| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185145 | A. Building<br>B. Wing | 01/22/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Cedar Ridge Health Campus | 1217 US Highway 62 E<br>Cynthiana, KY 41031 |

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 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure medication error rates are not 5 percent or greater.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, review of the manufacturer's instructions for use, and facility policy review, the facility failed to ensure a medication error rate of 5 percent (%) or less. Observation on 01/22/2026 revealed 2 errors administering insulin (given to lower blood sugar) out of 27 opportunities observed for correct medication administration, which yielded a medication error rate of 7.41%. The errors affected 2 of 5 residents observed for medication administration, Resident (R) 11 and R23.The findings include: Review of the facility's policy titled, Medication Administration - General Guidelines, revised 11/2018, revealed, Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Further review of the policy revealed, 4) FIVE RIGHTS - Right resident, right drug, right dose, right route and right time, are applied for each medication being administered. A triple check of these 5 Rights is recommended at three steps in the process of preparation of a medication for administration: (1) when the medication is selected, (2) when the dose is removed from the container, and finally (3) just after the dose is prepared and the medication put away.On 01/22/2026 at 1:25 PM, the Director of Health Services (DHS) stated the facility did not have a policy on insulin use. Review of the manufacturer's instructions for use in a document titled, NovoLog(R) (insulin aspart) Injection Flex Pen Instructions for Use, revised 02/2023, revealed the section titled, Giving the airshot before each injection, included, Before each injection small amounts of air may collect in the cartridge during normal use. To avoid injecting air and to ensure proper dosing: E. Turn the dose selector to 2 units and F. Hold your Novolog FlexPen with the needle pointing up. Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge, then G. Keep the needle pointing upwards press the push-button all the way in. Further review revealed, The dose selector returns to 0. A drop of insulin should appear at the needle tip. If not, change the needle and repeat the procedure no more than 6 times.Review of R23's Physician Order Report revealed the facility admitted the resident on 12/28/2020 with diagnoses to include type 2 diabetes mellitus with hyperglycemia. Further review of active orders as of 01/22/2026 revealed an order dated 07/06/2025 for insulin aspart U-100 (rapid acting insulin with a concentration of 100 units per milliliter [ml]) insulin pen, with instructions to give per sliding scale (dose of insulin based upon the blood glucose level). 1. During an observation of medication administration on the 100 Hall on 01/22/2026 at 11:43 AM, Licensed Practical Nurse (LPN) 3 attached a needle to R23's insulin aspart pen, turned the dose selector to ten units, and began to walk toward the resident. The State Survey Agency (SSA) Surveyor stopped LPN3 to confirm if she was ready to administer the insulin and asked about priming the pen. LPN3 stated she was not aware the needle needed to be primed prior to dialing the dose. Review of the manufacturer's instructions for use in a document titled, Instructions for Use Humalog ([NAME]-ma-log) KwikPen (insulin lispro) injection, revised 07/2023, specified, Prime before each injection. - Priming your Pen means removing the air from the<br><br>(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 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Needle and Cartridge that may collect during normal use and ensures that the Pen is working correctly. - If you do not prime before each injection, you may get too much or too little insulin. Further review revealed, Step 6: - To prime your Pen, turn the Dose Knob to select 2 units. Step 7: - Hold your Pen with the Needle pointing up. Tap the Cartridge Holder gently to collect air bubbles at the top. Step 8: Continue holding your Pen with Needle pointing up. Push the Dose Knob in until it stops, and [0] is seen in the Dose Window.Review of R11's Physician Order Report revealed the facility admitted the resident on 12/24/2025 with diagnoses to include type 2 diabetes mellitus with ketoacidosis without coma and type 2 diabetes mellitus with diabetic neuropathy, unspecified. Further review of active orders as of 01/22/2026 revealed an order dated 12/30/2025 for Humalog KwikPen Insulin (insulin lispro) insulin pen, with instructions to give five units three times a day with meals for diabetes.2. During an observation of medication administration on the 200 Hall on 01/22/2026 at 11:55 AM, Registered Nurse (RN) 2 attached a needle to R11's Humalog KwikPen, turned the dose selector to 5 units, and began to walk toward the resident. The SSA Surveyor stopped RN2 to confirm if she was ready to administer the insulin and asked about priming the pen. RN2 stated, Oh yeah, I am supposed to prime it with two units.During an interview on 01/22/2026 at 10:46 AM, LPN1 stated nurses should prime the insulin pen needle with two units prior to dialing in the dose to be administered to ensure the resident was getting the full amount ordered.During an interview on 01/22/2026 at 11:20 AM, the DHS stated nurses should follow the manufacturer's recommendations to prime the needle prior to use to ensure the full amount of insulin ordered was administered. During an interview on 01/22/2026 at 11:35 AM, the Interim Executive Director (ED) stated she expected the nurses to follow manufacturer guidelines with the use of insulin pens, and the medication error rate should be less than 5%. |