STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366004	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kensington at Anna Maria	849 North Aurora Road Aurora, OH 44202

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 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 record review, observation, interviews, review of the manufacturer's instruction for insulin flex pens and facility policy, the facility failed to ensure a medication error rate of less than 5 percent (%). There were four errors observed of 34 opportunities, resulting in an 8.82 % total error rate. This affected one Resident (#21) out of three residents observed for medication administration. The facility census was 88.Findings include:Review of the medical record for Resident #21 revealed an admission date of 04/28/25 with diagnoses of spinal stenosis, type two diabetes, chronic kidney disease, gastro-esophageal reflux disease, overactive bladder, atrial fibrillation, adult failure to thrive, and hyperlipidemia.Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of eight out of 15 which indicated severe cognitive decline. The functional assessment revealed Resident #21 needed supervised assistance with grooming and maximum assistance with toileting, transferring, and mobility via wheelchair.Review of the physician orders for Resident #21 revealed the resident was to receive 52 units of Humulin 70/30 Insulin subcutaneously in the morning via KwikPen Subcutaneous Suspension Insulin Pen-injector (100 units per milliliter). Resident #21 was also to receive Lispro Insulin (100 units per milliliter) per sliding scale insulin coverage.On 12/16/25 at 7:40 A.M. Resident #21's glucose Accu-Chek revealed a glucose level of 209. The sliding scale order for result of 209 was to administer 4 units of Lispro Insulin subcutaneously before meals (breakfast). Observation on 12/16/25 at 7:53 A.M. of medication administration to Resident #21 by Licensed Practical Nurse (LPN) #544 revealed the LPN attached the needle to the Humulin 70/30 insulin and dialed in 30 units. (There was not enough medication in the Humulin 70/30 insulin to give the full 54-unit dose and had to be divided with another insulin pen.). LPN #544 then applied the needle tip to the second Humulin 70/30 KwikPen and dialed in 24 units. LPN # 544 then applied a needle tip to the Lispro KwikPen insulin syringe and dialed in 4 units. LPN #544 then proceeded to administer all three insulin dosages per KwikPens but did not prime any of the three KwikPens prior to administration. Additionally, LPN #544 was observed to omit the morning dose of Midodrine 5 milligrams which the ordered parameter was to hold the medication if the systolic blood pressure was greater than 130. LPN #544 checked Resident #21's blood pressure which was 127/84. All other morning medications were observed given.Interview with LPN #544 on 12/16/25 at 7:58 A.M. verified that she did not prime the pens prior to dialing insulin dosage and administering to Resident #21. LPN #544 stated she forgot and knows to prime the pens. When asked what the resident's blood pressure was, LPN #544 stated Resident #21's blood pressure was 127/84 and his heart rate was 78.Interview with Director of Nursing (DON) on 12/16/25 at 12:10 P.M. verified that all insulin pens should be primed prior to dialing in dosage and administering to any resident. DON also confirmed that LPN #544 should have administered the Midodrine 5 milligram morning dose as the ordered parameter to hold the medication was a blood pressure greater than 130 systolic and the resident's blood pressure was lower than 130 systolic.Review of the undated facility policy titled, Multidose Pens of Injectable Medications revealed after placing needle hub onto injectable pen, prime the pen per manufacturer's guidelines which include: turning dose selector to 2 units, hold pen with needle pointing up, tap the pen cartridge gently a few times so air bubble rise to the top of the (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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cartridge, and press the injector button to check that insulin comes out of the needle. If the insulin does not come out, then try again. If still no insulin, attach a new needle and repeat. If after 6 trials and you still do not get insulin, discard the pen and use another pen.Review of the facility policy titled, General Guidelines for Medication Administration, dated 04/01/23, revealed to check the physician's order for correct dosage schedule. If a dose is withheld, an explanatory note is entered in the record.Review of the undated Manufacturer Instructions of KwikPen Insulin Pens revealed before each injection small amounts of air could collect in the cartridge during normal use. To avoid injecting air and to ensure proper dosing turn the dose selector to select two units. Hold the Tresiba insulin pen with the needle pointing up. Turn the dose selector to dial in two units. Press and hold the dose button until the dose counter shows 0. Make sure a drop appears. Turn the dose selector to select the number of units you need to inject. Wipe the skin with an alcohol swab and let it dry before you inject your dose. Press and hold the dose button.