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	04/22/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and resident and staff interviews, the facility failed to respect a resident's right to dignity when Resident #16 requested assistance to the bathroom and then incontinence care. Assistance was not provided to Resident #16 until after all the meal trays were passed out on the hall and other residents were assisted with eating. This affected 1 of 4 residents reviewed for dignity (Resident #16). Findings included:Resident #16 was admitted to the facility on [DATE] with diagnoses including non-progressive congenital joint contractures and chronic obstructive pulmonary disease.A Brief Interview for Mental Status assessment completed on 4/14/2026 indicated Resident #16 was cognitively intact.A care plan focus area, initiated on 4/16/2026 for Resident #16, documented a self-care performance deficit, with interventions including the need for one-person assistance for toileting and transfers.During an interview and observation conducted on 4/21/2026 at 2:22 PM, with a follow-up interview on 4/22/2026 at 9:41 AM, Resident #16 reported that she had received medication earlier that morning to stimulate a bowel movement. She stated that at 12:15 PM, she activated her call light, requesting assistance to the bathroom because she felt the medication beginning to work and believed she could reach the bathroom with help. She reported that Nurse Aide (NA) #1, whom she did not recognize, responded within five or six minutes. According to Resident #16, she informed NA #1 of her urgent need for assistance and her fear of having a bowel movement in bed. The resident stated that NA #1 turned off the call light and told her she would return, but no one came. The resident reported that she activated her call light again, at which time NA #2 entered the room to deliver her lunch tray. The resident stated she informed NA #2 that she now required incontinence care because no one assisted her to the bathroom. The resident reported that NA #2 also turned off her call light and stated she would return. The resident stated she became angry but waited, activating her call light again at 1:22 PM. Resident #16 reported she was certain of the time because she had both a wall clock and a phone visible and accessible. A clock was observed on the wall, and the resident was holding her phone during the interview. Resident #16 stated that a staff member from the rehabilitation department, identified as the Director of Rehabilitation Services, eventually answered her call light. Resident #16 reported she told this staff member she had been waiting for over an hour and required incontinence care. Resident #16 stated she received assistance only after the rehabilitation staff member notified a nurse aide. Resident #16 confirmed NA #2 did provide care for her, but she was so angry at that point that she did not recall the time. Resident #16 also confirmed she waited until after she received incontinence care to eat her lunch. Resident #16 stated she did not like sitting in her feces and felt frustrated and angry that she did not receive assistance when needed. She stated that at home, she was able to reach the bathroom independently and did not soil herself in an incontinence brief.During an interview on 4/21/2026 at 4:13 PM, NA #1 stated she did not recall the exact time but confirmed that before meal trays were distributed, Resident #16 activated her call light. NA #1 stated she responded to the call light and turned off the call light. NA #1 reported she was not assigned to Resident #16 that day and was unfamiliar with the resident's care needs because the resident was new. NA #1 stated she (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	informed Nurse #2 and NA #2 at the nurses' desk that Resident #16 reported the medication to move her bowels was beginning to work, and she needed help to the bathroom.During an interview on 4/21/2026 at 3:35 PM, NA #2 confirmed that NA #1 informed her that Resident #16 needed assistance to the bathroom. NA #2 stated that the lunch trays were already in the hallway at that time. She reported that it was a long-standing rule that residents could not receive incontinence care or be assisted to the bathroom while meal trays were in the hallway. NA #2 stated that Resident #16 did not eat her lunch while soiled but waited until trays were passed and NA #2 had finished assisting other residents with eating. NA #2 stated she then provided incontinence care and reheated Resident #16's lunch.During an interview on 4/21/2026 at 3:30 PM, Nurse #2 stated that NA #1 informed her and NA #2 around lunchtime that Resident #16 might need incontinence care. Nurse #2 stated Resident #16's call light may have been on for approximately ten minutes before NA #1 answered it, and stated the resident tended to exaggerate waiting times. Nurse #2 reported that meal trays for the adjacent hallway had just been delivered, and trays for her hallway were expected imminently when Resident #16 requested assistance. During an interview on 4/21/2026 at 3:55 PM, the Director of Rehabilitation Services stated she answered Resident #16's call light at lunchtime. She reported that Resident #16 stated she needed to be changed and had been waiting. The Director of Rehabilitation Services stated she notified the Assistant Director of Nursing (ADON) of Resident #16's needs.During an interview on 4/21/2026 at 4:08 PM, the ADON confirmed she was informed by the Director of Rehabilitation Services that Resident #16 required assistance at lunchtime. The ADON stated she located Nurse #2 and informed her that Resident #16 needed to be changed. The ADON stated Nurse #2 told her she would take care of it.During a second interview on 4/21/2026 at 4:47 PM, Nurse #2 stated the ADON texted her at 1:30 PM and informed her that Resident #16 needed to be changed. Nurse #2 stated she was assisting another resident with eating, and when she entered the hallway, NA #2 was already on her way to provide care. Nurse #2 stated that call lights were rarely left on for long because the sound was very annoying, and therefore she believed Resident #16's call light was not on for an extended period.During an interview on 4/22/2026 at 10:30 AM, the Director of Nursing stated that NA #2 should have assisted Resident #16 to the bathroom when she was informed of her needs. She stated she teaches nurse aide classes and that there has never been a rule prohibiting incontinence care while meal trays are in the hallway.During an interview with the Administrator conducted on 4/22/2026 at 2:45 PM, she reported that residents should receive assistance with toileting and incontinence care even if the meal trays were in the hallway. The Administrator stated that another staff member could have assisted with passing out meal trays while Resident #16 received needed care. The Administrator stated the incident represented a dignity issue and was unacceptable.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and staff interviews, the facility failed to protect a resident's right to be free from neglect when Resident #6's call light was disconnected by a staff member. This caused the resident to be unable to access assistance, and Resident #6 was found on the next shift to be soiled with urine and feces. This failure affected 1 of 2 residents who were reviewed for callˆsystem concerns (Resident #6).Findings included:Resident #6 admitted to the facility on [DATE] with diagnoses of chronic kidney disease and hypertension.Resident #6's admission Minimum Data Set (MDS) dated [DATE] indicated he had severe cognitive impairment. Further review of the MDS revealed Resident #6 needed substantial/maximum assistance with toilet hygiene and was incontinent with bowel and bladder. A telephone interview was conducted on 4/21/26 at 10:30 a.m. with Nursing Assistant (NA) 3 and she reported she had been assigned to Resident #6 on 2/21/26 at 7 p.m. to 7 a.m. on 2/22/26. She explained that Resident #6 had repeatedly pushed his call light throughout the shift. She had entered his room multiple times to provide assistance, though at times he did not require help and continued to hold the call light in his hand. NA #3 reported that around 5:15 a.m. she had removed the call light cord from the wall socket and placed a plastic fork in the socket to prevent the call light from ringing while she completed her last round. She further stated she had informed Nurse #4, who told her she could not do that and instructed her to replace the call light cord. NA #3 said she later returned to Resident #6's room between 5:30 a.m. and 5:45 a.m. to provide incontinence care but forgot to reinsert the call light cord.During a telephone interview on 4/21/26 at 11:13 a.m., Nurse #4 stated that NA #3 had informed her she removed the resident's call light cord because he was continuously pressing it while she attempted to complete her last round. Nurse #4 reported that she had instructed NA #3 to reconnect the call light. She intended to check behind NA #3 to ensure the cord had been reconnected but was called to another resident's room and forgot to follow up.NA #4 was interviewed on 4/22/26 at 9:49 a.m. She stated she had been assigned to Resident #6 for the 7 a.m. to 7 p.m. shift on 2/22/26. She reported arriving at work around 7 a.m. and hearing someone yelling as she walked down the hallway. The yelling came from Resident #6's room. When she entered, she observed a plastic fork in the call light socket. Resident #6 told her someone had removed his call light from the socket, although he could not identify who. NA #4 said the resident was soiled with urine and feces, and she took him to the shower for cleaning. NA #4 indicated she reported the situation to Nurse #1.Nurse #1 was interviewed on 4/21/26 at 1:37 p.m. She stated she had been informed by NA #4 that a plastic fork was lodged in Resident #6's call light socket. Nurse #1 reported that she checked the room, observed the fork in the socket, removed it, reconnected the call light cord, and notified the Director of Nursing (DON).The DON was interviewed on 4/22/26 at 11:43 a.m. She stated she had been informed on 2/22/26 that the resident's call light had been disconnected and a plastic fork had been inserted in the socket. She said she verified Resident #6 was unharmed. She suspended both NA #3 and Nurse #4 pending the investigation. Once the investigation concluded, NA #3 was terminated, and Nurse #4 and other staff members received additional education.During a telephone interview on 4/22/26 at 4:00 p.m., the previous Administrator stated that both Nurse #4 and NA #3 had been suspended pending the investigation. Nurse #4 was reinstated and provided education on rounding responsibilities and ensuring call lights were functioning. Additional education was provided for the rest of the staff, and NA #3 was terminated.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and resident and staff interviews, the facility failed to provide assistance to the bathroom and incontinence care to a resident upon request for 1 of 5 reviewed for the provision of activity of daily living care (Resident #16).Findings included:Resident #16 was admitted to the facility on [DATE] with diagnoses including non-progressive congenital joint contractures and chronic obstructive pulmonary disease.Review of an admission data collection note dated 4/13/2026 revealed Resident #16 was assessed as incontinent of bladder and bowel.A Brief Interview for Mental Status assessment completed on 4/14/2026 indicated Resident #16 was cognitively intact.A care plan focus area, initiated on 4/16/2026 for Resident #16, documented a self-care performance deficit, with interventions including the need for one-person assistance for toileting and transfers.Documentation in a daily skilled physical therapy note completed on 4/20/2026 revealed Resident #16 performed a transfer from the edge of the bed to a forward wheeled walker. Resident #16 then took a few steps, transferred to the wheelchair and then the commode with moderate assistance with verbal cues for hand positioning and pivoting. Resident #16 was noted to end the session back in the wheelchair.During an interview and observation conducted on 4/21/2026 at 2:22 PM, with a follow-up interview on 4/22/2026 at 9:41 AM, Resident #16 reported that she had received medication earlier that morning to stimulate bowel movement. She stated that at 12:15 PM, she activated her call light, requesting assistance to the bathroom because she felt the medication beginning to work and believed she could reach the bathroom with help. She reported that Nurse Aide (NA #1), whom she did not recognize, responded within five or six minutes. According to Resident #16, she informed NA #1 of her urgent need for assistance and her fear of having a bowel movement in bed. The resident stated that NA #1 turned off the call light and told her she would return, but no one came. The resident reported that she activated her call light again, at which time NA #2 entered the room to deliver her lunch tray. The resident stated she informed NA #2 that she now required incontinence care because no one assisted her to the bathroom. The resident reported that NA #2 also turned off her call light and stated she would return. The resident stated she became angry but waited, activating her call light again at 1:22 PM. Resident #16 reported she was certain of the time because she had both a wall clock and a phone visible and accessible. A clock was observed on the wall, and the resident was holding her phone during the interview. Resident #16 stated that a staff member from the rehabilitation department, identified as the Director of Rehabilitation Services, eventually answered her call light. Resident #16 reported she told this staff member she had been waiting for over an hour and required incontinence care. Resident #16 stated she received assistance only after the rehabilitation staff member notified a nurse aide. She stated that at home, she was able to reach the bathroom independently and did not soil herself in an incontinence brief.During an interview on 4/21/2026 at 4:13 PM, NA #1 stated she did not recall the exact time but confirmed that before meal trays were distributed, Resident #16 activated her call light. NA #1 stated she responded to the call light and turned off the call light. NA #1 reported she was not assigned to Resident #16 that day and was unfamiliar with the resident's care needs because the resident was new. NA #1 stated she informed Nurse #2 and NA #2 at the nurses' desk that Resident #16 reported the medication to move her bowels was beginning to work, and she needed help to the bathroom.During an interview on 4/21/2026 at 3:35 PM, NA #2 confirmed that NA #1 informed her that Resident #16 needed assistance to the bathroom. NA #2 stated that the lunch trays were already in the hallway at that time. She reported that it was a long-standing rule that residents could not receive incontinence care or be assisted to the bathroom while meal trays were in the hallway. NA #2 stated that Resident #16 did not eat her lunch while soiled but waited until trays were passed and NA #2 had finished assisting other residents with eating. NA #2 stated she then provided incontinence care and reheated Resident #16's lunch.During an interview on 4/21/2026 at 3:30 PM, Nurse #2 stated that NA #1 informed her and NA (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#2 around lunchtime that Resident #16 might need incontinence care. Nurse #2 stated Resident #16's call light may have been on for approximately ten minutes before NA #1 answered it. Nurse #2 reported that meal trays for the adjacent hallway had just been delivered, and trays for her hallway were expected imminently when Resident #16 requested assistance. During an interview on 4/21/2026 at 3:55 PM, the Director of Rehabilitation Services stated she answered Resident #16's call light at lunchtime that day. She reported that Resident #16 stated she needed to be changed and had been waiting. The Director of Rehabilitation Services stated she notified the Assistant Director of Nursing (ADON) of Resident #16's needs.During an interview on 4/21/2026 at 4:08 PM, the ADON confirmed she was informed by the Director of Rehabilitation Services that Resident #16 required assistance at lunchtime that day. The ADON stated she located Nurse #2 and informed her that Resident #16 needed to be changed. The ADON stated Nurse #2 told her she would take care of it.During a second interview on 4/21/2026 at 4:47 PM, Nurse #2 stated the ADON texted her at 1:30 PM that day and informed her that Resident #16 needed to be changed. Nurse #2 stated she was assisting another resident with eating, and when she entered the hallway, NA #2 was already on her way to provide care.During an interview on 4/22/2026 at 10:30 AM, the Director of Nursing stated that NA #2 should have assisted Resident #16 to the bathroom when she was informed of her needs. She stated she taught nurse aide classes and that there had never been a rule prohibiting incontinence care while meal trays were in the hallway.During an interview with the Administrator conducted on 4/22/2026 at 2:45 PM, she reported that residents should receive assistance with toileting and incontinence care even if the meal trays were on the hallway. The Administrator stated that another staff member could have assisted in passing out meal trays while Resident #16 received the needed care.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff, family, and resident interviews, the facility failed to provide wound treatments as ordered by a physician for 2 of 5 residents reviewed for the provision of care according to professional standards and the care plan (Residents #5 and #16). Findings included:1. Resident #5 was admitted to the facility on [DATE] and discharged from the facility on 3/9/2026. Resident #5 had a right below-the-knee amputation.Resident #5 had a physician's order dated 3/3/2026 that directed staff to wrap the right below-the-knee amputation site with an abdominal pad and Kerlix daily and as needed, and to monitor the site for signs and symptoms of infection.Resident #5's care plan dated 3/3/2026 had a focus area for a surgical wound to the right lower extremity, with an intervention to follow facility protocols for treatment of the injury. Review of the Treatment Administration Record revealed blank documentation spaces for the ordered wound treatment to the surgical site for Resident #5 on Saturday, 3/7/2026 and Sunday, 3/8/2026. Resident #5 had a Medicare 5-Day Minimum Data Set assessment dated [DATE] documenting a surgical wound with application of non-surgical dressing other than to the feet.During an interview on 4/21/2026 at 10:09 AM, Nurse #1 stated she was assigned to care for Resident #5 on 3/7/2026 and 3/8/2026 for the 7:00 AM to 7:00 PM shift. Nurse #1 reported she was an agency nurse and had recently begun working at the facility at the end of February 2026. Nurse #1 stated that on 3/7/2026 and 3/8/2026 she had not been informed that she was responsible for completing wound treatments in her assigned area over the weekend. Nurse #5 confirmed that if the treatment was not checked off on the Treatment Administration Record on 3/7/2026 and 3/8/2026, then she did not complete the ordered wound care for Resident #5.During an interview on 4/20/2026 at 1:42 PM a family member of Resident #5 reported that wound care was not provided to Resident #5 on the weekend of 3/7/2026 and 3/8/2026. The family member reported that area was bleeding on the sheets, but she could not get the nurse to put the dressing back on. The family member stated she attempted to put the dressing back on Resident #5 herself.The Director of Nursing was interviewed on 4/21/2026 at 12:48 PM and stated it was her expectation that the nurses complete wound care and treatments on the nursing shift it was ordered for on weekends when the treatment nurse was unavailable. The Director of Nursing acknowledged Nurse #1 was a contract agency nurse, but stated Nurse #1 should have known she was responsible for completing the ordered treatments on 3/7/2026 and 3/8/2026. 2. Resident #16 was admitted to the facility on [DATE] and had a diagnosis of bilateral lower extremity lymphedema.The electronic medical record showed Resident #16 had a care plan focus area initiated on 4/14/2026 for the risk for pressure ulcer development related to lymphedema, with an intervention to administer treatments as ordered and monitor for effectiveness.A basic interview for mental status assessment completed on 4/14/2026 indicated Resident #16 was cognitively intact.A physician's order for Resident #16 dated 4/15/2026 directed staff to apply Xeroform gauze to both legs, cover with abdominal pads and Kerlix from behind the toes to below the knees, and apply an ace wrap in the same manner every day shift.Review of the Treatment Administration Record for Resident #16 revealed a blank documentation space for the ordered treatment on Sunday, 4/19/2026 for her bilateral lymphedema. During a telephone interview on 4/21/2026 at 2:12 PM, Nurse #3 confirmed she was assigned to Resident #16 on 4/19/2026 for the 7:00 AM to 7:00 PM shift. Nurse #3 stated that she did not remember whether she administered the treatment and explained that she was a new nurse and not very skilled at wrapping legs. She confirmed that if the treatment was not checked off on the Treatment Administration Record, then she did not complete it. Resident #16 was interviewed on 4/21/2026 at 2:46 PM. Resident #16 confirmed she did not receive her leg treatment on 4/19/2026.During an interview on 4/21/2026 at 2:46 PM, the Director of Nursing stated Nurse #3 should have completed the treatment as ordered on 4/19/2026 for Resident #16 and confirmed that nurses assigned to the hall are responsible for completing treatment orders on weekends when the wound care nurse was not in the building.

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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 observations, record reviews, and staff interviews, the facility failed to have a medication error rate of less than 5% as evidenced by 2 medication errors out of 33 opportunities, resulting in a medication error rate of 6.06% for 1 of 2 residents observed for medication administration (Resident #12).The findings included:Resident #12 was admitted to the facility on [DATE] with diagnoses that included anemia, iron deficiency, and hyperlipidemia. Resident #12's physician order dated 4/2/26 for polysaccharide iron complex capsule 150 milligrams (mg) give 1 capsule by mouth one time a day for deficiency. There was no order for acidophilus 500 million (acidophilus 500 million refers to a probiotic supplement that contains 500 million active organisms per serving) located in the medical record. On 4/21/26 a continuous observation of medication administration occurred from 8:28 AM through 8:54 AM. Upon observation of Nurse #1's medication cart and the medication storage room during a medication administration pass, Nurse #1 was unable to locate a bottle of the polysaccharide iron complex capsules (150mg). While at her medication cart, Nurse #1 proceeded to pour one acidophilus 500 million tablet into Resident #12's medicine cup and stated since both medications were probiotics, one could be substituted for the other. Nurse #1 administered the acidophilus tablet along with Resident #12's other medications. On 4/21/26 at 9:10 AM, an interview was held with Nurse #1. She stated if a medication was not available in her medication cart, she would see if another cart on her hall had that medication. If the medication was available on that cart, she would get a cup of the capsules or tablets to finish her medication pass. If the medication was not available on either cart, she would look in the medication storage room. If the medication was not in the storage room, she would follow up with Central Supply to place an order for that medication. On 4/21/26 at 9:40 AM, an interview with Unit Manager #2 revealed if a medication was not available on the medication cart, she would check overstock. If the medicine was not in overstock, she would notify the family and provider. If the medication was a house stock medicine (such as a multivitamin, aspirin, Tylenol, vitamin D3, etc.), she would borrow the medicine from another cart. If that cart did not have the medication, she would let management know and request Central Supply to order it. It usually took less than a day to get house stock medications. If the medication was a prescription, she would check the overstock, medication rooms, or pull the medicine from the Pyxis (machine that housed prescription medications). She would also notify the provider to see if any changes were needed. An interview was conducted with Unit Manager #1 on 4/21/26 at 9:54 AM. She stated when a medication was not available, she would see if the medicine was in the Pyxis. She would notify the provider to order the medication or get a prescription. If the medication was an over-the-counter medication, she would exhaust her options by checking every medication cart, medication room, etc. She would notify the provider if the medication was not available to see if they wanted a substitute or to place the medication on hold. On 4/21/26 at 10 AM, an interview with the Director of Nursing (DON) revealed if a medication was not available on the medication cart, she would check all medication carts and medication storage rooms. If the medication was not available, she would follow up with Central Supply. If they could not obtain the medication, they would contact the provider. A follow up interview with the DON on 4/21/26 at 2:10 PM revealed polysaccharide iron complex is a different medication from acidophilus, and they should not be substituted. An interview conducted with the Nurse Practitioner (NP) on 4/22/26 at 10:15 AM revealed if a resident ran out of a medication, staff should notify him. He stated if the medication was not at the facility, they should call him and he could place a hold on that medication until it was received. The NP stated acidophilus probiotic is not the same medication as the polysaccharide iron complex and that staff should not be making that distinction. The NP stated staff should have notified him of the administration of the acidophilus. He also stated getting the acidophilus should not hurt Resident #12 and there was no harm caused. However, Resident #12 was not getting the benefits as he should with taking the acidophilus instead of the polysaccharide iron complex.

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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 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. Based on observations and staff interviews, the facility failed to store stock medications securely in the original covered and labeled bottles to prevent errors and possible contamination in 1 of 2 medication carts reviewed for medication storage (300 hall medication cart #1).The findings included: A medication administration observation of the medication cart #1 for the 300-hall occurred on 4/21/26 for Resident #12. This was a continuous observation that occurred from 8:28 AM through 8:54 AM. The observation revealed Nurse #1 did not have a bottle of Vitamin D3 (cholecalciferol) 25 micrograms (mcg)/1000 units (supplement) in her medication cart, nor was the medication available in the medication storage room. Nurse #1 obtained the medication from Unit Manager #1's medication cart #2 which was also assigned to the 300-hall. Unit Manager #1 poured 8 tablets of the Vitamin D3 25mcg/1000 units into a medicine cup, labeled the cup as Vit D3, and handed the cup to Nurse #1. Nurse #1 went back to her medication cart and placed the medicine cup into the top drawer of her medication cart. Nurse #1 confirmed she placed the Vitamin D3 in a medicine cup for continued use until she was able to get a bottle for her medication cart. A continuous medication administration observation on 4/21/26 from 8:54 AM through 9:08 AM with Nurse #1 revealed she did not have Acetaminophen 500 milligrams (mg) in medication cart #1 on the 300-hall for Resident #10. Nurse #1 obtained the medication from Unit Manager #1's medication cart #2. Unit Manager #1 poured 12 tablets of the Acetaminophen 500mg into a medicine cup and handed the cup to Nurse #1. Nurse #1 went back to medication cart #1 and placed the medicine cup into the top drawer of her cart. The medicine cup was not labeled. Nurse #1 stated she did not have a pen to write the medication name on the cup. Nurse #1 confirmed she placed the Acetaminophen in a medicine cup for continued use until she was able to get a bottle for her medication cart. On 4/21/26 at 9:10 AM, an interview was held with Nurse #1. She stated if a medication was not available in her medication cart, she would see if another cart on her hall had that medication. If the medication was available on that cart, she would get a cup of the medicines to finish her medication pass. If the medication was not available on either cart, she would look in the medication storage room. If the medication was not in the storage room, she would follow up with Central Supply to place an order for that medication. On 4/21/26 at 10 AM, an interview with the Director of Nursing (DON) revealed if a medication was not available on the medication cart, she would check all medication carts and medication storage rooms. If the medication was not available, she would follow up with Central Supply. If they could not obtain the medication, they would contact the provider. Interview and observation of Nurse #1's medication cart #1 with the Director of Nursing (DON) present on 4/21/26 at 10:15 AM revealed the open medicine cups that contained 12 tablets of Acetaminophen 500mg and 8 tablets of Vitamin D3 (cholecalciferol) 25mcg/1000 units had been discarded. Nurse #1 stated she received a bottle of Acetaminophen 500mg and Vitamin D3 25mcg/1000 units from the Assistant Director of Nursing (ADON). However, during this observation with the DON and Nurse #1, an open medicine cup of white tablets labeled Magnesium was observed in the top drawer of the medication cart. The small medicine cup was observed to be about half full of tablets. The number of tablets in the cup was unknown as Nurse #1 discarded the pills prior to counting. The DON stated medications were not supposed to be stored open (labeled or unlabeled) in a medicine cup in the medication cart.