STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345131	A. Building B. Wing	09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedar Hills Center for Nursing and Rehabilitation	3905 Clemmons Road Clemmons, NC 27012

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38904 Based on record review, observations, Nurse Practitioner, and staff interviews the facility failed to report the results of a urinalysis received on 8/8/2024 to the Nurse Practitioner until 8/12/2024, failed to report pain and distention of the lower abdomen to the Nurse Practitioner on 8/5/2024, and failed to report being unable to flush a urinary catheter for 1 of 1 Resident (Resident #1) reviewed for urinary catheter care. Findings included: Resident #1 was admitted to the facility on [DATE] with diagnoses of end stage renal disease, neuropathic bladder, and Parkinson's disease. A quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #1 was cognitively intact and had a urinary catheter in place. Resident #1's Physician's Orders indicated he had a Urinalysis with Culture if indicated ordered 8/5/2024 due to discolored urine. Review of a urinalysis laboratory result obtained 8/8/2024 indicated Resident #2 had a mixed flora and collection of a new urinary sample was suggested by the laboratory. On 8/28/2024 at 11:10 am an interview was conducted with Resident #1 and he stated on 8/5/2024 at 3:30 am Nurse #3 flushed his suprapubic urinary catheter because he was not having much urine output, his lower abdomen was distended, and he was having lower abdominal pain. Resident #1 stated when Nurse #3 flushed his suprapubic urinary catheter the flush liquid did not return. Attempts made to call Nurse #3 for an interview were unsuccessful. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nurse #2 was interviewed on 8/28/2024 at 1:19 pm and stated she worked on 8/5/2024 on the 7:00 am to 7:00 pm shift and was assigned to Resident #1. Nurse #2 stated on 8/5/2024 in morning report the 7:00 pm to 7:00 am nurse, Nurse #3, had flushed Resident #1's catheter at 3:30 am and Nurse #3 told her none of the fluid returned from the flush. She stated Nurse Practitioner (NP) #1, who was in the facility ordered a Urinalysis with Culture if indicated, and she obtained the urine sample for the Urinalysis with Culture and placed it in the refrigerator to go to the laboratory. Nurse #2 stated she did not report to NP #1 that Nurse #3 told her she had flushed Resident #1's suprapubic urinary catheter on 8/5/2024 at 3:30 am and did not get any liquid returned. Nurse #2 stated the Responsible Party called on 8/6/2024 and asked for the results of the Urinalysis with Culture and when Nurse #2 could not locate the results, she called the laboratory, and they had not picked up the urine sample that was obtained 8/5/2024. Nurse #2 stated she checked the refrigerator, and the urine sample was still in the refrigerator. Nurse #2 stated she called the laboratory back, asked them to pick up the urine sample, and they picked it up on 8/8/2024. Nurse #2 stated she did not report the Urinalysis with Culture not being sent on 8/5/2024 to NP #1 or that the Urinalysis with Culture was not sent to the laboratory until 8/8/2024. Nurse #2 stated she did not remember getting the results for the Urinalysis with Culture on 8/8/2024 and did not realize they had not been reported to NP #1 until the Responsible Party called on 8/12/2024 and said Resident #1 had called her and stated he was in pain. Nurse #2 stated she should have looked for the results of the Urinalysis with Culture on 8/8/2024 and reported the results to NP#1. Nurse #2 indicated the facility's laboratory findings are faxed to them by the laboratory, and she did not know why Resident #1's urinalysis findings were not sent. Nurse #1 stated Resident #1 had not reported any pain to her on 8/12/2024. \ On 8/30/2024 at 11:10 am a telephone interview was conducted with NP #1 and she stated she was not called regarding Resident #1 having pain and distention of his abdomen on 8/5/2024. NP #1 stated no one reported to her on 8/5/2024 that Resident #1's catheter was flushed on 8/5/2024 at 3:30 am and the fluid from the flush did not return. NP#1 stated she ordered the Urinalysis with Culture to rule out an infection on 8/5/2024. NP#1 stated she was not notified of the urinalysis with culture not being sent out on 8/5/2024 and she was not notified of the results of the urinalysis with culture on 8/8/2024 which showed Resident #1 had a urinary infection until Resident #1 was sent out to the hospital on 8/12/2024. NP#1 stated the facility should have reported the Urinalysis with Culture was not completed on 8/5/2024 when it was ordered, and they should have reported the Urinalysis with Culture results on 8/8/2024 so that Resident #1's infection would have been treated. During an interview with Director of Nursing (DON) #2 on 8/30/2024 at 1:40 pm she stated Nurse #2 should have notified her and NP #1 on 8/5/2024 of the Urinalysis with Culture not being picked up by the laboratory and Nurse #2 should have notified her and NP#1 the Urinalysis with Culture was not sent until 8/8/2024. The Administrator was interviewed on 8/30/2024 at 1:42 pm and she stated she was not aware of the NP #1 not being notified of the results of the urinalysis with culture on 8/8/2024. The Administrator stated Nurse #1 should have ensured the results were reported to NP #1 on 8/8/2024.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38904 Based on record review, observations, and staff interviews the facility failed to report an allegation of abuse to Adult Protective Services for 1 of 3 residents (Resident #6) who alleged staff to resident abuse which occurred on 7/25/2024 and was reported to the Administrator on 7/26/2024 but was not reported to Adult Protective Services until 8/1/2024. Findings included: The facility's Abuse, Neglect and Exploitation Policy reviewed on 1/1/2024 stated the facility would report all alleged violations to the Adult Protective Services and all other required agencies with 24 hours if the event that caused the allegation did not result in abuse or serious bodily injury. Resident #6 was admitted to the facility on [DATE] with diagnoses of hemiplegia and epilepsy. A quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #6 was severely cognitively impaired and required total assistance with bed mobility and transfers. According to the facility's investigation dated 7/26/2024 at 2:45 pm a Family Member reported Resident #6 told her a male nurse slapped him in the face on 7/25/2024 or 7/26/2024. The investigation indicated the accused was suspended pending an investigation, and the police were notified of the allegation. The facility unsubstantiated the allegation. During an interview with the Administrator on 8/29/2024 at 12:24 am she stated she was notified of the allegation of abuse by Resident #6's Family Member on 7/26/2024 and she notified Adult Protective Services on 8/1/2024. The Administrator stated Resident #6's Family Member reported someone had slapped Resident #6, and she realized now she should have reported the allegation within 24 hours of her being made aware of the allegation of abuse

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38904 Based on record review and resident, Responsible Party, and Nurse Practitioner interviews the facility failed to have a Urinalysis with Culture sample collected on 8/5/2024 tested at the laboratory that same day. The Urinalysis with Culture was not completed and reported to the facility until 8/8/24. In addition, the facility failed to follow through on 8/8/24 when the laboratory suggested a new urine sample when the results for the 8/5/24 indicated the sample was contaminated. The deficient practice occurred for 1 of 1 resident (Resident #1) reviewed for suprapubic catheter care. Findings included: Resident #1 was admitted to the facility on [DATE] with diagnoses of end stage renal disease, neurogenic bladder which required a suprapubic catheter, and Parkinson's disease. A quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #1 was cognitively intact and had a urinary catheter in place. A Nurse Practitioner's Progress Note dated 8/7/2024 indicated she saw Resident #1 on 8/5/2024 in the facility and Resident #1 brought to her attention his urine was purple. The Nurse Practitioner's Progress Note further stated Resident #1 had no abdominal distention and did not complain of pain, fever or chills; and she ordered a Urinalysis with Culture to rule out infection on 8/5/2024. Resident #1's Physician's Orders indicated he had a Urinalysis with Culture ordered 8/5/2024 due to discolored urine. A Urinalysis laboratory result obtained 8/8/2024 indicated Resident #2's urine had mixed bacteria, which indicated the sample was contaminated, and collection of a new urine sample was suggested by the laboratory. On 8/28/2024 at 11:10 am an interview was conducted with Resident #1 and he stated on 8/5/2024 at 3:30 am Nurse #3 flushed his suprapubic urinary catheter because he was not having much urine output, his lower abdomen was distended, and he was having lower abdominal pain. Resident #1 stated when Nurse #3 flushed his suprapubic urinary catheter the flush liquid did not return. Resident #1 stated Nurse #2 got a sample of his urine on 8/5/2024 for a Urinalysis with Culture, but they did not get the results. Resident #1 stated he went out to the hospital on 8/12/2024 due to decreased output and lower abdominal pain. Attempts were made to call Nurse #3, who attempted to flush Resident #1's suprapubic urinary catheter at 3:30 am on 8/5/2024, on 8/28/2024 at 7:24 pm, 8/29/2024 at 9:28 am, and 8/30/2024 at 11:50 am. A message was left for Nurse #3 with each attempt, and she did not return the calls. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/28/2024 at 1:13 am a phone interview was conducted with the Responsible Party and she stated on 8/5/2024 another Family Member who visited Resident #1 told her Resident #1's urine was purple, which she knew indicated he had an infection. The Responsible Party stated Resident #1 told the Family Member the nurse had flushed his catheter at 3:30 am that morning and nothing came back out and he was having lower abdominal pain, and his lower abdomen was distended. The Responsible Party stated she called back to the facility on [DATE] to check on the results of Resident #1's urinalysis that was ordered on 8/5/2024 and was told the urine sample was not sent to the laboratory and the staff could not tell her why it was not sent. She stated on 8/12/2024 she received a phone call from Resident #1, he stated he needed help, and the Responsible Party stated she called emergency services. Nurse #2 was interviewed on 8/28/2024 at 1:19 pm and stated she worked on 8/5/2024 on the 7:00 am to 7:00 pm shift and was assigned to Resident #1. Nurse #2 stated on 8/5/2024 in morning report the 7:00 pm to 7:00 am nurse, Nurse #3, stated she had flushed Resident #1's catheter at 3:30 am and none of the fluid returned from the flush. Nurse #1 stated she asked Resident #1 if he wanted to go to the hospital, but he said no. She stated Nurse Practitioner (NP) #1, who was in the facility on 8/5/2024, noticed Resident #1 had purple urine and ordered a urinalysis with culture if indicated. Nurse #2 stated she obtained the urine sample for the Urinalysis with Culture and placed it in the refrigerator to go to the laboratory. Nurse #2 stated the Responsible Party called on 8/6/2024 and asked for the results of the Urinalysis with Culture and when Nurse #2 could not locate the results, she called the laboratory and discovered they had not picked the urine sample that was obtained 8/5/2024. Nurse #2 stated she checked the refrigerator 8/6/24, and the urine sample was still in the refrigerator. Nurse #2 stated she called the laboratory back on 8/6/24 and asked them to pick up the urine sample. The laboratory did not pick up the Urinalysis with Culture sample until 8/8/2024. Nurse #2 stated she cared for Resident #1 on the 7:00 am to 7:00 pm shift on 8/6/2024, 8/7/2024, and 8/8/2024 and he did not complain of pain or discomfort and did not have abdominal distention. Nurse #2 stated she returned to work on 8/12/2024 received a call from the Responsible Party and the Responsible Party said Resident #1 had called her complaining of pain and told her he needed help. Nurse #2 stated she did not remember getting the results of the Urinalysis with Culture on 8/8/2024 and she did not report them to NP#1 until the Responsible Party called her on 8/12/24 to say she had called Emergency Medical Services for Resident #1. Nurse #2 stated Resident #1 had not complained of any discomfort or abdominal distention on 8/12/2024. Medication Aide #1 was interviewed on 8/28/2024 at 8:35 pm by phone and she stated she cared for Resident #1 on 8/9/2024 on the 7:00 am to 7:00 pm shift and he did not complain of any pain or discomfort, and his urine was a light orange color, which was normal for him. An interview was conducted with Nurse #13 on 8/28/2024 at 7:36 pm by phone and she stated she cared for Resident #1 on 8/11/2024 from 7:00 am to 11:30 pm and he did not have any complaints of pain or discomfort, and his urine was not discolored. A hospital Admission Note dated 8/12/2024 indicated Resident #1 had a history of Parkinson's disease with neurogenic bladder which required a suprapubic catheter which was placed in 11/2023. He reported pain from his suprapubic catheter yesterday, 8/11/2024, but he stated it was draining urine. The Admission Note also stated Resident #1 did not have any chills or fever. The plan of care on the Admission Note for Resident #1 indicated he would be admitted and receive intravenous antibiotics, and his suprapubic catheter was changed to a larger size. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Hospital Discharge Summary dated 8/20/2024 indicated Resident #1 had a history of Parkinson's disease and neurogenic bladder. He was treated in the hospital for 7 days with an intravenous antibiotic and returned to the facility after the completion of his antibiotics for a urinary tract infection due to a clogged catheter. On 8/30/2024 at 11:10 am a telephone interview was conducted with NP #1 and she stated Resident #1 had not complained of pain or distention on 8/5/2024 when she ordered the Urinalysis with Culture if indicated, and the only symptom had been that Resident #1's urine was purple. She stated she ordered the Urinalysis with Culture to rule out a urinary infection. NP #1 stated she was not aware Nurse #1 had flushed Resident #1's catheter at 3:30 am on 8/5/2024 and the liquid not returning after the flush could have been a sign his catheter was blocked. She stated she was not aware the Urinalysis with Culture was not completed until 8/8/2024 and she was not made aware of the results of the Urinalysis with Culture until 8/12/2024 when Resident #1 was sent to the hospital. NP #1 stated the facility should have reported the Urinalysis with Culture was not completed on 8/5/2024 when it was ordered, and they should have reported the Urinalysis with Culture results on 8/8/2024 so that Resident #1's infection would have been treated. During an interview with Director of Nursing (DON) #2 on 8/30/2024 at 1:40 pm she stated she was not made aware of Resident #1's Urinalysis with Culture sample not being sent to the laboratory on 8/5/2024 or the results not being reported to NP #1 on 8/8/2024 when they were sent to the facility by the laboratory. DON #2 stated the Urinalysis with Culture sample should have been sent when it was ordered on 8/5/2024 and the results should have been reported to NP #1 on 8/8/2024. DON #2 stated Nurse #2 completed a laboratory order for the Urinalysis with Culture on 8/5/2024 so the laboratory would have been aware the Urinalysis with Culture sample should be picked up. DON #2 stated the laboratory would have faxed Resident #1's laboratory findings to the facility and the nurses were responsible for reporting them to the Nurse Practitioner or Physician. The Administrator was interviewed on 8/30/2024 at 1:42 pm and she stated she was not aware of the Urinalysis with Culture not being sent to the laboratory when it was ordered on 8/5/2024 or NP #1 not being notified of the results of the Urinalysis with Culture on 8/8/2024. The Administrator stated Nurse #1 should have ensured the Urinalysis with Culture was sent on 8/5/2024 and the results were reported to NP #1 on 8/8/2024.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38904 Based on record review, observations and staff, Pharmacy Consultant and Nurse Practitioner interviews the facility failed to administer pain medication as ordered for 1 of 3 residents (Resident #9) reviewed for pain management. Findings included: Resident #9 was admitted to the facility on [DATE] with diagnoses of left knee replacement. A Physician's Order dated 8/28/2024 at 6:45 pm indicated Resident #9 should receive Oxycodone/Acetaminophen 5/325 milligrams, a narcotic pain medication, for pain every 4 hours for pain rated at 4 or more on a pain scale of 1 to 10. An admission Minimum Data Set (MDS) had not been completed for Resident #9. A late entry note written on 8/29/2024 at 5:25 am by Nurse #6 indicated Resident #9 arrived at the facility 8/28/24 at 5:45 pm with an incision to his left knee which was covered with a bandage. His vital signs were normal, he was alert and oriented with some confusion, and he was resting. A progress note written by Nurse #7 on 8/28/24 at 9:34 pm indicated Resident #9 reported his pain was a 6 on a scale of 1 to 10 and he was experiencing muscle spasms to his left lower extremity. A progress note dated 8/28/2024 at 9:37 pm written by Nurse #7 indicated Resident #9's pain medications were not available. Review of Resident #9's Medication Administration Record for 8/28/2024 indicated he did not receive any pain medication when his pain rated at a 6, on a scale of 1 to 10. A Packaging and Delivery Slip from the pharmacy indicated Resident #9's Oxycodone/Acetaminophen 5/325 milligrams was delivered to the facility on [DATE] at 7:12 pm. An interview was conducted by phone on 9/17/2024 at 12:52 pm with Nurse #6 and she stated she worked on 8/28/2024 at 7:00 pm until 8/29/2024 at 7:00 am and admitted Resident #9 to the facility. She stated Resident #9 arrived at the facility at 5:45 pm on 8/28/2024 and she did not get his admission orders faxed to the pharmacy until sometime between 7:00 pm and 11:00 pm. Nurse #6 stated she gave Resident #9 Acetaminophen from the standing orders on 8/28/2024 at 6:00 pm for mild pain but failed to document she had given it. Nurse #6 stated she checked on Resident #9 three or four times the night of 8/28/2024 and he did not complain of pain. She stated she filled his ice pack machine that was on his knee each time she was in his room. Nurse #7 was interviewed by phone on 9/18/2024 at 8:35 am and she stated she cared for Resident #9 on 8/28/2024 from 7:00 pm until 8/29/2024 at 7:00 am but she does not remember Resident #9. She stated the medications were delivered to the facility at 7:00 pm on 8/29/2024. She stated she could not remember if she was able to give him anything that night (8/28/2024) for pain and could not recall documenting the resident's pain was 6 on 8/28/2024. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/29/2024 at 5:37 pm an observation of Resident #9 revealed he was in bed with his eyes closed and he did not answer when his name was called. On 9/17/2024 at 12:42 pm the Consultant Pharmacist was interviewed by phone, and she stated the hard script for Resident #9's Oxycodone/Acetaminophen 5/325 milligrams was not faxed to the pharmacy until 8/29/2024 at 8:06 am and it was delivered to the facility on [DATE] at 7:12 pm. The Consultant Pharmacist stated there were two doses of the Oxycodone/Acetaminophen 5/325 milligrams taken from the electronic emergency backup medications on 8/29/2024 at 4:11 pm by the Corporate Nurse Consultant. On 9/18/2024 at 11:05 am an interview by phone was conducted with Nurse Aide (NA) #3 and she stated on 8/28/2024 on the 3:00 pm to 11:00 pm shift she was not assigned to Resident #9, but she did help NA #9 change him at 6:30 pm and 9:00 pm but she did not go back into his room after 9:00 pm. NA #3 stated Resident #9 complained of pain when she was in his room with Nurse Aide #9 at 6:30 pm and 9:00 pm. She stated he was not crying or moaning but he did state he was having pain. Nurse Practitioner (NP) #2 was interviewed by phone on 9/18/2024 at 1:41 pm and she stated she was the on-call provider for 8/28/2024 to 8/31/2024 when Resident #9 was admitted to the facility. NP #2 stated a resident that was only two days post op like Resident #9 would definitely need a narcotic pain medication and would be having moderate to severe pain. During an interview with Director of Nursing (DON) #2 on 8/30/2024 at 1:30 pm she stated she was not made aware of any issues with pain medications not being available to Resident #9. DON #2 stated the Nurse should have checked the emergency backup for the medication and if it was not available, she should have ordered the pain medication stat (to arrive immediately) from the pharmacy and notified the Physician to inquire if a pain medication that was available could be administered. DON #2 stated Nurse #7 should have reported to her that Resident #9's pain medication was not available. DON #2 stated she did not know why Resident #9's pain medications were not delivered until 8/29/2024. The Administrator was interviewed on 8/30/2024 at 1:34 pm and she stated Resident #9's pain medication should have been given from the emergency backup supply and if it was not available from the emergency backup Nurse #7 should have been sent a stat (immediate delivery) order to the pharmacy to send the pain medication immediately and the Physician should have been notified the medication was not available.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38904 Based on record review and staff interviews the facility failed to have pain medication available as ordered by the Nurse Practitioner on admission to the facility and provide nursing staff access to the electronic emergency backup medication storage for 1 of 3 residents reviewed for pain management (Resident #9). Findings included: Resident #9 was admitted to the facility on [DATE] with diagnosis of left knee replacement. A Physician's Order dated 8/28/2024 at 6:45 pm indicated Resident #9's admission medication orders included Oxycodone/Acetaminophen 5/325 milligrams, a narcotic pain medication, which was ordered every 4 hours as needed for pain rated at 4 or more on a scale of 1 to 10. A Nurse's Progress Note written 8/28/2024 at 9:34 pm written by Nurse #7 stated Resident #9 reported his pain was a 6 on a scale of 1 to 10 and he was experiencing muscle spasms to his left lower leg. An interview was conducted by phone on 9/17/2024 at 12:52 pm with Nurse #6 and she stated she worked on the 3:00 pm to 11:00 pm shift on 8/28/2024 and the 11:00 pm to 7:00 am shift on 8/28/2024 and admitted Resident #9 to the facility. Nurse #6 stated she faxed the hard script for Resident #9's Oxycodone/Acetaminophen 5/325 milligrams to the pharmacy between 7:00 pm and 11:00 pm and she did not receive the medication the in the medication that night. Nurse #6 stated she gave Resident #9 Acetaminophen 350 milligrams (2 tablets) per the facility's standing orders between 5:00 pm and 6:00 pm but she did not remember anyone telling her he had pain after 6:00 pm on 8/28/2024. Nurse #6 stated she was aware the order for Resident #9's pain medication indicated he should have Oxycodone/Acetaminophen 5/325 milligrams, 1 tablet, for pain rated at 4 or more on a scale of 1 to 10. Nurse #6 stated she did not have access to the electronic emergency backup medications but she had not needed it since Resident #9 did not complain of pain after receiving the Acetaminophen at 6:00 pm. On 8/28/2024 at 9:37 pm Nurse #7 wrote another Nurse's Progress Note which stated Resident #9's pain medication was not available. The Nurse's Progress Note did not include if the Nurse Practitioner was made aware of the medication not being available. Nurse #7 was interviewed on 9/18/2024 at 8:35 am and stated she worked at the facility on 8/29/2024 on the 7:00 pm to 7:00 am shift. Nurse #7 stated she did not remember Resident #9 and she did not remember anyone complaining of pain on 8/29/2024 when she worked. Nurse #7 stated if she signed the pain medication out for Resident #9 that night then she gave it and if his pain had not been relieved she would have called Director of Nursing #2 and then the physician if she did not have the pain medication that was prescribed. Nurse #7 stated she nor the other nurses working on 8/29/2024 had access to the electronic emergency backup system. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345131	A. Building B. Wing	09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedar Hills Center for Nursing and Rehabilitation	3905 Clemmons Road Clemmons, NC 27012

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/30/2024 at 1:30 pm Director of Nursing (DON) #2 was interviewed and stated she was not made aware of Resident #9's pain medication not being available on 8/28/2024. DON #2 stated Nurse #7 should have checked the emergency backup for the medication and if it was not available, she should have called the physician or nurse practitioner to see if a medication that was available could have been administered for Resident #7's pain. DON #2 stated she did not know why Resident #9's admission medications did not arrive, and the orders should have been sent to the pharmacy as soon as Resident #9 was admitted and admission medication orders were received. During an interview with the Administrator on 8/30/2024 at 1:34 pm she stated Resident #9's pain medication should have been given from the emergency backup supply and if it was not available Nurse #7 should have sent a stat order to the pharmacy to send his medications immediately. The Administrator also stated the Physician or Nurse Practitioner should have been made aware Resident #9 did not have pain medication.

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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 - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38904 Based on record review and staff, Pharmacist, Nurse Practitioner, and Resident interviews the facility failed to administer antiseizure medication and pain medication for 2 of 3 residents (Resident #8 and Resident #9) reviewed for providing pharmaceutical services to meet residents' needs. administration. Resident #8 did not receive her antiseizure medication on 7/15/2024 and 7/16/2024, and Resident #9 was admitted with a left total knee replacement and did not receive pain medication when admitted to the facility. Findings included: 1. Resident #8 was admitted to the facility on [DATE] with diagnoses malignant neoplasm to the brain resulting in seizures and brain necrosis due to radiation therapy. Resident #8's Physician's orders included an order written 7/15/2024 for Lamotrigine 200 milligrams twice daily; Lamotrigine 25 milligrams (2 tablets) at bedtime for seizures; and Levetiracetam 1000 milligrams (2 tablets) two times a day for seizures. Resident #8's Medication Administration Record (MAR) for 7/2024 was reviewed and the following medications ordered by the Physician were not documented as administered: Lamotrigine 200 milligrams, Lamotrigine 25 milligrams, or Levetiracetam 1000 milligrams were not signed on the MAR as given at 9:00 pm on 7/15/2024. Lamotrigine 200 milligrams and Levetiracetam 2000 milligrams were not signed on the MAR as given at 9:00 am on 7/16/2024. The Packing and Delivery Slips for Resident #8's Lamotrigine 200 milligrams, Lamotrigine 25 milligrams, and Levetiracetam 1000 milligrams indicated the medication was not delivered to the facility until 7/16/2024. On 8/29/2024 at 4:26 pm a phone interview was conducted with Resident #8 and she stated she was admitted to the facility on [DATE] and did not get her antiseizure medication the day she was admitted or the next morning. During an interview with Nurse #1 on 8/30/2024 at 4:02 pm she stated she cared for Resident #8 on the 7:00 pm to 7:00 am shift on 7/15/2024. Nurse #1 stated Resident #8's antiseizure medication did not arrive from the pharmacy during her shift, and she did not administer it. Nurse #1 stated she arrived for her shift at 7:00 pm and the when the pharmacy medication delivery arrived, after 7:00 pm, Resident #8's medications were not in the delivery. Nurse #1 stated she did not call the pharmacy to request a stat order for the seizure medications or notify the Nurse Practitioner #1 of the medication not being available. An admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #8 was cognitively intact. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #8's Care Plan dated 7/29/2024 indicated she had a seizure disorder, and the interventions included administer seizures medication as ordered and monitor for effectiveness. Director of Nursing (DON) #1, who no longer was employed at the facility, was interviewed by phone on 8/30/2024 at 2:49 pm and she stated Resident #8's antiseizure medications were not available from the pharmacy on the day she admitted , 7/15/2024, and they were not delivered that evening. DON #1 stated her antiseizure medications were not delivered until 7/16/2024. DON #1 stated Resident #8's medications should have been ordered from the pharmacy stat (to arrive as soon as possible) so that she would not miss doses of her antiseizure medication, and she had not been made aware the medication did not arrive from the pharmacy until the day after she was admitted to the facility. On 8/30/2024 at 2:13 pm the Pharmacist was interviewed by phone and stated Resident #8 not receiving the prescribed antiseizure medications on the evening of 7/15/2024, when she was admitted , and the missed dose on the morning of 7/16/2024 contributed to her having seizures. The Pharmacist stated when a medication is not available from the emergency back-up medications, they should be ordered stat (immediate delivery) from the pharmacy to arrive as soon as possible. During an interview with the Administrator on 8/30/2024 at 1:42 pm she stated she was not made aware of Resident #8 not getting her antiseizure medications on the night she was admitted [DATE] and the next morning 7/16/2024. The Administrator stated she was aware Resident #8 had a history of a brain tumor and seizures. She stated Resident #8's medications should have been ordered from the pharmacy as soon as she was admitted , to ensure they arrive as soon as possible if they were not available in the emergency backup medications. 2. Resident #9 was admitted to the facility on [DATE] with diagnoses of left knee replacement, kidney disease, and heart disease. An Admission Minimum Data Set (MDS) had not been completed for Resident #9. A Physician's Order dated 8/28/2024 at 6:45 pm indicated Resident #9 should receive Oxycodone/Acetaminophen 5/325 milligrams, a narcotic pain medication, for pain every 4 hours for pain rated at 4 or more on a pain scale of 1 to 10. A Nurse's Progress Note written on 8/28/2024 at 5:45 pm by Nurse #6 indicated Resident #9 arrived at the facility at 5:45 pm with an incision to his left knee which was covered with a bandage. His vital signs were within normal range, and he was resting. On 8/28/2024 at 9:34 pm Nurse #7 wrote a Nurse's Progress Note that indicated Resident #9 reported his pain was a 6 on a scale of 1 to 10 and he was experiencing muscle spasms to his left lower extremity. A Nurse's Progress note dated 8/28/2024 at 9:37 pm written by Nurse #7 indicated Resident #9's pain medications were not available. A Packaging and Delivery Slip from the pharmacy indicated Resident #9's Oxycodone/Acetaminophen 5/325 milligrams was delivered to the facility on [DATE]. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/30/2024 at 1:05 pm an attempt was made to reach Nurse #7, who worked the 7:00 pm to 7:00 am shift on 8/29/2024 when Resident #9 was admitted with no return call from Nurse #7. During an interview with Director of Nursing (DON) #2 on 8/30/2024 at 1:30 pm she stated she was not made aware of any issues with medications not being available to Resident #9. DON #2 stated the Nurse should have checked the emergency backup for the medication and if it was not available, she should have ordered the medication stat (to arrive immediately) from the pharmacy and notified the Physician to inquire if a medication that was available could be ordered. DON #2 stated Nurse #7 should have reported to her that Resident #9's pain medication was not available. DON #2 stated she did not know why Resident #9's medications were not delivered until the day after he was admitted to the facility. The Administrator was interviewed on 8/30/2024 at 1:34 pm and she stated Resident #9's pain medication should have been given from the emergency back up supply and if it was not available from the emergency back up the pharmacy should have been sent a stat order to send the medication immediately and the Physician should have been notified the medication was not available.