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	01/22/2026

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation, interview, record review, and facility policy review, the facility failed to ensure the resident's right to privacy by allowing a video camera to be installed, which actively monitored a resident's room without documented consent or adherence to facility policy for 1 of 2 residents reviewed for dignity, Resident (R) 3. The findings include: Review of the facility's policy titled, Resident Electronic Monitoring SOP [Standard Operating Procedure], undated, revealed, The resident, attorney-in-fact, or guardian must authorize the installation and use of the device for remote monitoring on our standard authorization form. The campus must prior approve any electronic monitoring devices to make sure that they are the type allowable by law, and only facility personnel may install the devices after they have been approved. We may post notices in and outside the resident's room that electronic monitoring is in use.Review of the facility's policy titled, Resident Rights Guidelines, revised 05/11/2017, revealed, Our residents have a right to: a. Be treated with dignity and respect and d. Privacy.Review of R3's admission Record revealed the facility admitted the resident on 01/04/2025 with diagnoses of heart disease, acute kidney failure, atrial fibrillation, malnutrition, diabetes mellitus, and dementia.Review of R3's annual Minimum Data Assessment [MDS], with an Assessment Reference Date (ARD) of 11/14/2025, revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of 11 of 15, indicating R3 had moderate cognitive impairment.Review of R3's Care Plan included a problem statement initiated on 01/04/2025 that indicated the resident was at risk for falls related to weakness and impaired balance. Interventions directed staff to monitor with a non-recording portable video camera (initiated 12/10/2025).During an observation on 01/19/2026 at 10:28 AM, a camera was observed mounted inside R3's room, positioned high on the wall to the left of the door, pointing directly at the bed. The monitor for the camera was located behind the nurses' station.During an observation on 01/20/2026 at 8:55 AM, the camera in R3's room was on, and the monitor was visible on the desk behind the nurses' station.During an observation on 01/21/2026 at 11:34 AM, the camera in R3's room remained in place, pointed toward the bed, with the unattended monitor active at the nurses' station.Review of R3's Physician Order Report, for the timeframe of 12/20/2025 through 01/20/2026, revealed no orders for the use of the electronic monitoring device. Review of R3's medical record revealed no written consent was found for the use of the monitor/camera. The facility obtained verbal consent from R3's Power of Attorney (POA) during the survey on 01/21/2026.Attempts were made to contact R3's POA during the survey on 01/20/2026 at 6:21 PM, 01/21/2026 at 10:45 AM, and 01/22/2026 at 8:46 AM and 10:28 AM, to confirm that the use of the video monitor had been discussed and consent obtained. There was no response from the POA by the end of the survey on 01/22/2026. During an interview on 01/21/2026 at 1:27 PM, the Ombudsman stated she researched state law and found that cameras in resident rooms were not allowed, although there was conflicting information about audio consent. She stated that at a minimum, a policy and consent should be in place.During an interview on 01/22/2026 at 8:40 AM, the Director of Environmental Services stated at first, she had not obtained consent for anything for any resident, then she was the witness during a phone call to R3's POA the previous day (during the survey) for the camera. She stated she heard the POA say it was okay.During an interview on 01/22/2026 at 8:45 AM, the Director of Health Services (DHS) stated the facility (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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	obtained verbal consent the previous day because they did not realize they needed to obtain consent. During an interview on 01/22/2026 at 9:35 AM, Clinical Support Staff 5 stated it was a state law that the Executive Director (ED) had the right to request a camera in the facility. She stated it was a fixed monitoring device and not recording, and the ED gave verbal approval for it. During an interview on 01/22/2026 at 10:45 AM, Activities Staff 4 stated when the facility installed the camera, the staff was told to make sure it was turned off during personal care and whenever the resident was not in the room.During an interview on 01/22/2026 at 10:46 AM, Licensed Practical Nurse (LPN) 1 stated staff was told when the camera was installed, they needed to turn it off whenever personal care was being provided. LPN1 stated the monitor was on and sitting at the desk next to her. During a concurrent observation, LPN1 turned the monitor face down. She stated there was a button on the monitor to turn it off, or the staff could just unplug it when they were in the room.During an interview on 01/22/2026 at 11:35 AM, the Interim ED stated the facility had verbal consent from the POA prior to the use of the camera, but they were not sure it was documented. She stated they thought the consent to photograph included in the admission record covered it, and they had tried to contact the POA twice to confirm the consent, with no response.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **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 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 (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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%.