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	06/26/2026

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

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 and staff interviews, the facility failed to protect resident #8's private healthcare information (PHI) by leaving confidential medical information unattended, visible, and accessible to others on a laptop screen for 1 of 2 treatment carts observed (300-hall treatment cart).The findings included:On 6/25/2026 at 9:52 AM an observation of the 300-hall treatment cart revealed the treatment cart was left unattended when the Treatment Nurse left and entered Resident #8's room to complete the treatment ordered. The Treatment nurse left the computer screen open facing the hallway displaying resident #8's personal identifying information including the resident's name, diagnoses, and orders for treatment. Before closing the door to Resident #8's room to complete the ordered treatment, the Treatment Nurse was asked by Surveyor to place privacy screen on to protect Resident #8's PHI from being revealed. There was one resident in a wheelchair in the hallway during this time. During an interview on 6/25/2026 at 9:54 AM with the Treatment Nurse she acknowledged she did not lock the laptop screen on the treatment cart when she walked away. She indicated she knew she should have locked the laptop screen before leaving the area to ensure resident information was not visible to others. An interview on 6/25/2026 at 10:42 AM with the Director of Nursing (DON) revealed the Treatment Nurse should not have walked away and left resident information displayed on screen without locking it. She indicated screens should be locked to protect resident's privacy whenever the treatment cart was left unattended.

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 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. Based on record review, staff interviews, and between review and staff the facility failed to ensure 2 of 2 narcotic reconciliation records reviewed were signed and dated when controlled substances were administered (100 and 300 hall).The findings included: The facilities Controlled Substance Administration and Accountability policy dated 12/2022 with a review dated of 12/2025 under Section f ii stated, All controlled substances obtained from non-automated medication cart or cabinet are recorded on the designated usage form. a. A review on 6/24/2026 at 1:58 PM of the 300-hall side B narcotics reconciliation record showed that at the time of review, there was no record indicated in the narcotics reconciliation record of a controlled substance being administered. The last administration of a controlled substance in the in the narcotic reconciliation record for 300-hall B was signed for administration on 6/23/2026. Nurse #2 was interviewed on 6/24/2026 at 2:06 PM and stated she had administered lorazepam 0.5 mg earlier in the shift and had not signed the narcotic reconciliation record for administration of the controlled substance when she administered the lorazepam. Nurse #2 stated she knew she was supposed to sign the narcotic reconciliation record at the time the medication was administered. She stated this was to ensure the count for the medication was correct. Nurse #2 stated she knew if she forgot to go back and sign the record the medication count would not be accurate and the medication administered would not be accounted for. Nurse #2 was observed to sign the narcotic reconciliation record at time of the interview. Nurse #2 stated she was aware it was a careless error. Nurse #2 showed the electronic Medication Administration Record (Mar) during the interview revealing the lorazepam being administered earlier in the shift. b. A review on 6/24/2026 at 2:40 PM of the 100-hall narcotics reconciliation record showed that at the time of review, there was no record indicated in the narcotics reconciliation record of a narcotic medication being administered on 6/24/2026. Nurse #3 was interviewed on 6/24/2026 at 2:44 PM and stated she had not signed the narcotic reconciliation record when she administered the hydromorphone but knew she was supposed to sign the narcotic reconciliation record when the medication was administered earlier in her shift. She stated she was aware that if she did not sign for the administering of the medication, the medication count would be incorrect, and she could be held accountable for the narcotic medication. During the interview Nurse #3 shared the electronic MAR revealing she had administered the hydromorphone earlier in the shift. She was unable to give a reason why she did not sign for administering the medication at the time it was administered. Nurse #3 was observed to sign the narcotic reconciliation record at the time of interview. The Director of Nursing (DON) was interviewed on 6/25/2026 at 10:46 AM and stated she expected the narcotic reconciliation record to be signed when the medication was administered. The DON was unable to explain why the narcotic reconciliation record was not signed at the time the medication was administered. An interview with the Administrator was completed on 6/26/2026 at 1:14 PM and she stated the narcotic reconciliation record should be signed at the time the medication is administered by the nurse that administered the medication. The Administrator was unable to explain why the medications were not signed for at the time they were administered. The Administrator stated she expected nurses to sign the narcotic reconciliation record when a narcotic and controlled substance was administered to ensure the medication count was correct.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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, record review, staff, and Corporate Nurse Consultant interviews, the facility failed to store medication in its original package with labeling and dispensing instructions (300 hall Medication Cart), failed to remove expired medication (100 hall Medication Cart), and failed to secure two unlocked treatment carts. These failures occurred in 2 of 2 medication carts and 2 of 2 treatment carts (100 and 300 hall) reviewed for medication storage.Findings Included:1). An observation of the 300 hall medication cart was completed on 06/24/2026 at 1:27 PM accompanied by Nurse #2. During this observation five pills were observed loose and not in their original package. The five loose pills were observed in the over-the-counter medication drawer of the medication cart. An interview with Nurse #2 on 6/24/2026 at 1:28 PM revealed that she was unaware of where the loose pills came from and she was unable to identify the pills. Nurse #2 stated she was not aware she had pills that were loose in her medication cart. Nurse #2 could not recall seeing the loose pills when she checked her cart at the beginning of her shift or when she was administering medications earlier in the shift. Nurse #2 stated she had been assigned to this medication cart for the day shift on 6/24/2026. The Director of Nursing (DON) was interviewed on 6/25/2026 at 10:44 AM and she stated that she was unsure why there were loose medications on the 300-hall medication cart. The DON stated she had been doing checks weekly of the medication carts. The DON was unable to explain why there were loose medications on the medication cart. An interview was completed with the Corporate Nurse Consultant on 6/25/2026 at 11:25 AM. The Corporate Nurse Consultant stated she had checked the 300-hall medication cart the morning of 6/24/2026 and there were no loose medications in the cart at that time. She was unable to explain why the loose medication was observed in the medication cart. The Corporate Nurse Consultant stated she has helped with the medication cart checks as well as the DON and nurse assigned to the cart. An interview with the Administrator was completed on 6/26/2026 at 1:15 PM and she could not explain why there were loose medications on the 300-hall medication cart. The Administrator stated the medication carts were checked by the DON and Corporate Nurse multiple times a week and there had not been an issue with loose medications that she was aware of. The Administrator stated that with the routine checks of the medication carts there should have been no loose medications observed. 2). An observation on 6/24/2026 at 2:13 PM of the 100-hall medication cart accompanied by Nurse #3 revealed a bottle of opened Vitamin D3 (vitamin supplement) capsules with an expiration date of 5/2026. An Interview with Nurse #3 was completed on 6/24/2026 at 2:15 PM and she confirmed that the bottle of the Vitamin D3 capsules had expired 5/2026 and should have been removed from the medication cart. Nurse #3 stated she had not observed the expired bottle when completing her checks at the start of the shift. The bottle was removed from the medication cart during this interview with Nurse #3. The Director of Nursing (DON) was interviewed on 6/25/2026 at 10:44 AM and stated medication checks were completed weekly by herself and the nurse assigned to the medication cart and the Vitamin D3 capsules should have been removed when they expired. The DON was unsure why the bottle of Vitamin D3 had not been discarded and replaced at the time of expiration. An interview with the Administrator was completed on 6/26/2026 at 1:15 PM. The Administrator stated the medication carts were checked multiple times a week by the DON and other nursing staff at the facility. The Administrator stated that with the weekly checks of the medication carts there should have been no expired medications observed. The Administrator was unable to explain why an expired bottle of Vitamin D3 was on the 100-hall medication cart. The administrator stated the expired medication should have been removed at the time of expiration and replaced with a current date bottle of medication. 3a). On 6/25/2026 at 9:52 AM an observation of Nurse #1 completing wound care was made. Nurse #1 was observed leaving the 300-hall treatment cart unattended and entering a resident's room without locking the cart. The (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	treatment cart contained medication supplies used for wound care treatments. There was one resident in a wheelchair in the hallway approximately three feet from the treatment cart. Nurse #1 returned to the 300-hall treatment cart to lock the treatment cart when the Surveyor brought it to her attention. Nurse #1 again returned to the 300-hall treatment cart at 9:53 AM to get forgotten supplies and returned to the resident's room to complete treatment. When exiting the room after the observation of treatment was completed it was observed that Nurse #1 left the 300-hall treatment cart unlocked from when she had gotten her forgotten supplies to complete the wound care. There were two residents leaving their room in the hallway during this observation. The two residents were approximately three feet from the treatment cart. An interview with Nurse #1 was completed on 6/25/2026 at 10:02 AM and she was unaware she had not locked the treatment cart when getting the bandage she had forgotten. She stated she should have locked it back before going back into the residents' room to complete the wound treatment. 3b). An observation at 10:32 AM on 06/25/2026 of the treatment cart located on the 100-hall at the nurse's station was observed unattended and unlocked. Medicated supplies were being stored on the 100-hall treatment cart at the time of observation. The time that the treatment cart was left unattended and unlocked was unknown. At 10:39 AM the Director of Nursing (DON) confirmed the treatment cart on the 100 hall was unlocked. The DON was interviewed on 6/25/2026 at 10:44 AM and stated she could not explain why the treatment carts were left unlocked and unattended. She stated staff were aware of locking the treatment and medication carts when leaving them unattended. An interview was completed with the Corporate Nurse on 6/25/2026 at 11:25 AM. The Corporate nurse shared that the DON observed the treatment cart unlocked when passing in the hallway and was the one responsible for locking the treatment cart on the 300 hall. A follow up interview was completed with the DON on 6/26/2026 at 1:14 PM and she confirmed that she had observed the treatment cart unlocked on 6/25/26. The exact time was unknown, but she stated when she observed the treatment cart was unlocked, and she locked the treatment cart at that time. The Director of Nurse did not know why the treatment cart was unlocked while unattended. An interview with the Administrator was completed on 6/26/2026 at 1:15 PM. The Administrator stated she could not explain the unlocked treatment carts. The Administrator stated that every time she made rounds on the hallways the medication/treatment carts were always observed to be locked.