training annually, including training for dementia management, resident abuse prevention, and identified performance weaknesses for two of two nurse aides reviewed (NA 1 and NA 2).Findings include:Review of NA 1's personnel record revealed that the facility hired them on August 28, 2023.Review of facility training records dated April 17, 2025, to April 17, 2026, revealed that NA 1 completed only 31 minutes of in-service education in infection control and respirator use. Review of Employee NA 2's personnel record revealed that the facility hired them on December 19, 2023.Review of facility training records dated April 17, 2025, to April 17, 2026, revealed that NA 2 completed only 3 hours and 48 minutes of in-service education in safe resident handling, mechanical lift use, elopement prevention, and ethics. In an interview on April 17, 2026, at 12:59 p.m., the Director of Nursing and the Nursing Home Administrator confirmed that employees NA 1 and NA 2 had not completed the required annual in-service training. 28 Pa. Code 201.19(7) Personnel policies and procedures28 Pa. Code 201.20(a)(6)(d) Staff development