STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365920	A. Building B. Wing	11/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Embassy of Lebanon	700 Monroe Road Lebanon, OH 45036

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39702 Based on medical record review, observations, interviews and policy reviews the facility failed to ensure urinary catheter care was provided in a dignified manner. This affected one (#19) out of three residents reviewed for resident rights. The facility census was 63. Findings include Review of medical record for Resident #19 revealed an admitted [DATE]. Diagnoses included neuromuscular dysfunction of bladder, inflammatory disorder of male genital organ, cystitis without hematuria, tracheostomy, and obstructive and reflux uropathy. Review of Quarterly Minimum Data Set (MDS) dated [DATE] for Resident #19 revealed an resident was cognitively intact. Resident #19 was substantial maximal assistance for toileting, and bathing. Resident #19 was coded with placement if an indwelling urinary catheter. Review of plan of care dated 09/19/24 revealed that Resident #19 was at risk for potential for complications related to the use of suprapubic catheter related to neurogenic bladder. Interventions included change Foley collection bag per facility policy and as needed, encourage adequate fluid intake daily, notify the physician of abnormal lab values, obtain vital signs if resident becomes symptomatic, position catheter bad, and tubing below the level of the bladder to ensure no tubing, make sure tubing was not under resident legs, and provide Foley catheter care per facility policy and as needed. Review of the physician orders for Resident #19 revealed an order dated 12/11/23 catheter care every day shift and night shift. (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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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 11/18/24 at 2:20 P.M. with Certified Nursing Assistant (CNA) #20 revealed staff knocked on the door of Resident #19, donned personal protective equipment and advised Resident #19 that she would be providing catheter care. CNA #20 donned gloves and gown, entered residents room, gathered equipment, laid paper towel on the floor and set the urinal on the paper towel under the urinary drainage bag. CNA #20 removed the blanket and sheet exposing the superpublic cath. CNA #20 explained what she was going to be doing and then stabilizing the tubing using soap and water the CNA cleaned the tubing to the drainage bag. CNA #20 using an alcohol pad cleaned the tubing on the drainage bag and emptying the urine into the urinal without touching the sides of the urinal. Once completed the tubing was again wiped with alcohol and inserted into the storage tube on the drainage bag. CNA #20 then measured the urine and disposed the urine in the commode. Interview on 11/18/24 at 2:27 P.M. with CNA #20 verified she did not pull the curtain and did not shut the door to the room, potentially exposing Resident #19 to staff, residents or visitors passing in the hallway. Interview on 11/19/24 at 3:30 P.M. with Director of Nursing (DON) verified the curtain should have been pulled or the door should have been closed to provide resident with privacy. Review of the facility policy titled Quality of Life- Dignity dated 08/2019 stated under number 10, staff shall promote, maintain, and protect resident privacy, including bodily privacy during assistance with personal care and during treatment and procedures. This deficiency represents non-compliance investigated under Complaint Number OH00159216.

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39702 Based on medical record review and staff interviews, the facility failed to ensure urinary catheter care was completed and documented as ordered. This affected one (#64) of three residents reviewed for catheter care. The facility census was 63. Findings include: Medical record review for Resident #64 revealed an admission on 05/20/24 and a discharge on 08/10/24 with diagnoses including but not limited to infection and inflammatory reaction due to other urinary catheter, neuromuscular dysfunction of the bladder, quadriplegia and history of sepsis. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] for Resident #64 revealed an intact cognition. Resident #64 was coded with delusions. Resident #64 was dependent on staff for eating, bed mobility, transfers and toileting. Resident #64 was assessed as having a urinary suprapubic catheter and a colostomy. Review of the plan of care for Resident #64 dated 05/21/24 revealed a potential for complications related to use of suprapubic catheter due to neurogenic bladder. Interventions included assist with suprapubic catheter care as needed, educate resident to report signs and symptoms of infections, and monitor for signs and symptoms of urinary tract infections. Review of the physicians orders for Resident #64 revealed an order dated 05/31/24 for suprapubic catheter care every shift. Review of the Treatment Administration Record (TAR) for June 2024 for Resident #64 revealed no documentation of completed or refused catheter care on 06/06/24, 06/10/24, 06/11/24, 06/12/24, 06/18/24, 06/19/24, 06/20/24, 06/21/24, 06/22/24, 06/23/24, 06/27/24 on day shift. Review of the TAR for July 2024 for Resident #64 revealed no documentation of completed of refused catheter care on 07/03/24, 07/05/24, 07/06/24, 07/07/24, 07/20/24, 07/21/24 on day shift. Interview on 11/25/24 at 3:10 P.M. with Director of Nursing (DON) verified the documentation for catheter care was not initialed as completed or refused and it should have been for Resident #64. This deficiency represents non-compliance investigated under Complaint Number OH00159216.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39702 Based on medical record review, observation, staff interview and policy review, the facility failed to follow the physician orders for medication administration. This affected two (#30 and #64) of four residents reviewed for medication administration. The facility census was 63. Findings include: 1. Medical record review for Resident #30 revealed an admission on 07/03/24 with diagnoses of insomnia. Review of the quarterly Minimum Data Set (MDS) assessment for Resident #30 revealed a moderately impaired cognition. Resident #30 requires staff assistance for the completion of activities of daily living. Review of the physicians orders for Resident #30 revealed an order dated 10/04/24 and a for melatonin oral tablets 3 milligrams with directions for administration to give 3 mg by mouth at bedtime for insomnia and an order dated 07/03/24 for melatonin oral tablets 3 mg with directions to administer 3 tablets by mouth at bedtime for insomnia. Review of the medication administration record (MAR) for the month of October 2024 for Resident #30 revealed resident was administered melatonin 3 mg tablets one tablet at bedtime and melatonin 3 mg tablets give three tablets at bedtime. Interview on 11/19/24 at 2:30 P.M. with the Director of Nursing (DON) verified the MAR for the month of October 2024 revealed Resident #30 received melatonin in error and should not have had two orders for the same medication. 2. Medical record review for Resident #64 revealed an admission on 05/20/24 with diagnoses that include quadriplegia, hypotension, and chronic pain. Review of the Admission MDS dated [DATE] for Resident #64 revealed an intact cognition. Resident #64 was dependent on staff for activities of daily living. Review of the active physician orders for Resident #64 for the month of May 2024 revealed an order dated 05/24/24 for midodrine oral tablet 10 milligrams (mg), give 10 mg by mouth every hour hours, hold if blood systolic blood pressure (SBP) is over 110. Review of the medication administration record for Resident #64 for the month of May 2024 revealed medication was administered eight times (05/24/24 at midnight, on 05/27/24 at midnight, on 05/28/24 at 4:00 P.M., on 05/29/24 at midnight, on 05/29/24 at 4:00 P.M., on 05/31/24 at midnight, at 8:00 A.M. and at 4:00 P. M.) when documented blood pressure was not obtained/documented or elevated over 110 SBP. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the active physician orders for Resident #64 for the month of June 2024 revealed an order dated 05/24/24 and discontinued on 06/14/24 for midodrine oral tablet 10 milligrams (mg), give 10 mg by mouth every eight hours, hold if blood SBP is over 110. Further review revealed a time of medication administration change dated 06/14/24. Review of the medication administration record for Resident #64 for the month of June 2024 revealed medication was administered seventeen times (06/01/24 at 4:00 P.M., 06/02/24 at 4:00 P.M., 06/06/24 at 8:00 A.M., 06/06/24 at 8:00 P.M., 06/08/24 at midnight, 06/09/24 at midnight, 06/10/24 at 4:00 P.M., 06/11/24 at 8:00 A.M., 06/11/24 at 4:00 P.M., 06/14/24 at midnight, 06/14/24 at 4:00 P.M., 06/15/25 at hour of sleep (hs), 06/15/24 at 2:00 P.M., 06/17/24 at 8:00 A.M., 06/19/24 at hs, 06/26/24 at hs and 06/28/24 at hs) when documented blood pressure was not obtained/documented or elevated over 110 SBP. Review of the active physician orders for Resident #64 for the month of July 2024 revealed medication was administered eight times (07/03/24 at 2:00 P.M., 07/04/24 at HS, 07/18/24 at HS, 07/19/24 at 2:00 P.M. 07/20/24 at 2:00 P.M., 07/21/24 at HS, 07/23/23 at 2:00 P.M. and 07/30/24 at HS) Review of the active physician orders for Resident #64 for the month of August 2024 revealed an order dated 06/14/24 for midodrine oral tablet 10 milligrams (mg), give 10 mg by mouth upon rising, 2:00 P.M. to 5:00 P. M. and at HS hold if blood SBP is over 110. Review of the MAR for Resident #64 for the month of August 2024 revealed medication was administered five times (08/01/24 at HS, on 08/03/24 at HS, on 08/04/24 at HS, 08/05/24 at HS and 08/10/24 at 8:00 A.M. Interview on 11/21/24 at 4:10 P.M. with the DON verified medication was not administered as ordered when SBP were elevated over 110 or the blood pressure was not obtained prior to administration. Review of the facility's policy titled Medication Administration dated November 2017 revealed it is the policy of this facility to administer medication as ordered in accordance with manufacturer recommendations. This deficiency represents non-compliance investigated under Complaint Number OH00159216.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39702 Based on medical record review, observation, staff interview, review of medication manufacturer instructions, and review of facility policy, the facility failed to ensure a staff member primed (performed a safety test) when using an insulin pen-injector, resulting in a significant medication error. This affected one (#2) of five residents observed for medication administration. The facility census was 63. Findings include: Review of Resident #02's medical record revealed an admitted [DATE]. Diagnoses included type one diabetes mellitus. Review of an admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #02 was cognitively intact and received insulin injections. Review of the physician orders for Resident #02 revealed orders dated 11/07/24 for Lantus SoloStar Subcutaneous Solution Pen-injector 100 units per milliliter (long-acting insulin) inject 45 units subcutaneously when rising for diabetes mellitus and Humalog kwik pen Subcutaneous Solution pen injector 100 unit/ml inject per sliding scale of 150-201 give three units, 201-250 give six units, 251-300 give nine units, 301-350 give 12 units and 351-400 give 15 units before meals and if blood sugar is over 400 call physician. Observation on 11/20/24 at 8:00 A.M. revealed Licensure Practical Nurse (LPN) #95 removed Resident #02's Lantus SoloStar Subcutaneous Solution Pen-injector and the Humalog Kwik Pen Subcutaneous Solution Pen injector from the medication cart and applied a new needle to both pens. LPN #95 then entered Resident #02's room. LPN #95 dialed 45 units on the Lantus SoloStar Subcutaneous Solution Pen-injector and dialed up 12 units of Humalog kwik pen subcutaneous solution per physicians order for blood sugars of 323. LPN #95 did not prime the Lantus SoloStar Subcutaneous Solution Pen-injector needle or the Humalog kwik pen subcutaneous solution pen injector before dialing the dose. LPN #95 then administered the insulin into Resident #34's right abdomen. During an interview on 11/20/24 at 8:20 A.M., LPN #95 confirmed she did not prime Resident #02's Lantus SoloStar Subcutaneous Solution Pen-injector needle or the Humalog Kwik Pen Subcutaneous solution pen injector before administering the ordered dose. Review of the manufacturer instructions for the Lantus SoloStar Subcutaneous Solution Pen-injector and the Humalog Kwik Pen Subcutaneous Solution Pen-injector revealed after attaching a needle to the pen, a safety test must be performed. A safety test was completed by: Dial a test dose of two units. Hold pen with the needle pointing up and lightly tap the insulin reservoir so the air bubbles rise to the top of the needle. This will help you get the most accurate dose. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Press the injection button all the way in and check to see that insulin comes out of the needle. The dial will automatically go back to zero after you perform the test. If no insulin comes out, repeat the test two more times. If there is still no insulin coming out, use a new needle and do the safety test again. Always perform the safety test before each injection. Never use the pen if no insulin comes out after using a second needle. Review of the facility's policy titled Medication Administration dated November 2017 revealed it is the policy of this facility to administer medication as ordered in accordance with manufacturer recommendations. This deficiency represents non-compliance investigated under Complaint Number OH00159216.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39702 Based on medical record, staff interviews and policy review, the facility failed to ensure staff accurately documented dietary intake of meals. This affected one (#64) of three residents reviewed for staff assistance with dietary intake. The facility census is 63. Findings include: Medical record review for Resident #64 revealed an admission on 05/20/24 and a discharge on 08/10/24 with diagnoses including but not limited to quadriplegia and history of sepsis. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] for Resident #64 revealed an intact cognition. Resident #64 was coded with delusions. Resident #64 was dependent on staff for eating, bed mobility, transfers and toileting. Review of the plan of care for Resident #64 is at risk for self care deficit related to diagnoses sepsis, paraplegia due to post motor vehicle accident and chronic pain. Resident is alert and oriented times three, communicates needs effectively, and requires total assistance with activities of daily living. Review of the physicians orders for Resident #64 revealed a diet order for a regular, regular texture, thin liquid diet. Review of the medical nutrition and hydration assessment dated [DATE] for Resident #64 revealed admission weight of 127.9 pounds with an ideal body weight of 115 pounds, Resident #64 was a dependent diner with intakes of meals between fifty and seventy five percent. Registered dietician note revealed resident denies any chewing or swallowing problems on current diet with recommendations of fortified foods. Discharge weight on 08/10/24 revealed a weight of 116.2 pounds. Review of the facility staff schedule dated 06/28/24 revealed there was a staff member assigned to Resident #64 to assist with meal consumption. Review of the facility state tested nursing assistant (STNA) documentation for Resident #64 dated 06/15/24 to 06/28/24 revealed no documentation/percentages consumed for twenty one different meals. Further review of the document revealed no dietary intakes were recorded for 06/15/24, 06/16/24, 06/19/24, and partial documentation on 06/17/24 (no noon or evening meal), 06/18/24 (no evening meal), 06/20/24 (no evening meal), 06/21/24 (no evening meal), 06/23/24 (no noon or evening meal), 06/24/24 (no evening meal), 06/25/24 (no evening meal), 06/27/24 (no noon or evening meal and 06/28/24 (no evening meal). (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 11/20/24 with Registered Dietician (RD) #167 stated no concerns with weight loss during stay. RD #167 stated Resident #64 did not report to her any lack of staff support for meals or times when she did not receive a meal tray. RD #167 stated weight stabilized after admission and reflected loss of additional fluids received at the hospital. RD #167 verified the lack of documentation in the medical record for percentage of meals consumed and reports she completes her own assessment with interviews of residents. Interview on 11/25/24 at 3:25 P.M. with Director of Nursing (DON) verified the meal intake documentation was not complete as it should have contain percentages consumed for all meals and didn't. Review of the facility policy titled Activities of Daily Living (ADL's) Supporting, dated 03/2018 revealed the facility failed to implement the policy as written. The policy states appropriate care and services will be provided for residents who are unable to care out ADL's independently in accordance with the plan of care including dining (meals and snacks). This deficiency represents non-compliance investigated under Complaint Number OH00159216.