

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395832	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/21/2026
NAME OF PROVIDER OR SUPPLIER Lebanon Valley Home The		STREET ADDRESS, CITY, STATE, ZIP CODE 550 East Main Street Annville, PA 17003	
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 0600 Level of Harm - 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical record, facility documentation, and staff interviews, it was determined the facility failed to implement interventions to prevent an accident during a transfer for one of four sampled residents (Resident 1), which resulted in actual harm (fractures of the leg). The incident has been identified as past non-compliance. Findings include: Review of the facility policy titled, Freedom from Abuse, Neglect, and Exploitation of Residents and Misappropriation of Resident Property last reviewed January 22, 2026, revealed a resident had the right to be free from neglect. Staff were to provide goods and services to a resident that were necessary to avoid physical harm, pain, mental anguish, or emotional distress. In addition, staff were to provide comfort, safety, and help. Review of the facility policy entitled, Accident Prevention - Resident last reviewed January 22, 2026, revealed the facility would implement interventions consistent with a resident's needs, goals, plan of care, and current standards of practice to reduce the risk of an accident. Review of Resident 1's clinical record revealed Resident 1 was admitted to the facility on [DATE], with diagnoses including Alzheimer's disease (brain disorder that slowly affects memory and the ability to perform everyday tasks), dementia (loss of thinking, remembering, and reasoning skills that is severe enough to interfere with daily life), muscle weakness, difficulty walking, heart failure, and atrial fibrillation (irregular heart rhythm). Review of Resident 1's Minimum Data Set (MDS) assessment (periodic evaluation of resident care needs) dated May 25, 2026, revealed that Resident 1 had memory impairment, loss of mobility on both sides of lower extremities, and was dependent on staff for bed mobility, transferring, dressing, personal hygiene, bathing, and toileting. Review of Resident 1's care plan revealed the facility identified Resident 1 had functional impairment (decline in a person's ability to carry out activities of daily living due to a physical, cognitive, or mental health condition) and required assistance from two staff members to transfer Resident 1 using a gait belt (safety device used in transferring and walking residents to prevent falls) for all transfers. Review of investigative documents revealed on June 22, 2026, during the evening shift, Resident 1 was in her room sitting in a wheelchair. Nurse Aide (NA) 2 transferred the resident to her bed by bear hugging the resident and placing her into bed without assistance from a second staff member. The transfer method was not consistent with the resident's transfer status requiring two staff to assist and using a gait belt. Further review of investigative documentation revealed when asked about the transfer and any signs of pain from Resident 1, NA 2 responded, She's always yelling. Review of Resident 1's clinical record indicated on June 23, 2026, at 6:54 a.m., a nurse aide (NA 1) reported Resident 1 complained of pain in her right ankle. A nurse noted the resident had some swelling in the right ankle compared to the left ankle. Nursing documentation dated June 23, 2026, at 8:18 a.m., revealed Resident 1's right leg was noticeably internally rotated, and her right lower leg was warm with increased swelling and redness. (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 395832	If continuation sheet Page 1 of 2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395832	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/21/2026
NAME OF PROVIDER OR SUPPLIER Lebanon Valley Home The		STREET ADDRESS, CITY, STATE, ZIP CODE 550 East Main Street Annville, PA 17003	
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 0600 Level of Harm - Actual harm Residents Affected - Few	The nurse noted Resident 1 yelled in pain with movement of the right leg or when the leg was touched. An immediate (stat) X-ray was performed on June 23, 2026, at 8:53 a.m., with the results being inconclusive. On June 23, 2026, at 12:20 p.m., the physician requested the resident be transferred to the hospital for further evaluation. The results of the X-rays obtained at the hospital dated June 23, 2026, revealed the resident had a broken shin bone, located between the knee and the ankle and a broken bone located at the ankle joint. Review of an investigative statement dated June 23, 2026, revealed NA 2 was asked what the resident's transfer status was. NA 2 replied, Two-assist with a stand aid or Hoyer. I really don't know. I just always put her into bed the same way I did last night with a bear hug. Interview on July 21, 2026, at 12:30 p.m., with the Director of Nursing (DON) revealed Resident 1's care plan indicated two staff members were required to transfer the resident from the wheelchair to the bed with a gait belt. The DON revealed Nurse Aide (NA) 2 transferred the resident in a bear hug out of the wheelchair and placed her into bed. NA 2 did not call for assistance and did not use the appropriate transfer method. In an interview on July 21, 2026, at 2:30 p.m., the Director of Nursing confirmed NA 2 transferred Resident 1 inappropriately and was negligent with care provided to the resident that resulted in injuries. NA 2 failed to follow the resident's care plan and transfer requirements, which resulted in actual harm to Resident 1. The facility identified NA 2 was negligent in the care provided to Resident 1 at the time of the incident, and on June 23, 2026, through June 24, 2026, implemented the following corrective action plan: 1. On June 23, 2026, all residents who received care from NA 2 during the evening shift on June 22, 2026, were assessed for injuries, pain, or any concerns related to care provided. No injuries, pain, or complaints were identified. 2. All staff were re-educated June 24 through July 13, 2026, on transferring residents and abuse prevention. Education included the importance of following each resident's transfer status and care plan, potential for resident harm, staff consequences when transfer requirements are not followed, staff acknowledgment of completion through a read and sign process, and a post-education quiz to assess understanding of the material. 3. A transfer audit process was implemented on June 24, 2026. RN (registered nurse) supervisors were required to complete five transfer audits to monitor compliance with resident transfer requirements. Each audit included verification of the resident's transfer lift form, observation of the resident's transfer method, compliance with the transfer lift form during the transfer, presence of the required number of staff members for the transfer, the appropriate transfer equipment, and maintenance of resident safety throughout the transfer. 4. Audit results and trends were reviewed through the facility's Quality Assurance and Performance Improvement program. Findings were used to identify opportunities for improvement, provide additional education as needed, and ensure ongoing compliance with safe resident transfer practices. 5. The Director of Nursing or designee initiated weekly audits. The first audit was done on June 24, 2026. 6. The Director of Nursing or designee will review completed transfer audits weekly to identify trends, ensure corrective actions are completed, and provide additional education as needed. In addition, unannounced spot checks on nurse aides while completing transfers will be completed. On July 21, 2026, a review was conducted to verify the complete implementation of the facility's corrective action plan. All staff interviewed confirmed they received the training described in the facility's action plan. All nursing staff were aware of the requirements for resident transfers and the abuse policy. Staff were observed transferring sampled residents according to their care plan. All training was completed by July 13, 2026. 28 Pa. Code 201.18(b)(1)(3) Management 28 Pa. Code 211.10(d) Resident care policies 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services		