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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365920	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/14/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of facility self-reported incidents (SRI's), staff interviews and policy review, the facility failed to timely report an allegation of verbal abuse to the survey agency as required. This affected one (#53) of three residents reviewed for abuse. The facility census was 59. Findings include: Medical record review for Resident #53 revealed an admission on [DATE] with diagnoses including but not limited to chronic obstructive pulmonary disease, intermittent explosive disorder, psychosis not due to substance or physiological condition, dementia with behavioral disturbances and anxiety. Review of the annual Minimum Data Set (MDS) assessment for Resident #53 dated 03/27/26 revealed a severely impaired cognition. Resident #53 was not coded with any behaviors during the assessment period. Resident #53 was dependent for all activities of daily living. Resident #53 was coded as receiving the following medication drug classifications during the look back period: antianxiety, antidepressant, diuretic, opioid, hypoglycemic, anticonvulsant. Resident #53 was coded as receiving hospice services. Review of the plan of care for Resident #53 revealed resident had cognitive loss related to dementia as evidenced by memory problems, impaired decision making and altered mental status dated 05/19/2017. Interventions include daily interaction with family members, monitor Resident #53's responses to assess understanding and repeat as indicated, honor resident choices whenever possible and attempt to assess her preferences by monitoring response to care. Review of the progress note dated 03/25/26 at 5:38 P.M. for Resident #53 revealed resident experiencing increased anxiety. Nurse Practitioner increased Ativan to one milligram (mg) three times a day from 0.5 mg. Hospice sending nurse for additional evaluation. Review of the progress noted dated 03/26/26 to 04/18/26 was silent for any documentation related to behaviors. Review of the facility SRI's revealed there were no SRI's involving the incident for Resident #53. Interview on 04/09/26 at 4:33 A.M. with Licensed Practical Nurse (LPN) #35 stated the facility has several residents that have requested that Certified Nursing Assistant (CNA) #31 not provide care for them. CNA #31 has been reported to management for being verbally abusive to other staff members and was suspended during the investigation. LPN #35 stated the facility took staff witness statements at that time frame, but CNA #31 was able to return to work and then bragged about having a paid vacation. LPN #35 stated CNA #31 has refused to assist other staff members when asked. LPN #35 stated he/she was aware of CNA #31 being reported for bullying behaviors towards employees but does not have any information of a specific incident involving residents. LPN #35 confirmed multiple current residents have requested CNA #31 not be assigned to their care. LPN #35 denied knowledge of a formal list of residents that have requested facility to provide alternate staff when CNA #31 is assigned to the unit they reside on. Interview on 04/09/26 at 5:18 A.M. with CNA #33 stated he/she had knowledge of CNA #31 being escorted out of the facility in February for allegations of unacceptable behavior towards other staff members. CNA #33 reported that residents were questioned at that time and several residents reported the CNA as being loud and confrontational at times. Interview on 04/09/26 at 5:50 A.M. with CNA #32 stated she was in the room assisting CNA #31 with care for Resident #53 when she witnessed the staff member raise her voice and start (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	clapping her hands in front of the residents' face while providing care. CNA #32 reported the incident to the Director of Nursing (DON) via text and stated she was never contacted for additional information. CNA #32 reported the incident in her opinion was verbal abuse. Review on 04/13/26 of a facility file revealed a witness statement dated 04/01/26 and handwritten by certified nurse assistant (CNA) #31. The document stated CNA #31 and CNA #32 revealed CNA had gotten Resident #53 up in her chair and the resident was screaming uncontrollably. CNA #31 documented that she gently clapped her hands together and stated the resident name and that she needed her to calm down. CNA #31 stated she was not aggressive but trying to get her attention. CNA #31 documented that when she clapped her hands and called the residents' name she calmed down. CNA #31 statement stated Resident #53 started screaming again because of the shower. Continued review of the documents revealed one other statement from Licensed Practical Nurse (LPN) #38 stating she did not witness CNA #31 being aggressive to Resident #53. The file also contained a document with current employee's names and phone numbers revealing that a test message titled Abuse and Neglect was sent on 04/01/26 at 7:53 A.M. The file did not include any other documentation, investigation, witness statements or body assessments related to the incident. Interview on 04/13/26 at 10:43 A.M. with DON stated she spoke with the staff member reporting the incident on the morning of 04/02/26 and requested that she write a witness statement. DON verified that she never received the information and concluded the incident was not abuse due to the knowledge of the residents' history of behaviors and staff statements that were provided. Interview on 04/13/26 at 1:31 P.M. with Administrator stated the facility did not initiate a SRI regarding the identified incident and should have. Review of the facility policy titled Abuse, Neglect and Exploitation, undated revealed reporting of all alleged violations to the administrator, state agency, adult protective services and to all other required agencies with specified time frames. This deficiency is based on incidental findings discovered during the course of this complaint investigation.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of facility self-reported incidents (SRI), staff interviews and facility policy, the facility failed to have documented evidence that an allegation of abuse was thoroughly investigated for Resident #53. This affected one (#53) of three residents reviewed for abuse. The facility census was 59. Findings include: Medical record review for Resident #53 revealed an admission on [DATE] with diagnoses including but not limited to chronic obstructive pulmonary disease, intermittent explosive disorder, psychosis not due to substance or physiological condition, dementia with behavioral disturbances and anxiety. Review of the annual Minimum Data Set (MDS) assessment for Resident #53 dated 03/27/26 revealed a severely impaired cognition. Resident #53 was not coded with any behaviors during the assessment period. Resident #53 was dependent for all activities of daily living. Resident #53 was coded as receiving the following medication drug classifications during the look back period: antianxiety, antidepressant, diuretic, opioid, hypoglycemic, anticonvulsant. Resident #53 was coded as receiving hospice services. Review of the plan of care for Resident #53 revealed resident had cognitive loss related to dementia as evidenced by memory problems, impaired decision making and altered mental status dated 05/19/2017. Interventions include daily interaction with family members, monitor Resident #53's responses to assess understanding and repeat as indicated, honor resident choices whenever possible and attempt to assess her preferences by monitoring response to care. Interview on 04/09/26 at 5:50 A.M. with Certified Nursing Assistant (CNA) #32 stated she was in the room assisting CNA #31 with care for Resident #53 when she witnessed the staff member raise her voice and start clapping her hands in front of the residents' face while providing care. CNA #32 reported the incident to the Director of Nursing (DON) via text and stated she was never contacted for additional information. CNA #32 reported the incident in her opinion was verbal abuse. Review on 04/13/26 of a facility file revealed a witness statement dated 04/01/26 and handwritten by certified nurse assistant (CNA) #31. The document stated CNA #31 and CNA #32 revealed CNA had gotten Resident #53 up in her chair and the resident was screaming uncontrollably. CNA #31 documented that she gently clapped her hands together and stated the resident name and that she needed her to calm down. CNA #31 stated she was not aggressive but trying to get her attention. CNA #31 documented that when she clapped her hands and called the residents' name she calmed down. CNA #31 statement stated Resident #53 started screaming again because of the shower. Continued review of the documents revealed one other statement from Licensed Practical Nurse (LPN) #38 stating she did not witness CNA #31 being aggressive to Resident #53. The file also contained a document with current employee's names and phone numbers revealing that a test message titled Abuse and Neglect was sent on 04/01/26 at 7:53 A.M. The file did not include any other documentation, investigation, witness statements or body assessments or resident interviews were included in the investigation file Interview with the Administrator on 04/13/26 at 1:31 P.M. verified the above findings and confirming that a SRI and thorough investigation should have been completed and was not. Review of the facility policy titled Abuse, Neglect and Exploitation, undated revealed an immediate investigation is warranted when suspicion of abuse, neglect, or exploitation occurs. Additionally, states identifying and interviewing all involved persons including the alleged victim, alleged perpetrator and witnesses. This deficiency is based on incidental findings discovered during the course of this complaint investigation.

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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 record review, observations, staff and resident interviews and policy review, the facility failed to ensure two (#22 and #21) dependent residents were assisted in a timely manner for meal assistance. Additionally, the facility failed to provide care and services for one (#46) dependent resident with facial hair. This affected three (#22, #21 and #46) out of three residents reviewed for activities of daily living. The facility census was 59. Findings include: 1. Medical record review for Resident #21 revealed an admission on [DATE] with diagnoses including but not limited to chronic respiratory failure, displaced fracture of third cervical vertebra, and quadriplegia. Review of the admission Minimum Data Set (MDS) assessment for Resident #21 dated 02/27/26 revealed an impaired cognition with a brief interview for mental status (BIMS) score of twelve. Resident #21 eating was coded as not applicable. Resident required total staff dependence for toileting, bed mobility and transfers. Resident #21 was coded as receiving nutrition via a feeding tube. Review of the plan of care for Resident #21 required assistance for activities of daily living (ADL) due to quadriplegia. Interventions included resident is totally dependent and does not participate in any aspect of care (eating, toileting, bed mobility bathing and mobility). Review of the active physician orders for Resident #21 revealed an order dated 03/18/26 for regular diet, pureed texture, and thin consistency. Observation on 04/08/25 at 5:25 P.M. of meal tray being delivered to residents' rooms. Observation on 04/08/26 at 6:08 P.M. of Resident #21 laying in bed with eyes closed. Observation of the meal tray sitting on the bedside table covered and in front of the resident. No staff are present in room assisting with meal. 2. Medical record review for Resident #22 revealed an admission on [DATE] with diagnoses including but not limited to amyotrophic lateral sclerosis (ALS). Review of the MDS assessment for Resident #22 dated 03/20/26 revealed an intact cognition with a brief interview for mental status (BIMS) score of eleven. Review of the comprehensive plan of care for Resident #22 revealed resident is at high risk for aspiration ad complications due to dysphagia related to respirator dependence. Interventions include diet as ordered, feed in upright position and maintain for one hour due to aspiration risk. Review of the active physician orders for Resident #22 revealed an order for regular diet, regular texture and regular fluids. Observation on 04/08/25 at 5:25 P.M. of meal tray being delivered to residents' rooms. Observation on 04/08/26 at 6:10 P.M. of Resident #22 sitting in his bed in his room. No staff are present in room assisting with meal. Observation of meal tray sitting on the table in the residents' room with cover on it and untouched. Interview on 04/08/26 at 6:05 P.M. with Resident #22 stated the staff have not been in to feed him yet and he is unable to feed himself. Resident #22 states he did not see the staff deliver the evening meal to the room as he has limited vision in his right eye. The meal tray was sitting to the right of the resident on a small table against the wall. Interview on 04/08/26 at 6:10 P.M. with Regional Director of Operations (RDO) verified the trays in Resident #21 and #22's room without staff assisting residents with meal consumption. RDO verified staff should not have left the tray in the room to deliver other trays. RDO stated it is the expectation of staff to assist residents with meals on delivery. Review of facility policy titled Nutrition Services dated 03/2017 stated the facility will provide meals for each resident with preferences accommodated, timely meal service and assistance with eating as needed. 3. Medical record review for Resident #46 revealed an admission on [DATE] with diagnoses to include but not limited to chronic obstructive pulmonary disease, moderate persistent asthma and schizoaffective disorder bipolar type. Review of the quarterly MDS dated [DATE] for Resident #46 revealed an impaired cognition with a BIMS score of eight. Resident #46 was note coded with any behaviors or rejection of care. Resident #46 required staff assistance for eating (set up or clean up), moderate assistance with bed mobility and transfers and dependent for toileting, personal hygiene and bathing. Review of the plan of care for Resident #46 revealed resident needs assistance with activities of daily living. Interventions include resident is totally dependent and does not participate in and aspect (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of the task, requires the assistance of two staff members for showering and bathing. Review of the facility shower schedule for Resident #46 revealed resident was scheduled for showers on Wednesday and Saturday on the evening shift. Review of the facility electronic health record for certified nursing assistant documentation revealed Resident #46 did not receive a shower on 04/04/26 as scheduled. Observation on 04/07/26 at 4:10 P.M. of Resident #46 talking on the phone with a family member. Resident #46 had long white facial hair on chin, jaw line and upper lip. Review of the shower sheets for Resident #46 dated 03/13/25, 03/15/26, 03/23/26 and 03/25/26 were silent for any documentation that Resident #46 was shaved during her shower. The facility was unable to provide shower sheets for shower completed on 04/01/26 or 04/04/26. Review of the electronic health record for Resident #46 bathing task documentation dated 04/04/26 indicated bathing showering task as not applicable. Interview on 04/08/26 at 4:25 P.M. with RDO verified Resident #46 had long hair on chin, jawline and upper lip. RDO stated he would have staff assist the resident with shaving. This deficiency is based on incidental findings discovered during the course of this complaint investigation.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on review of staffing schedules. staff and resident interviews and policy review, the facility failed to ensure a registered nurse (RN) was present in the facility for eight consecutive hours a day as required. This had the potential to affect all 59 residents residing in the facility. The facility census was 59. Findings include: Review of the staffing schedules dated 04/01/26 to 04/07/26 revealed a RN/Director of Nursing (DON) present in the facility for eight hours daily Monday through Friday. Review of the facility employment punches dated 04/06/26 revealed the facility did not have a registered nurse working at the facility. Additionally, the employment time punches revealed three Licensed Practical Nurses (LPN) each working 12 hours shifts remained in the facility to care for the residents. Interview on 04/08/26 at 12:41 P.M. with Resident #12 stated the DON had to go with him for the surgical appointment that was on Monday at an outpatient surgical center. Resident #12 stated there was a mix up with the times and the respiratory therapist could not go with him. Resident #12 reported the same thing happened for the appointment on 04/02/26. Interview on 04/08/26 at 2:40 P.M. with Transportation Coordinator (TC) #19 stated the DON left the facility with Resident #12 for his outpatient surgery in bordering city about 40 minutes from the facility at 10:00 A.M. TC #19 stated they had to be there a few hours before the procedure and the hospital staff required someone to be with the resident during the procedure. TC #19 stated the administration called the surgical center and verified that a respiratory therapist did not need to stay and the DON returned to the facility. TC #19 stated she was only in the facility for about 20 minutes and had to return to the surgical center to pick up Resident #19. TC #19 stated another staff member had to go to the surgical center as she had already left for the day. Interview on 04/08/26 at 4:56 P.M. with the DON verified that she accompanied Resident #12 to the surgical center on 04/02/26 and 04/06/26. DON verified the staffing tool reflected the incorrect hours for her on 04/06/26. DON verified she was not in the facility continuously for eight hours as required and did not have a registered nurse in the facility on 04/06/26. Interview on 04/13/26 at 9:13 A.M. with Administrator verified that DON went with Resident #12 to the appointment on 04/06/26 and was not in the facility for the required 8 hours. Interview on 04/13/26 at 2:12 P.M. with Regional RN #127 verified the employment punches on 04/06/26 did not have the required eight RN hours for facility coverage. Review of the facility policy titled Sufficient Staffing dated 01/2026 stated a registered nurse will serve as the Director of Nursing and will provide administrative oversight of nursing services consistent with regulatory requirements. This deficiency represents non-compliance investigated under Complaint Number 2794837.

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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** Based on record review, staff interview, and policy review, the facility failed to ensure medications were administered to the correct resident resulting in significant mediation errors. This affected one (#60) of three residents reviewed for medication administration. The facility census was 59. Findings include: Medical record review for Resident #60 revealed an admission on [DATE] with diagnoses including but not limited to end stage renal disease, hemorrhage due to vascular prosthetic devices and implants, hypertension and hypothyroidism. Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] for Resident #60 was not completed and in progress. Review of the plan of care for Resident #60 dated 04/04/26 revealed resident was prescribed antibiotic therapy related to pneumonia for seven days. Interventions included administer medication as ordered, observing adverse reactions related to antibiotics, and report pertinent laboratory results to physician. Review of the physicians orders for Resident #60 revealed orders for aspirin enteric coated 81 milligrams (mg) on tablet at bedtime dated 03/28/26, calcium carbonate vitamin D 600mg-10mg one tablet at bedtime dated 03/28/26, cefuroxime axetil 250 mg one tablet by mouth for seven days dated 03/28/26, dialysis on Monday, Wednesday and Friday, ferrous sulfate oral tablet 325 mg one tablet daily dated 03/28/26, latanoprost ophthalmic emulsion 0.0005 % one drop in both eyes at bedtime dated 03/28/26, levothyroxine sodium oral tablet 75 micrograms (mcg) on tablet daily dated 03/28/26, omega- three oral capsule 500 mg one capsule by mouth daily dated 03/28/26, Prevastatin sodium oral tablet 20 mg one table by mouth dated 03/28/26, prilosec over the counter tablet delayed release 20 mg one tablet daily dated 03/28/26, theragram M oral tablet give one tablet daily at bedtime dated 03/28/26, torsemide oral tablet 20 mg one tablet by mouth every Tuesday, Thursday, Saturday and Sunday dated 03/28/26, Vitamin b 12 oral tablet give one tablet by mouth daily dated 03/28/26, hydralazine oral tablet 25 mg one tablet by mouth three times a day dated 02/28/26, Review of the progress note for Resident #60 dated 04/03/28 at 8:30 P.M. revealed family member was notified of medication errors and new orders to obtain vital signs every four hours were given. Review of the progress notes for Resident #60 dated 04/03/26 at 10:28 P.M. revealed nurse administered another resident's (#5) medication to this resident. Vital signs taken were blood pressure 101.56, pulse 67, respirations 18 and temperature 98.0 Fahrenheit (F). On call Nurse Practitioner (NP) notified and instructed to start neuro checks every hour and vital signs every four hours. Intervention implemented 15-minute checks. Review of the e-interact change in condition evaluation dated 04/03/26 at 10:29 P.M. revealed abnormal vital signs and resident is tired, weak confused or drowsy. Vital signs were documented as blood pressure 71/44, pulse 60 and regular, respirations 10 and temperature was 98.8 F and oxygen saturation rate was 90 percent on room air. Resident #60 has a medication allergy to metformin. Resident #60 code states was do not resistate comfort care arrest. Resident #60 was experiencing a mental status change to include increased confusion with an abrupt onset. Resident #60 neurological assessment relevant to the change in condition has been reported and includes aletered level of consciousness, and abnormal speech. Family was notified along with the provider with orders to sent to the emergency room for evaluation and monitoring. Review of the hospital progress note dated 04/07/26 for Resident #60 revealed resident was admitted to hospital on [DATE] altered mental status. Diagnoses documented revealed acute hypoxic and hypercapnic respiratory failure requiring mechanical ventilation and extubated on 04/05/26. Resident #60 was diagnosed with septic shock secondary to pneumonia. Review of the facility investigation documents dated 04/04/25 revealed Resident #60 was hospitalized from [DATE] to 03/27/26 for sepsis secondary to pneumonia and hypothermia prior to admission. The medication error occurred at approximately 7:45 P.M. on 04/03/26 when Resident #60 received aspirin 81 mg one tablet, Entresto 24-26mg one tablet, Lasix 20 mg one tablet, Lexapro 20 mg one tablet, metformin 1000mg one tablet, metoprolol tartrate 12.5 mg one tablet, quetiapine fumarate 200 mg one (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	tablet, Rexulti 2 mg one tablet, Seroquel 200 mg one tablet and Xanax 0.25 mg one tablet. Interview on 04/8/26 at 10:30 A.M. with Licensed Practical Nurse (LPN) #21 verified the medication error occurred involving Resident #60. LPN #21 stated the two residents involved had the same last name and resided on the same unit with rooms beside each other. LPN #21 stated she was interrupted during her medication pass by the potentially dangerous behaviors of another resident. LPN #21 stated she failed to follow the five rights of medication administration. LPN #21 stated once she realized the error she immediately notified on call nurse practitioner (NP) and began monitoring the resident vital signs as ordered. LPN #21 stated she obtained the vital signs and noted a change in mental status and low blood pressure, notified the NP again with new orders to transfer the resident to the hospital. LPN #21 verified the family was notified of the incident. Interview on 04/08/26 at 1:10 P.M. with NP #125 stated Resident #60 was being treated for sepsis prior to admission. NP #125 stated the resident was returned to the hospital on [DATE] due to a dislodged dialysis port and the antibiotic was initiated for pneumonia at that time. NP #125 stated Resident #60 was admitted and treated with mechanical ventilation for treatment of septic shock on 04/03/26. NP #125 stated it was her opinion that the hospitalization was due to the continued respiratory decline and not solely on the medication error that occurred. Review of the facility policy titled Adverse Consequences and Medication Errors dated 04/2014 stated a medication error is defined as the preparation of administration of drugs or biological which is not in accordance with the physicians' orders or accepted professional standards. In the event of a significant medication related error immediate action is taken as necessary to protect the residents' safety and welfare. Significant is defined as resulting in cognitive deterioration or impairment. This deficiency represents non-compliance investigated under Complaint Number 2975141.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 record review, observations, staff interviews and policy review, the facility failed to ensure prescribed medications were not left in residents room unsecured and unsupervised. This affected three (#29, #10 and #45) out of three residents reviewed for medication storage. The facility census was 59. Findings include: 1. Medical record review for Resident #45 revealed an admission on [DATE] with diagnoses including but not limited to cerebrovascular disease, hemiplegia affecting the right side, contractures of muscles multiple sites. Review of the quarterly Minimum Data Set (MDS) assessment for Resident #45 dated 01/09/26 revealed an impaired cognition with a brief interview for mental status (BIMS) score of twelve. Resident #45 required set up assistance from staff for eating, dependent on staff for toileting, and moderate assistance for transfers and bed mobility. Resident #45 was incontinent of bladder and bowel. Resident #45 was coded as having applications of ointments and medication to areas other than feet during the assessment period. Review of the plan of care for Resident #45 dated 06/18/21and revised on 04/25/22 revealed resident had potential for alteration in skin integrity and requires protective/preventative skin care maintenance related to diabetes mellitus, decreased mobility, right sided hemiplegia, and chronic skin condition. Interventions include application of house barrier, weekly skin assessments and pressure relieving devices. Review of the active physicians' order for Resident #45 revealed an order for Diclofenac Sodium external gel 1 % apply to right shoulder 4 grams topically two times a day for pain dated 08/09/25. Observation on 04/08/26 at 10:05 A.M. of Resident #45's room revealed two tubes of diclofenac sodium gel in room unsecured and unsupervised. Additionally, one bottle of dyna-hex 4 antiseptic solution was located in Resident #45's room. Both items were labeled if ingested contract poison control Interview on 04/08/26 at 10:05 A.M. with Director of Nursing (DON) verified the tubes of diclofenac sodium gel and dyna-hex should not have been left in the residents room unsupervised and unsecured. DON verified items should be stored and locked in treatment cart. 2. Medical record review for Resident #10 revealed and admission on [DATE] with diagnoses including but not limited to acute chronic respiratory failure with hypoxia, non-traumatic subarachnoid hemorrhage, and hypothyroidism. Review of the quarterly MDS assessment for Resident #10 dated 03/27/26 revealed an impaired cognition with a BIMS score of eleven. Resident #10 required set up assistance from staff for eating, and was dependent on staff for toileting, transfers and bed mobility. Resident #10 was incontinent of bowel and was coded as having an indwelling urinary catheter. Resident #10 was coded as having applications of ointments and medication to areas other than feet during the assessment period. Review of the plan of care for Resident #10 revealed resident had potential for alteration in skin integrity and requires protective/preventative skin care maintenance related to decreased mobility, foley catheter, gastrostomy tube. Interventions included application of house barrier, weekly skin assessments and pressure relieving devices. Review of the physicians' orders for Resident #10 were silent for any topical medications. Observation on 04/09/26 at 3:15 P.M. of Resident #10 room revealed a bottle of prescription nystatin powder 100,000 units/gram sitting on the residents' dresser unsecured and unsupervised. Additionally, the pharmacy label adhered to the bottle stated for external use only keep out of eyes, inside of mouth or nose and to contact poison control if ingested. Interview on 04/09/26 at 3:20 P.M. with DON verified the Nystatin powder should not have been left in Resident #10's room and should be stored in the treatment cart. 3. Medical record review for Resident #29 revealed an admission on [DATE] with diagnoses including but not limited to neurocognitive disorder with Lewy bodies, dementia with psychotic disturbances, delusions, and Parkinson's disease. Review of the quarterly MDS assessment dated [DATE] for Resident #29 revealed impaired cognitive status with a BIMS score of twelve. Resident #29 requires set up assistance for eating, bed mobility and (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365920	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/14/2026
NAME OF PROVIDER OR SUPPLIER Embassy of Lebanon		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	transfers. Resident #29 required moderate assistance for toileting. Review of the plan of care for Resident #29 revealed resident has neuromuscular impairment related to Parkinson's disease. Interventions include medications as ordered and caution resident to potential for increase unsteadiness and requested assistance as needed. Review of the active physician orders for Resident #29 revealed an order dated Inbrija (Parkinson treatment) inhalation capsule 42 milligrams (mg) inhale 2 puffs every 12 hours as needed for tremors sated 05/28/25. Observation on 04/07/26 at 1:20 P.M. of Resident #29 revealed the inhalation device for Inbrija inhaler in residents' room on her dresser unsecured and unsupervised. Interview on 04/07/26 at 1:20 P.M. with LPN #22 verified the inhaler for Resident #29 should not have been left in the room as she does not have an order for bedside self-administration. Review of the facility policy titled Storage of Medication dated 04/2007 stated the facility shall store all drugs and biological in a safe, secure and orderly manner. This deficiency is based on incidental findings discovered during the course of this complaint investigation.