STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365690	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedarview Care Center	115 Oregonia Road 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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NONCOMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on medical record review, review of the medication error log, review of the incident report, staff and resident interview, and policy review, the facility failed to ensure residents were free from significant medication errors. This affected one (Resident #25) out of 22 sampled residents. The facility census was 70. Findings Include: Review of the medical record for Resident #25 revealed an admission date of 10/03/25 with diagnosis including chronic obstructive pulmonary disease, type two diabetes, and chronic pain.Review of the Minimum Data Set (MDS) assessment for Resident #25 dated 01/22/26 revealed the resident had moderate intact cognition. Resident was also assessed to be dependent on staff for activities of daily living (ADLs).Review of the physician's orders for Resident #25 revealed an order dated 11/15/25 to 11/17/25 for oxycodone oral tablet 5 milligrams (mg) one tablet every six hours. Resident #25 had another order dated on 11/18/25 to 12/26/25 for oxycodone hydrochloride oral tablet 5 mg a half tablet (2.5 mg) every six hours.Review of Resident #25's narcotic documentation/log revealed from 11/18/26 to 11/26/26 she received oxycodone oral tablet 5 mg one tablet every six hours instead of the ordered half tablet dose of 2.5 mg.Review of the medication error log revealed the facility had a medication error involving Resident #25 on 11/18/25.Review of the incident report dated 11/26/25 revealed the facility Medical Director and the Director of Nursing (DON) notified and assessed Resident #25 due to being their own responsible party.Interview on 03/18/26 at 5:50 P.M. the DON verified from 11/18/25 to 11/26/25 staff administered oxycodone oral tablet 5 mg one tablet every six hours. The DON stated the facility nurses gave Resident #25 the wrong dose of oxycodone hydrochloride due to not knowing the order changed. The medical provider noticed the error and alerted the facility. The DON stated Resident #25 had 29 wrong doses of oxycodone 5 mg tablets instead of oxycodone oral tablet 5 mg one half tablet (2.5 mg) every six hours.Interview on 03/19/26 at 8:45 A.M Resident #25 verified the facility managed her medications. Review of facility policy titled, Administering Medications dated 02/14/24 revealed the individual administering the medication checks the label three times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. The deficient practice was corrected on 11/26/25 when the facility implemented the following corrective actions: On 11/26/25, the DON was made aware of a medication error.On 11/26/25, the DON made the Administrator aware of the medication error.On 11/26/25, the DON completed a head to toe assessment on Resident #25 no abnormal findings.On 11/26/25, the DON interviewed Resident #25 who stated, I'm doing good.On 11/26/25, the DON audited all residents receiving narcotics to ensure new orders were transcribed correctly. On 11/26/25, the DON completed education with the Registered Nurses (RNs) and the Licensed Practical Nurses (LPNs) on transcribing medication orders and residents' rights to medication.On 11/28/25, the DON completed a chart audit and any medications needing reorders were reorder and any orders not matching the cart were updated as well as the physician.On or before 11/26/25, the DON/designee educated all staff on the abuse policy, including requirements for reporting abuse.On 11/26/25, the DON/ designee started conducting the following audits:Audit one resident three times a week for four weeks, then once a month for three months. Review of the audits (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	completed revealed no additional errors.There had been no other allegations of medication error per staff towards residents since Resident #25's medication error on 11/18/25.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, staff interview, review of the facility document Stability of Common Insulins in Vials and Pens, and policy review, the facility failed to ensure the safe storage of insulin. This affected two (Resident #07 and #19) out of 17 residents with insulin orders. In addition, the facility failed to ensure ophthalmic medication was labeled with an open date. This affected one (Resident #39) out of 12 residents with ophthalmic orders. The facility census was 70.Findings Include:1. Review of the medical record for Resident #07 revealed an admission date of 01/20/26. Diagnoses included bipolar disorder, diabetes mellitus, and schizophrenia.Review of the minimum data set (MDS) assessment dated [DATE] revealed Resident #07 had severe cognitive impairment and was dependent on staff for activities of daily living (ADL).Review of Resident #07's physician orders revealed an order dated 02/17/26 for Insulin Lispro subcutaneous solution pen-injector 100 unit per milliliter (unit/mL) (insulin Lispro) and insulin glargine subcutaneous solution 100 unit/mL (insulin Lantus).Observation of a medication cart on 03/18/26 at 10:40 A.M with Registered Nurse (RN) #96 revealed Resident #07's Lantus and Lispro insulins had an open date of 02/17/26.Interview on 03/18/26 at 10:41 A.M. RN #96 verified the open date for Resident #07's Lantus and Lispro was 02/17/26 and the medication should have been discarded.2. Review of the medical record for Resident #19 revealed an admission date of 09/19/25. Diagnoses included type two diabetes, seizures, and hyperlipidemia.Review of the MDS assessment dated [DATE] revealed Resident #19 had severe impaired cognition and was dependent on staff for ADLs.Review of Resident #19's current physician orders revealed an order for a NovoLog flex pen subcutaneous solution pen-injector 100 unit/mL (insulin aspart).Observation on 03/18/26 at 10:45 A.M. of the medication cart with RN #96 revealed Resident #19's Novolog had an open date of 02/15/26.Interview on 03/18/26 at 10:50 A.M. RN #96 verified Resident #19's Novolog had an open date of 02/15/26 and the medication should have been discarded.3. Review of the medical record for Resident #39 revealed an admission date of 04/12/24 with diagnosis including amyotrophic lateral sclerosis, chronic allergic conjunctivitis, and presence of intraocular lens.Review of the MDS assessment dated [DATE] revealed Resident #39 had intact cognition and was dependent on staff for ADLs. Review of Resident #19's current physician orders revealed an order for Simbrinza (an eye drop medication to reduce pressure) ophthalmic suspension 1-0.2 percent (%) (Brinzolamide-Brimonidine Tartarte). Observation on 03/18/26 at 10:53 A.M of the medication cart with RN #96 revealed Resident #39's Brinzolamide-Brimonidine Tartrate had no open date.Interview on 03/18/26 at 10:55 A.M. RN #96 verified Resident #39's Brinzolamide-Brimonidine should have an open date and the medication should have been discarded due to not having an open date.Interview on 03/19 at 10:45 A.M. the Director of Nursing (DON) verified Resident #07 and Resident #19's insulins should have been discarded due to expiration and Resident #39's medication should have had an open date.Review of the facility diabetic information titled Stability of Common Insulins in Vials and Pens, updated November revealed Novolog (aspart), Humalog (lispro), and Lantus (glargine) should be discarded in 28 days after being opened.Review of the facility policy titled, Storage of Medications dated April 2019 revealed outdated or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed.