STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185145	A. Building B. Wing	01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedar Ridge Health Campus	1217 US Highway 62 E 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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 49267 Based on observation, interview, record review, and facility policy review, the facility failed to develop a comprehensive person-centered care plan for each resident to meet his or her preferences and goals for 1 of 14 sampled residents (Resident (R) 6). Observation of R6 on 01/22/2025 at 9:02 AM and again on 01/23/2025 at 9:00 AM revealed an Occupational Therapist (OT) assisting the resident with application of a left arm splint. During interviews with staff and R6, it was determined the splint was a resident preference worn at her discretion and not a recommendation of the facility. However, the resident's preference was not included in her comprehensive care plan. The findings include: Review of the facility's policy titled, Comprehensive Care Plan Guideline, dated 05/22/2018, revealed the purpose was to ensure appropriateness of services and communication that would meet the resident's needs, severity/stability of conditions, impairment, disability, or disease in accordance with state and federal guidelines. Further review revealed care plan interventions should be reflective of risk area(s) or disease processes that impacted the individual resident. Review of R6's Face Sheet revealed the facility admitted the resident on 10/18/2024 with diagnoses including chronic kidney disease (CKD), urinary tract infection (UTI), left-sided weakness following a stroke, and multiple myeloma. Review of R6's Minimum Data Set [MDS] with an Assessment Reference Date (ARD) of 10/21/2024, revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of 15 out of 15, which indicated the resident was cognitively intact. Further review revealed R6 had an upper extremity impairment on one side. Review of R6's Comprehensive Care Plan, dated 10/21/2024, revealed the care plan contained no interventions that addressed R6's preferences related to use of a left-hand splint. Review of R6's outside hospital records revealed an inpatient OT note, dated 10/15/2024, that stated R6 would benefit from a left resting hand splint. Further review revealed OT provided a prefabricated left upper extremity (LUE) resting hand orthotic. However, it was not the appropriate size, and the resident was educated on steps to acquire an orthotic after discharge from the hospital. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R6's facility's OT Evaluation, dated 10/19/2024, revealed R6 needed partial to moderate assistance for upper body dressing. Further review revealed a musculoskeletal assessment of the left upper extremity (LUE) impairment with a notation that the resident had worn a left resting hand splint. Observation on 01/22/2025 at 9:02 AM revealed OT1 returned R6 to her room via a wheelchair and applied a splint to R6's left hand before he exited the room. In an immediate interview with OT1, he stated the resident's splint was worn for comfort purposes only and was not part of her therapy services. Additional observation of R6 in her room on 01/23/2025 at 9:00 AM revealed OT1 applied a splint to the resident's left hand. In an interview with R6 on 01/24/2025 at 9:38 AM, she stated she was given a hand splint when she was hospitalized and brought it with her to the facility, but it was too big for her hand. R6 stated someone at the facility brought her a smaller one, and it fit better. She further stated she wore it most days during the day but took it off at night. In an interview with Registered Nurse (RN) 2 on 01/24/2025 at 9:42 AM, she stated she had observed R6 with the splint in place but had neither applied nor removed it. RN2 further stated the resident wore the splint for comfort and therapy applied/removed the splint as needed per R6's preference. In an interview with OT1 on 01/24/2025 at 9:53 AM, he stated R6 had a LUE splint when she was admitted to the facility. He stated he noticed it one day in her room, and when asked, she stated it was too big, so he offered to find a smaller one and ordered it online. OT1 stated the splint served no purpose other than comfort and was used at the resident's request. He further stated if the splint was used per the resident's preference, it should be included on her care plan. In an interview on 01/24/2025 at 9:46 AM with the Therapy Director, she stated R6 used the splint on her left hand for comfort only, and it was not something recommended by therapy or ordered by the physician at the facility. The Therapy Director stated the resident had a splint when she was admitted , but it was too big, so one of the therapists ordered a smaller one that was a more appropriate size. She further stated neither the physician at the facility nor therapy ordered the splint. However, the Therapy Director stated if R6 wore the splint per her preference, it should be included on her care plan. In an interview with the MDS Coordinator on 01/24/2025 at 9:17 AM, she stated information from a resident's hospital discharge summary as well as their history and physical was used for their initial MDS. She further stated nursing completed baseline care plans and information from all sources was used for compilation of the Comprehensive Care Plan (CCP). The MDS Coordinator stated therapy put in their own orders, and R6 had no orders for a splint from either therapy or the physician. She further stated for ongoing assessments, in addition to medical record information, she assessed residents and made observations. The MDS Coordinator stated she had not observed R6 with a brace to her LUE. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the Director of Nursing (DON) and the Regional Nurse Consultant (RNC) on 01/24/2025 at 10:23 AM, both stated a note should have been placed in R6's electronic health record (EHR) that stated the resident wore the splint for comfort. The DON stated she was torn because there was not a physician order, so she was not sure it had to be on her care plan. When asked about resident preferences and actions performed by the facility, the RNC stated if staff was helping the resident with the splint as need or requested, information related to her preferences should have been included on her plan of care. In an interview with the Administrator on 01/24/2024 at 1:57 PM, she stated it was not necessary to include the splint on R6's care plan because it was not required for her care, not ordered by the physician, and not recommended by therapy. When asked about resident preferences in relation to care plans, the Administrator stated all resident preferences could not be included on a care plan because it would never end, and she was not sure how a plan of correction would be completed that addressed that. Additionally, the Administrator stated R6 probably could have applied the splint by herself (however, both observations revealed it was applied by OT1). The Administrator stated she could somewhat understand what the State Survey Agency (SSA) Surveyor said, but it was still only a preference and not an order. The Administrator further stated she was unaware R6 even had a splint.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28707 Based on observation, interview, and review of the facility's policy, the facility failed to store food in accordance with professional standards for food service safety. Observation on [DATE] of the shared nourishment refrigerator and freezer for the 100, 200, and 300 Units revealed multiple food items that were not labeled or dated. The findings include: Review of the facility's policy titled, Food Brought Into Facility, dated [DATE], revealed food brought in by family members, friends, or guests must be properly labeled and dated after being inspected by a staff member that had been properly trained to receive and inspect food. Observation on [DATE] at 8:53 AM of the shared nourishment refrigerator for the 100, 200, and 300 Units contained a 20 ounce bottle of Mountain Dew, not labeled or dated to indicate who it belonged to and when it was stored. Observation of the freezer revealed a partially consumed frozen Mountain Dew 20 ounce bottle, a frozen small chocolate Frosty, and a small bowl of what appeared to be strawberry ice cream with chocolate syrup that was covered with clear wrap. None of these items were labeled or dated indicating who they belonged to or when they had been brought in. In an interview on [DATE] at 8:59 AM with the Dietary Manager (DM), she stated she checked everything yesterday, so non-resident items or non-labeled items had been added either yesterday evening or this morning. In an additional interview with the DM on [DATE] at 11:05 AM, she stated she had determined the Mountain Dew in the freezer and refrigerator both belonged to a resident in room [ROOM NUMBER], and staff had failed to label and date them when placed in the refrigerator and freezer. In an additional interview on [DATE] at 10:11 AM with the DM, she stated the resident in room [ROOM NUMBER] asked staff to make his Mountain Dew cold, so they placed the opened one in the freezer and the unopened one in the refrigerator. However, staff failed to mark his name on them. The DM stated she did not know who the small Frosty belonged to, and the ice cream had been taken off a tray for another resident and saved for later. However, again they were not labeled and dated. The DM stated she did not know why staff had not labeled and dated the items and was not sure if staff had been educated on labeling and dating items placed in the refrigerator, as there was some newer staff in the building that had not been present during the previous survey. The DM stated food items not labeled or dated could potentially spoil and if consumed lead to illness for residents. In an interview on [DATE] at 2:09 PM with the Administrator, she stated she knew dietary staff checked nourishment refrigerators every evening for items not labeled, dated, or expired when stocking snacks, so she knew these unlabeled/undated items had not been in there long. She stated staff had been educated on the facility's policy on labeling and dating items placed in nourishment refrigerators. She stated her expectation was for staff to label and date everything placed in the nourishment refrigerator and freezer, even if staff anticipated the food item would only be there for a short time.