

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

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Form Approved OMB
No. 0938-0391

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 07/16/2026
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)		
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 observation, staff interviews and policy review, the facility failed to ensure food items and kitchen equipment were maintained in a manner to prevent foodborne illness. This had the potential to affect all 45 residents who receive food from the kitchen. Findings include: 1. Observation of the facility's kitchen on 07/13/26 at 10:10 A.M. revealed there was a dirty pair of gloves that were turned inside out sitting on the ledge underneath the steam table, and there was gray debris resembling dust on a fan which was located over the knives and pointed towards the steam table, on the hood above the stove, and on the plate cover rack. Interview with Dietary Manager #64 on 07/13/26 at 10:10 A.M. verified there was a dirty pair of gloves that were turned inside out sitting on the ledge underneath the steam table and gray debris resembling dust on a fan which was located over the knives and pointed towards the steam table, on the hood above the stove, and on the plate cover rack. Review of the facility's food receiving and storage policy dated October 2017 revealed food services would maintain clean food storage areas at all times. 2. Observation of the facility's kitchen on 07/14/26 at 4:30 P.M. revealed [NAME] #57 took the temperatures of the food items on the steam table during dinner meal service. The tuna salad was 48.6 degrees Fahrenheit and the pasta salad was 49.3 degrees Fahrenheit. [NAME] #57 continued to serve to the pasta and tuna salad to the residents. Interview with [NAME] #57 on 07/14/26 at 4:30 P.M. verified the tuna salad was being held at 48.6 degrees Fahrenheit and the pasta salad was being held at 49.3 degrees Fahrenheit during food service on 07/14/26. Review of the facility's food preparation and service policy dated October 2018 revealed the danger zone for food temperatures was between 41 degrees Fahrenheit and 135 degrees Fahrenheit.		

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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview and policy review, the facility failed to ensure resident's received food portions based on the men spreadsheet. This had the potential to affect 41 residents who the facility identified who were on a regular or mechanical soft diet. The facility census was 45. Findings include: Review of the facility's therapeutic spreadsheet dated 07/14/26 revealed the regular diet included tuna salad served on a tortilla and four ounces of coleslaw. The mechanical soft diet included tuna salad on bread and one soft baked cookie. Observation of tray line in the kitchen on 07/14/26 at 4:30 P.M. revealed [NAME] #57 was serving residents who were ordered regular diets sere served tuna salad with no tortilla or bread and a three ounce scoop of coleslaw. [NAME] #57 was serving residents who were ordered mechanical soft diets a tuna salad without any bread and two cookies. Interview with [NAME] #57 on 07/14/26 at 4:30 P.M. verified residents on a regular diet were served a three ounce scoop of coleslaw and no tortilla/bread. Residents on a mechanical soft diet were served two cookies and no bread. [NAME] #57 verified the therapeutic spreadsheet stated to serve the tuna salad on a tortilla or bread and one cookie for residents on a mechanical soft diet. Review of the facility's menus policy dated October 2018 revealed menus for regular and therapeutic diets were written at least two weeks in advance. The dietitian reviewed and approved all menus.		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observations, staff interviews, and policy review, the facility failed to ensure residents had a safe and sanitary environment. This affected 12 (#2, #7, #12, #16, #23, #24, #32, #35, #38, #40, #43, and #45) of 45 residents who resided at the facility. The facility census was 45. Findings include:1. Observation on 07/23/26 at 10:20 A.M. revealed Resident #40 and #45 shared a room. Observations of the bathroom revealed a white sheet on the ground around the toilet, with approximately half the sheet being visibly wet. The bathroom had a strong odor of urine and several gnats were observed. The bathroom floor was painted and was peeling up near the door way. Interview on 07/13/2026 at 10:25 A.M. with Housekeeping Aide (HA) #23 revealed Resident #40 and #45 frequently urinate on the bathroom floor and a sheet was put down to soak up the urine. HA #23 verified that gnats were in the bathroom and there was an odor of urine. HA #23 verified the floor was recently painted and was starting to peel and there was visible liquid pooling underneath the paint layer that he assumed was urine. Interview on 07/13/2026 at 10:29 A.M. with Director of Nursing (DON) #54 verified Resident #40 and #45's flooring was recently redone. DON #45 verified the bathroom had an odor of urine, gnats and a liquid on the floor. Interview on 07/16/2026 at 9:33 A.M. with Maintenance Director #23 stated the removed the tile flooring and painted the floor in Resident #40 and #45's room due to urine causing the tiles to keep peeling up. He verified the paint was peeling due to urine on the floor. 2. Observation of Resident #23, #24 and #35's bathroom on 07/16/26 at 9:59 A.M. revealed the baseboard in the bathroom was falling off the wall and the wall behind the baseboard was exposed. There were chunks of the wall that had broken apart and were laying behind the baseboard. Observation of Resident #2 and #7's room on 07/16/26 at 10:01 A.M. revealed there was a brown round stain on the ceiling tile above the sink in the bathroom and gray debris on the ceiling vent in the bathroom. There was gray debris on the ceiling vent in Resident #2 and Resident #7's room near the door to their room. Observation of Resident #32 and #38's room on 07/16/26 at 10:02 A.M. revealed the floor throughout Resident #32 and #38's room was sticky. There was also a brown build up around the edges of Resident #32 and #38's floor throughout their room. Observation of Resident #12, #16 and #43's room on 07/16/26 at 10:04 A.M. revealed the baseboard in Resident #12, #16 and #43's bathroom was falling off the wall exposing the dry wall underneath and there was a brown build up around the edges of Resident #12, #16 and #43's floor throughout their room. Interview with Regional Director of Clinical Operations (RDCO) #77 on 07/16/26 at 9:59 A.M verified the baseboard in Resident #23, #24 and #35's bathroom was falling off the wall; there was a brown round stain on the ceiling tile above the sink in Resident #2 and Resident #7's bathroom; there was gray debris on the ceiling vent in Resident #2 and Resident #7's bathroom; there was gray debris on the ceiling vent in Resident #2 and Resident #7's room near the door to their room; the floor throughout Resident #32 and #38's room was sticky; there was a brown build up around the edges of Resident #32 and #38's floor throughout their room; the baseboard in Resident #12, #16 and #43's bathroom was falling off the wall exposing the dry wall underneath; and there was a brown build up around the edges of Resident #12, #16 and #43's floor throughout their room. Review of the facility's Homelike Environment policy dated May 2017 revealed residents were provided with a safe, clean, comfortable and homelike environment. This deficiency represents non-compliance investigated under Complaint Number 2992063 and Complaint Number 3022583.		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, the facility failed to complete a discharge summary after Resident #74 was discharged to another facility and failed to ensure the appropriate information was communicated when Resident #3 was transferred to the hospital. This affected two (#3 and #49) of six residents reviewed for discharges and transfers. The facility census was 45. Findings include: 1. Review of the medical record revealed Resident #49 had an admissions date of 11/10/25 and a discharge date of 06/03/26. Diagnoses included schizoaffective disorder, bipolar disorder, drug induced subacute dyskinesia, dementia, borderline personality disorder and post-traumatic stress disorder (PTSD). Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #49 was cognitively impaired. Review of the medical record revealed a discharge summary was not completed for Resident #49. Interview on 07/14/2026 at 3:13 P.M. with Social Services #74 verified the discharge summary for Resident #49 was not completed. Review of the undated facility policy titled Discharge Summary and Plan revealed when a discharge is anticipated, a discharge summary and post-discharge plan will be developed to assist the resident to adjust to his/her new living environment. 2. Review of the medical record revealed Resident #3 had an admissions date of 02/20/25 with diagnoses including type II diabetes mellitus, chronic obstructive pulmonary disease, and obstructive sleep apnea. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #3 was cognitively intact. Review of the progress notes revealed on 05/21/26 at 3:00 P.M., Resident #3 called 911 and was being transported to the hospital. Review of the progress note dated 05/21/26 at 4:43 P.M. revealed the registered nurse from the hospital contacted the facility to request Resident #3's paperwork. Facility nurse stated Resident #3 did not have paperwork because he called 911 independently. The hospital nurse was given report and paperwork was faxed to the hospital. Interview on 07/15/26 at 12:43 with the Director of Nursing (DON) verified the nurse should send paperwork anytime a resident is transferred to the hospital. The DON verified the nurse should have sent paperwork when Resident #3 was transferred to the hospital. Review of the facility policy titled Transfer or Discharge, Information for Receiving Provider dated 07/30/25 revealed when a resident is transferred (return anticipated) specific information about the resident is conveyed to the receiving provider.		

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and staff interview, the facility failed to notify the state mental health authority with a significant change pre-admission screening and resident review (PASARR) for residents with a change in their mental health or physical conditions. This affected two (#2 and #37) of four residents reviewed for significant change PASARR. The facility census was 45. Findings include: 1. Review of Resident #2's medical record revealed Resident #2 was admitted to the facility on [DATE] with diagnoses including schizoaffective disorder bipolar type. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #2 was moderately cognitively impaired. Review of the PASARR dated 01/23/26 revealed Resident #2 had indications of serious mental illness. Resident #2's diagnosis of schizoaffective disorder was marked on the PASARR. Review of Resident #2's progress notes revealed on 01/27/26 at 3:23 P.M., a referral was made for an inpatient psychiatric evaluation due to a recent escalation in behaviors and physical aggression. Resident #2 was accepted for inpatient psychiatric treatment for assessment and stabilization. On 02/10/26, Resident #2 returned from the psychiatric hospitalization. Review of Resident #2's medical record from 01/27/26 to 07/14/26 revealed no documentation that the facility completed a significant change PASARR or notified the state mental health authority of Resident #2's psychiatric hospitalization or change in mental health condition on 01/27/26. Interview with Regional Director of Operations (RDO) #75 on 07/14/26 at 2:56 P.M. verified the facility did not complete a significant change PASARR or notified the state mental health authority of Resident #2's psychiatric hospitalization or change in mental health condition on 01/27/26. 2. Review of Resident #37's medical record revealed Resident #37 admitted to the facility on [DATE] with diagnoses including paranoid schizophrenia and anxiety disorder. Review of the discharge return anticipated Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #37 was moderately cognitively impaired. Review of the PASARR dated 10/22/25 revealed Resident #37 had indications of serious mental illness. Resident #37's diagnoses of schizophrenia and panic or other severe anxiety disorders were marked on the PASARR. Review of Resident #37's progress note dated 03/02/26 revealed a call was placed to Resident #37's mental health provider related to increased delusions and aggression. Resident #37 was being verbally aggressive with peers and staff and were yelling, cursing and making threats to harm others. Resident #37 was picked up at 11:00 P.M. by the transportation provider and Resident #37 was transferred to the psychiatric hospital for evaluation. The local police were called to assist with Resident #37's transfer to the hospital. (continued on next page)		

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/16/26, Resident #37 returned from the psychiatric hospital. Review of Resident #37's medical record from 03/02/26 to 07/14/26 revealed no documentation the facility completed a significant change PASARR or notified the state mental health authority of Resident #37's psychiatric hospitalization or change in mental health condition on 03/02/26. Interview with Regional Director of Operations (RDO) #75 on 07/14/26 at 2:56 P.M. verified the facility did not complete a significant change PASARR or notified the state mental health authority of Resident #37's psychiatric hospitalization or change in mental health condition on 03/02/26.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to monitor residents' blood sugars and notify the physician of a resident's blood sugar that was outside of parameters according to physician's order. This affected one (#38) of twelve residents reviewed for quality of care. The facility census was 45. Findings include: Review of Resident #38's medical record revealed Resident #38 was admitted to the facility 10/13/16. Diagnoses included type two diabetes mellitus with hypoglycemia without coma. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #38 was cognitively intact. Review of the physician order dated 05/22/26 revealed Resident #38 was ordered insulin Lispro 100 units per millimeter (ml) inject as per sliding scale. Blood sugar readings greater than 400 milligrams (mg) per deciliter (dl) should be given five units and then rechecked in two hours. Call the physician if the blood sugar reading was still greater than 400 mg/dl. Review of Resident #38's blood sugar readings dated 05/31/26 revealed Resident #38's blood sugar level was 539 mg/dl on 05/31/26 at 9:58 A.M. and 444 mg/dl on 05/31/26 at 4:58 P.M. There were no additional blood sugars taken between 05/31/26 at 9:58 A.M. and 05/31/26 at 4:58 P.M. There was no documentation the physician was notified of Resident #38's blood sugar levels being above 400 mg/dl on 05/31/26. Review of Resident #38's blood sugar readings dated 06/07/26 revealed Resident #38's blood sugar level was 429 mg/dl on 06/07/26 at 12:47 P.M. and 429 mg/dl on 06/07/26 at 5:18 P.M. Resident #38's blood sugar readings dated 06/07/26 revealed there were no additional blood sugars taken between 06/07/26 at 12:47 P.M. and 06/07/26 at 5:18 P.M. There was no documentation the physician was notified of Resident #38's blood sugar levels being above 400 mg/dl on 06/07/26. Interview with the Director of Nursing (DON) on 7/15/26 at 11:34 A.M. verified Resident #38's blood sugar reading was 539 mg/dl on 05/31/26 at 9:58 A.M. and 444 mg/dl on 05/31/26 at 4:58 P.M. The DON also verified Resident #38's blood sugar reading was 429 mg/dl on 06/07/26 at 12:47 P.M. and 429 mg/dl on 06/07/26 at 5:18 P.M. The DON confirmed there was no documentation that any additional blood sugars were taken on 05/31/26 or on 06/07/26 or that the physician was notified of Resident #38's blood sugar levels being above 400 mg/dl on 05/31/26 or on 06/07/26 for more than two hours.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and medical record review, the facility failed to ensure a resident's pharmacy recommendation was timely addressed and implemented according to the physician's response to the pharmacy recommendation. This affected one (#35) of five residents reviewed for unnecessary medications. The facility census was 45. Findings include: Review of Resident #35's medical record revealed Resident #35 admitted to the facility on [DATE]. Diagnoses including schizoaffective disorder bipolar type and major depressive disorder. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #35 was cognitively intact. Review of the physician order dated 10/27/22 revealed Resident #35 was ordered divalproex sodium tablet delayed release 500 milligrams (mg) give 500 mg by mouth two times a day related to schizoaffective disorder depressive type. Review of Resident #35's pharmacy recommendation dated 11/17/25 revealed Resident #500's divalproex sodium tablet delayed release 500 mg give 500 mg by mouth two times a day was recommended to be reduced. Psychiatrist #80 addressed the pharmacy recommendation on 12/08/25 and wrote to decrease Resident #35's divalproex sodium tablet delayed release to 375 mg two times a day if it was okay with Physician #78. Review of Resident #35's medical record from 11/17/25 to 07/14/26 revealed no documentation that Physician #78 was contacted regarding the 11/17/25 pharmacy recommendation or the recommended gradual dose reduction of Resident #35's divalproex sodium tablet delayed release 500 mg two times a day to divalproex sodium tablet delayed release 375 mg two times a day. Resident #35's divalproex sodium tablet delayed release 500 mg two times a day was not reduced to 375 mg two times a day. Resident #35's divalproex sodium tablet delayed release 500 mg two times a day order remained in place from 11/17/25 to 07/14/26. Interview with the Regional Clinical Director (RCD) #76 on 07/15/26 at 1:51 P.M. verified Resident #35's divalproex sodium tablet delayed release 500 mg two times a day was not reduced to 375 mg two times a day and Resident #35's divalproex sodium tablet delayed release 500 mg two times a day order remained in place from 11/17/25 to 07/14/26. RCD #76 confirmed Psychiatrist #80 addressed the pharmacy recommendation on 12/08/25 and wrote to decrease Resident #35's divalproex sodium tablet delayed release to 375 mg two times a day if it was okay with Physician #78. RCD #76 confirmed the facility did not have any documentation that Physician #78 was contacted regarding the 11/17/25 pharmacy recommendation or the recommended gradual dose reduction of Resident #35's divalproex sodium tablet delayed release 500 mg by mouth two times a day to divalproex sodium tablet delayed release 375 mg two times a day as recommended by Psychiatrist #80.		

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F 0801 Level of Harm - Potential for minimal harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on review of personnel file, staff interviews, and policy review, the facility failed to have a qualified director of food and nutritional services, a full time qualified dietician or other full time clinically qualified nutrition professional. This had the potential to affect all 45 residents who received food from the kitchen. Findings include: Review of Dietary Manager (DM) #64's personnel file revealed DM #64 was hired at the facility on 08/30/23 as the facility's Housekeeping Director. DM #64 was not a certified dietary manager, a certified food service manager, had any national certification for food service management, had an associate's or higher degree in food service management or in hospitality or had two or more years of experience in the position of director of food and nutrition services in a nursing facility setting and had completed a course of study in food safety and management. Interview with Regional Director of Clinical Operations (RDCO) #77 on 07/15/26 at 3:31 P.M. verified DM #64 was the facility's DM and Housekeeping Director. RDCO #77 verified DM #64 was not a certified dietary manager, a certified food service manager, had any national certification for food service management, had an associate's or higher degree in food service management or in hospitality or had two or more years of experience in the position of director of food and nutrition services in a nursing facility setting and had completed a course of study in food safety and management. Interview with DM #64 on 07/15/26 at 3:35 P.M. verified DM #64 recently became the DM in addition to being the Housekeeping Director. DM #64 verified she was not a certified dietary manager, a certified food service manager, had any national certification for food service management, had an associate's or higher degree in food service management or in hospitality or had two or more years of experience in the position of director of food and nutrition services in a nursing facility setting and had completed a course of study in food safety and management. DM #64 reported she was supposed to complete her certifications but did not have time to complete them. Telephone interview with Registered Dietitian (RD) #79 on 07/16/26 at 8:33 A.M. verified RD #79 did not work full time at the facility. RD #79 reported she visited the facility quarterly and she did not go in the kitchen during her visits. RD #79 stated that the facility also had a dietary technician that was at the facility weekly but did not work full time at the facility. Review of the facility's dietician policy dated October 2017 revealed the director of food service management would be designated if the dietitian was not employed at the facility full time. The director of food service management would be a certified dietary manager, a certified food service manager, be nationally certified in food service management and safety, have an associate's degree or higher in food service manager or hospitality, or meet any state requirements for food service and dietary.		