

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  366296	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/19/2025
NAME OF PROVIDER OR SUPPLIER  Cedars of Lebanon Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  102 East Silver Street 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)
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on resident interview, observation, medical record review, staff interview, and review of the facility policy, the facility failed to ensure medications were not left at the bedside. This affected one (#18) of three residents reviewed for medication storage. The facility census was 45. Findings include: Review of the medical revealed Resident #18 was admitted to the facility on [DATE]. Diagnoses included diabetes, chronic non pressure ulcer of the right heel, lymphedema, congestive heart failure, atherosclerotic heart disease, benign prostatic hyperplasia, chronic kidney disease, atrial fibrillation, chronic pain syndrome, neuroleptic induced Parkinsonism, chronic obstructive pulmonary disease (COPD), insomnia, cellulitis of the right lower limb, mood disorder, personality disorder, cardiomyopathy, obstructive sleep apnea, major depressive disorder, anxiety disorder, and hypothyroidism. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #18 had intact cognition, had no behaviors, and received an opioid (pain medication). Review of September 2025 physician 's orders revealed Resident #18 had an order for oxycodone-acetaminophen 5-325 milligrams (mg) one tablet every six hours for pain and Tylenol Cold and Flu 500 mg four times daily for 14 days for respiratory and body aches. Further review revealed Resident #18 did not have a physician order to leave medications at the bedside. Interview on 09/19/25 at 10:10 A.M. with Resident #18 revealed staff always left medications on his bedside table. Concurrent observation revealed the resident had two yellow tablets and a blue tablet in a medication cup in his bedside table. Resident #18 stated the agency nurse left it in his room a couple days ago and he kept it because he was going to take them later if he needed them. Interview on 09/19/25 at 12:50 P.M. with Licensed Practical Nurse (LPN) #225 verified Resident #18 had three tablets in a medication cup in his room. LPN #225 confirmed the medications were two yellow Tylenol Cold and Flu 500 mg tablets and one blue oxycodone with acetaminophen 5-325 mg, which was a narcotic. Review of the facility policy titled, Administering Oral Medications, dated October 2010, revealed the purpose of the policy was to provide guidelines for the safe administration of oral medication. Further review revealed staff were to remain with the resident until all medication had been taken. This deficiency represents non-compliance investigated under Complaint Number 2577683.</p>

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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