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	02/13/2026

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 record review, resident interview and staff interviews the facility failed to treat a resident in a dignified and respectful manner when Nurse Aide #7 and Nurse Aide #8 were delayed in responding to a resident's call for assistance and told the resident to stop using her call light causing the resident to be upset and mad. The deficient practice affected 1 of 3 residents reviewed for dignity (Resident #82).Findings included:Resident #82 was admitted to the facility on [DATE] with diagnoses that included fracture of left hand, fracture of left radius, muscle weakness, and anxiety. Resident #82 transferred to the hospital on 2/9/26. The admission comprehensive Minimum Data Set (MDS) assessment for Resident #82 dated 1/29/26 revealed she was cognitively intact, had no behaviors, and required assistance of staff with toileting, bed mobility, and transfers. She was coded to use a wheelchair for mobility. A grievance reporting form was initiated by the Social Worker on 2/5/26 and stated C.N.A's (Certified Nursing Assistant) aren't properly changing resident in a timely manner. Aides at night aren't coming in when they do they tell her not to ring out. The grievance was investigated by the Director of Nursing (DON). The result of the investigation dated 2/13/26 was NA #7 and NA #8 were suspended pending investigation, received disciplinary action regarding timeliness of care and customer service and would receive education on customer service and timelines of care. In addition, NA #7 and NA #8 would not be assigned to Resident # 82 in the event of readmission to the facility. An interview was completed with Resident #82 on 2/9/26 at 10:42 AM. Resident #82 indicated that nursing assistants made her wait over 30 minutes to answer her call light for incontinence care needs and told her not to call for help which made her upset and mad. She further revealed she could not recall the date this occurred but that a grievance had been submitted regarding this complaint. During the interview Nurse # 5 came into the room and initiated a transfer to the hospital per Resident #82's family member's request. NA #7 was not available for interview during the survey. NA #8 was not available for interview during the survey. An interview was conducted with the DON and the Administrator on 2/13/26 at 2:08 PM. The DON and Administrator indicated the investigation revealed NA #7 and NA #8 were assigned to Resident #82's hall the night of 2/5/26 from 7:00 PM-7:00 AM and found that the NA's were delayed in providing Resident #82 with care and admitted to telling Resident #82 not to call out for assistance but did so in a joking manner. The DON indicated NA #7 and NA #8 received disciplinary action and felt they did not treat Resident #82 with respect. The Administrator indicated that staff should treat all residents with dignity and respect.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observations and staff and resident interviews, the facility failed to place survey results in a location readily accessible to residents and visitors and failed to post notice of the availability of the survey results for 1 of 4 days of the survey (2/11/26).The findings included:An interview and observation with Receptionist #1 on 02/11/26 at 1:00 PM revealed he worked Monday through Friday from 6:30 AM to 3:30 PM. Receptionist #1 revealed he was not aware where the survey results were located. Receptionist #1 revealed he had worked as a receptionist for four years and did not recall anyone ever asking for the survey results. Receptionist #1 pointed out an unlabeled binder that was on the wall in the lobby area about 5 feet off the ground in a wire rack. Receptionist #1 stated he was not aware if that was the survey results and had not been educated on what the survey results binder was for. An observation of the binder at 1:00 PM revealed it to be the survey results binder, but there was no posting or indication of where it was located. An observation further revealed it would not be possible for residents in wheelchairs to reach the survey results binder without assistance. Observation of the facility on 02/11/26 at 3:00 PM revealed no posted notice of the location of survey results.A Resident Council group meeting was conducted on 02/12/26 at 10:30 AM. During the meeting, Resident #49, Resident #50, Resident#59, Resident#70, and Resident #78 indicated they did not know what survey results were or where the survey results were located.An interview with the Activity Director on 02/12/26 at 1:30 PM revealed she had not reviewed information about survey results and where they were located during Resident Council meetings. The Activity Director further revealed she was not aware that residents needed to be educated on what survey results were and where they were located. The Activity Director believed survey results were in the front lobby but was not sure of the exact location.A phone interview with Receptionist #2 on 02/12/26 at 1:45 PM revealed she had worked in the facility for about four years and worked Monday through Thursday 2:00 PM to 8:00 PM, and Fridays from 11:30 AM until 8:00 PM. Receptionist #2 stated she believed the survey results were in a drawer in the front lobby desk. Receptionist #2 stated she had not been educated about what the survey results were or where they were located. Receptionist #2 revealed residents nor visitors had asked to review the survey results when she had worked. An interview with the Administrator on 02/12/26 at 3:00 PM revealed she was aware the survey results were up front in the lobby located near the front door on the wall. The Administrator said she was not aware there was no posted notice of where the survey results were located. The Administrator revealed she was aware the survey results needed to be labeled for all residents and visitors. The Administrator agreed the survey results book needed to be lowered so that all residents and visitors had access to them. The Administrator stated she was not aware that Receptionist #1 and Receptionist #2 had not been educated where the survey results were located.

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to inform and provide written information to a resident regarding the residents' right to accept or refuse medical/surgical treatment and to formulate an advanced directive for 1 of 33 sampled residents reviewed for advanced directives (Residents #105). Findings included: Resident #105 was admitted to the facility on [DATE]. The nursing admission assessment dated [DATE] indicated Resident #105 was cognitively intact. There was no documentation in Resident #105's medical record indicating the resident was informed of his right to accept or decline medical or surgical treatment prior to making an advance directive decision and/or an advance directive formulated for code status. During an interview on 2/11/26 at 11:36 AM, Resident #105 indicated she had not received any paperwork or education on advanced directives and/or been informed of her right to accept or refuse medical/surgical treatment. Resident #105 stated she wanted to be resuscitated if her heart stopped. During an interview on 02/11/26 at 12:11 PM, the Social Worker (SW) acknowledged the facility did not inform and had not provided any documentation indicating Resident #105 had the right to accept or decline medical or surgical treatment or formulate an advance directive. The SW indicated the process in place was she would give residents information on advance directives if they requested it. An interview was conducted on 02/12/26 at 11:06 AM with Nurse #6 and she verified there was no order in Resident #105's physician orders in the electronic medical record or the code status book at the Nurses station indicating Resident #105's code status information. She indicated she was unsure why there was not an order and would check with the Director of Nursing (DON). An attempt to contact Nurse #7 for interview on 02/12/26 at 11:54 AM and was unsuccessful. On 02/13/26 at 9:25 AM an interview was conducted with the DON, and she indicated she expected the admitting nurse to get the code status during admission and get an order from the physician, and the SW would provide the education for advance directive choices with the resident and/or responsible party (RP). During an interview on 02/13/26 at 4:06 PM, the Administrator stated it was her expectation that staff explained to residents their choices concerning advance directives and an order would be in place for code status. The Administrator indicated she was not aware that written documentation needed to be provided to residents concerning advanced directives and was unsure who was responsible for providing the information.

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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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to provide a Centers for Medicare and Medicaid Services (CMS) Skilled Nursing Facility Advanced Beneficiary Notice (SNF-ABN) form 10555 (liability notice that informs Medicare Part A beneficiaries of potential Medicare non-coverage before providing custodial care or items that are usually paid for by Medicare) prior to discharge from Medicare Part A skilled services for 2 of 3 residents reviewed for beneficiary protection notification review (Resident #116 and Resident #117).The findings included:1. Resident #116 was admitted to the facility on [DATE]. He was admitted to Medicare Part A skilled services on 11/6/25.Resident #116's Medicare Part A skilled services ended on 11/28/25. He remained in the facility.Record review revealed there was no documentation Resident #116, or his responsible party were issued a CMS SNF-ABN form 10555 prior to discharge from Part A Medicare services. During an interview with the facility Social Worker on 2/12/26 at 3:26 PM she stated it was her job to issue the SNF-ABN. The Social Worker stated that on 11/26/25 she issued Resident #116 the Advance Beneficiary Notice of Non-Coverage form (form specifically used for Medicare Part B items and services) and therefore Resident #116 had not received the correct notification. An interview was conducted with the Administrator on 2/13/26 at 2:07 PM who indicated she was not aware that the Social Worker had been using the wrong form and Resident #116 should have received the CMS SNF-ABN form 10555 as required by Federal guidelines. 2. Resident #117 was admitted to the facility on [DATE]. He was admitted to Medicare Part A skilled services on 11/28/25.Resident #117's Medicare Part A skilled services ended on 12/17/25. He remained in the facility.Record review revealed there was no documentation Resident #117, or his responsible party were issued a CMS SNF-ABN form 10555 prior to discharge from Part A Medicare services. During an interview with the facility Social Worker on 2/12/26 at 3:27 PM she stated it was her job to issue the SNF-ABN. The Social Worker stated that on 12/15/25 she issued Resident #117 the Advance Beneficiary Notice of Non-Coverage form (form specifically used for Medicare Part B items and services) and therefore Resident #117 had not received the correct notification. An interview was conducted with the Administrator on 2/13/26 at 2:07 PM who indicated she was not aware that the Social Worker had been using the wrong form and Resident #117 should have received the CMS SNF-ABN form 10555 as required by Federal guidelines.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to develop a baseline care plan within 48 hours of admission for 9 of 30 residents reviewed for baseline care plan (Residents #30, #105, #106, #110, #6, #109, #82, #99, and #72).Findings included: 1. Resident #30 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis that included paraplegia and neuromuscular dysfunction of bladder. A review of the medical record revealed no documented evidence that a baseline care plan was completed for Resident #30. Attempts made to contact the Nurse who admitted Resident #30 were unsuccessful. An interview was conducted on 02/13/26 at 8:45 am with the Unit Manager (UM). She was not aware that a baseline care plan was not completed for Resident #30. The UM attempted to locate the baseline care plan without success and confirmed it had not been completed. She stated that the baseline care plan should have been completed no later than 48 hours after the resident was admitted to the facility. An interview was conducted on 02/13/26 at 9:24 am with the Director of Nursing (DON). The DON was not aware that a baseline care plan was not completed for Resident #30. The DON stated it was the responsibility of the admitting nurse to complete baseline care plans. She stated if the admitting nurse could not complete the baseline care plan, the oncoming nurse should complete it. She stated if the baseline care plan was not completed by the next day, it should be completed by the unit managers. An interview was conducted on 02/13/26 at 3:00 pm with the Administrator. The Administrator was not aware that a baseline care plan was not completed for Resident #30. She stated that the facility's staff turnover rate was high and they were addressing several issues. 2. Resident #6 was admitted to the facility on [DATE] with a diagnosis that included closed fracture, dementia and type 2 diabetes. A review of the medical record revealed no documented evidence that a baseline care plan was completed for Resident #6. Attempts made to contact the Nurse who admitted Resident #6 were unsuccessful. An interview was conducted on 02/13/26 at 8:45 am with the Unit Manager (UM). She was not aware that a baseline care plan was not completed for Resident #6. The UM attempted to locate the baseline care plan without success and confirmed it had not been completed. She stated that the baseline care plan should have been completed no later than 48 hours after the resident was admitted to the facility. An interview was conducted on 02/13/26 at 9:24 am with the Director of Nursing (DON). The DON was not aware that a baseline care plan was not completed for Resident #6. The DON stated it was the responsibility of the admitting nurse to complete baseline care plans. She stated if the admitting nurse (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	could not complete the baseline care plan, the oncoming nurse should complete it. She stated if the baseline care plan was not completed by the next day, it should be completed by the unit managers. An interview was conducted on 02/13/26 at 3:00 pm with the Administrator. The Administrator was not aware that a baseline care plan was not completed for Resident #6. She stated that the facility's staff turnover rate was high and they were addressing several issues. 3. Resident #72 was admitted to the facility on [DATE] with a diagnosis that included hypothyroidism, hypertension, dementia, and history of falls. A review of the medical record revealed no documented evidence that a baseline care plan was completed for Resident #72. Attempts made to contact the Nurse who admitted Resident #72 were unsuccessful. An interview was conducted on 02/13/26 at 8:45 am with the Unit Manager (UM). She was not aware that a baseline care plan was not completed for Resident #72. The UM attempted to locate the baseline care plan without success and confirmed it had not been completed. She stated that the baseline care plan should have been completed no later than 48 hours after the resident was admitted to the facility. An interview was conducted on 02/13/26 at 9:24 am with the Director of Nursing (DON). The DON was not aware that a baseline care plan was not completed for Resident #72. The DON stated it was the responsibility of the admitting nurse to complete baseline care plans. She stated if the admitting nurse could not complete the baseline care plan, the oncoming nurse should complete it. She stated if the baseline care plan was not completed by the next day, it should be completed by the unit managers. An interview was conducted on 02/13/26 at 3:00 pm with the Administrator. The Administrator was not aware that a baseline care plan was not completed for Resident #72. She stated that the facility's staff turnover rate was high and they were addressing several issues. 4. Resident #105 was admitted to the facility on [DATE] with diagnoses that included protein calorie malnutrition and chronic wounds. Review of Resident #105's medical records revealed no baseline care plan had been developed as of 02/11/26. During an interview on 02/11/26 at 11:55 AM with the Director of Nursing (DON), she indicated the baseline care plan should be completed by the admitting nurse and she was not sure why it had not been completed. Attempts to contact Nurse #8 who had admitted Resident #105 were unsuccessful. An interview was conducted on 02/13/26 at 4:08 PM with the Administrator, who indicated she expected the admitting nurse to complete the baseline care plan within 24 to 48 hours of admission to the facility and to follow the regulations. 5. Resident #106 was admitted to the facility on [DATE] with diagnosis that included in part, acute on chronic systolic (congestive) heart failure and acute respiratory failure. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #106's medical record revealed no documented evidence that a baseline care plan had been developed. Attempts were made to contact the Nurse who admitted Resident #106 and were unsuccessful. An interview was conducted on 2/11/26 at 12:43 PM with Unit Manager #2. She indicated the baseline care plan was completed by the admitting nurse at the time of admission and was part of the admission process. An interview was conducted with the Director of Nursing (DON) on 2/11/2026 at 1:42 PM. The DON stated that the admitting nurse was to complete the baseline care plan upon admission and it was the Unit Manager and DON's responsibility to review to make sure it was completed in 48 hours. She explained if the baseline care plan was not completed, they would assist with completing it. The DON stated did not know why the baseline care plan had not been completed for Resident #106. An interview with the Administrator was conducted on 2/13/26 at 10:28AM. The Administrator stated she expected baseline care plans to be completed within the required time frame to ensure the needs of the residents were being addressed and met. 6. Resident #110 was admitted [DATE] with diagnosis that included displaced fracture of the left femur and chronic obstructive pulmonary disease. A review of Resident #110's medical record revealed no documented evidence that a baseline care plan had been developed. Attempts were made to contact the Nurse who admitted Resident #106 and were unsuccessful. An interview was conducted on 2/11/26 at 12:43 PM with Unit Manager #2. She indicated the baseline care plan was completed by the admitting nurse at the time of admission and was part of the admission process. An interview was conducted with the Director of Nursing (DON) on 2/11/2026 at 1:42 PM. The DON stated that the admitting nurse was to complete the baseline care plan upon admission and it was the Unit Manager and DON's responsibility to review to make sure it was completed in 48 hours. She explained if the baseline care plan was not completed, they would assist with completing it. The DON stated did not know why the baseline care plan had not been completed for Resident #110. An interview conducted with the Administrator was conducted on 2/13/26 at 10:28AM. The Administrator stated she expected baseline care plans to be completed within the required time frame to ensure the needs of the residents were being addressed and met. 7. Resident #109 was admitted on [DATE] with a diagnosis of influenza virus, pneumonia and chronic obstructive pulmonary disease. A review of Resident #109's medical record revealed no documented evidence that a baseline care plan had been developed. An interview with Nurse #5 who admitted Resident #109 was conducted on 2/12/2026 at 10:06 AM. Nurse #5 explained the baseline care plan was not included in the list of assessments which needed to be (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	completed for new admissions. Nurse #5 stated she was aware that a baseline care plan must be completed within 48 hours, but the Unit Manager would complete these. An interview was conducted on 2/11/26 at 12:43 PM with Unit Manager #2. She indicated that the baseline care plan was completed by the admitting nurse at the time of admission and was part of the admission process. An interview was conducted with the Director of Nursing (DON) on 2/11/2026 at 1:42 PM. The DON stated that the admitting nurse was to complete the baseline care plan upon admission and it was the Unit Manager and DON's responsibility to review to make sure it was completed in 48 hours. She explained if the baseline care plan was not completed, they would assist with completing it. The DON stated did not know why the baseline care plan had not been completed for Resident #109. An interview conducted with the Administrator was conducted on 2/13/26 at 10:28AM. The Administrator stated she expected baseline care plans to be completed within the required time frame to ensure the needs of the residents were being addressed and met. 8. Resident #82 was admitted on [DATE] with diagnoses that included fracture of left hand, pneumonia, diabetes and chronic pain syndrome. Review of Resident #82's record revealed a baseline care plan had not been developed. An interview was conducted on 2/12/26 at 9:34 AM with Minimum Data Set (MDS) Coordinator #1. She stated upon admission, the baseline care plans were completed by the admission nurse. After reviewing Resident #82's record she indicated that the baseline care plan had not been completed and should have been completed by the admitting nurse. An interview with the Director of Nursing (DON) was conducted on 2/13/25 at 2:05 PM. After a review of Resident #82's record the DON stated the baseline care plan for Resident #82 had not been completed and should have been completed by the admitting nurse or by the unit manager and felt this was an oversight. 9. Resident #99 was admitted on [DATE] with diagnoses that included multiple fractures of the pelvis and chronic obstructive pulmonary disease. Review of Resident #99's record revealed a baseline care plan had not been developed. An interview was conducted on 2/12/26 at 9:34 AM with Minimum Data Set (MDS) Coordinator #1. She stated upon admission that the initial care plans were completed by the admitting nurse. After reviewing Resident #99's record she noted it had not been completed. He explained the baseline care plan should have been completed by the admitting nurse. An interview was conducted with Nurse #2 on 2/12/26 at 9:19 AM. Nurse #2 indicated she was the nurse assigned to Resident #99 at the time of her admission but did not complete the baseline care plan and thought the unit manager was responsible for the completion of the baseline care plan. An interview was conducted with Unit Manager #2 who assisted with Resident #99's admission paperwork. She indicated she did not complete the baseline care plan as she had not yet been trained and thought the admission nurse was responsible. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to develop a comprehensive care plan in the areas of activities of daily living and activities (Resident #13), and discharge goal (Resident #4) for 2 of 30 residents whose care plans were reviewed (Resident #13 and Resident #4). The findings included:1. Resident #13 was admitted to the facility on [DATE] with diagnoses that included neurocognitive disorder with Lewy bodies and muscle weakness.A significant change Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #13 was cognitively impaired, was dependent on staff for personal hygiene, bathing, and toileting and felt it was somewhat important to be included in group activities.A review of Resident #13's comprehensive care plan revised on 12/29/25 revealed that no care plan had been developed for activities of daily living (ADL) or activities.An interview was conducted with MDS Coordinator #1 on 2/12/26 at 9:34 AM. The MDS Coordinator #1 indicated per the MDS assessment, Resident #13 was dependent on staff for ADL and was not care planned as the care area did not trigger on the MDS.An interview was conducted with the Assistant Activities Director on 2/11/26 at 11:50 AM. She indicated that she completed the significant change MDS assessment dated [DATE] and coded Resident #13 as feeling it was somewhat important to do things with groups of people. The Assistant Activities Director further revealed she did not create an activities care plan as she had not been trained yet on how to complete a care plan and agreed a care plan should have been developed for Resident #13 in the area of activities. An interview was conducted with the Administrator on 2/11/26 3:11 PM. The Administrator stated that a care plan should have been developed for Resident #13 in the area of ADL by the MDS Coordinator and in the area of activities by the Assistant Activities Director and was unsure why these areas were omitted. 2. Resident #4 was admitted to the facility on [DATE] with diagnoses that included polyarthritis and metabolic encephalopathy. Resident #4 discharged home on 2/2/26.An admission MDS assessment dated [DATE] revealed Resident #4 was cognitively intact and participated in discharge planning with a goal to return to the community. The comprehensive care plan dated 12/29/25 revealed no interventions or goals related to discharge planning.An attempt was made to interview Resident #4 and his emergency contact, but attempt was not successful. An interview was conducted with the Social Worker on 2/12/26 at 11:30 AM. She indicated she was responsible for discharge planning and developing discharge planning care plans. The Social Worker indicated she was aware of Resident #4's goal to discharge back to the community but had not developed a discharge care plan and felt that this was an oversight.An interview was conducted with the Director of Nursing on 2/13/26 at 11:38 AM and she indicated the Social Worker should have created a discharge care plan for Resident #4 and felt this was an oversight.An interview was conducted with the Administrator on 2/13/26 at 11:40 AM and she indicated the Social Worker should have created a discharge care plan for Resident #4 and felt this was an oversight.

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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 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 interview of the staff, residents, and a family member, the facility failed to provide dependent residents nail care (Residents #8 and #10) and facial hair care (Resident #10). The deficient practice affected 2 of 10 residents reviewed for activities of daily living (Residents #8 and #10). Findings included:1. Resident #8 was admitted on [DATE] with a diagnosis of non-Alzheimer's dementia. The quarterly Minimum Data Set, dated [DATE] documented that Resident #8's cognition was moderately impaired. The resident was dependent for bathing, dressing and personal care, and was incontinent of bowel and bladder. The active diagnoses were dementia, anxiety, and muscle weakness. The care plan for Resident #8 dated 12/27/25 documented a self-care deficit due to weakness. The resident required assistance with personal care, including clean and trim nails. On 2/09/26 at 11:51 am, an observation and interview were conducted. Resident #8's 10 fingernails were approximately 1/2 inch long, jagged as if broken, with a small amount of brown debris underneath. The resident expressed that she would like nail care to both hands and held up her hands.On 2/9/26 at 11:53 am, the assigned nurse aide (NA) #7 observed Resident #8's nails and was interviewed. NA #7 stated the nails were long and was not sure why they had not been cut. The NA stated she would provide nail care. On 2/12/2026 at 11:40 am, Resident #8 was observed while her assigned NA #6 was present. The nails had not been trimmed and still had brown debris underneath. The resident again held up her hands. NA #6 stated she had not offered nail care that morning but would provide care now.On 2/12/26 at 12:20 pm, Resident #8 was observed with nails cut and cleaned.On 2/13/26 at 10:30 am, the Director of Nursing (DON) was interviewed. The DON stated the nursing staff was required to provide nail care during bathing and as needed.2. Resident #10 was admitted to the facility on [DATE] with a diagnosis of stroke. Resident #10's quarterly Minimum Data Set, dated [DATE] documented the resident had severely impaired cognition and was sometimes understood. The resident was dependent for activities of daily living (ADL). The active diagnoses were stroke, dementia and a right-hand contracture.Resident #10's physician progress note dated 12/30/25 documented Resident #10 was minimally interactive, calm and cooperative.Resident #10's care plan dated 1/4/26 documented an ADL self-care deficit. The resident required assistance with all bathing and dressing. The intervention for nail care was cleaning and trimming on bath day. Personal and oral care required assistance from staff. Facial hair care was not mentioned. The resident could refuse on occasion.Resident #10's physician progress note dated 1/13/26 documented Resident #10 was stable with no behaviors or refusals reported by nursing or observed by the physician. Resident #10's psychiatry note dated 1/28/26 documented the resident was stable with no changes. There were no refusals reported. On 2/09/26 at 11:41 am, Resident #10 was observed and an interview was attempted. The resident had mild body odor, facial hair on the upper lip, chin and lower cheeks that was approximately 1.5 inches long, and long nails. The resident had a contracture of the right hand, and his right thumb nail was noted to be an inch long and jagged. The resident indicated he wanted a shave but did not respond regarding nail care.On 2/9/26 at 11:59 am, NA #7 was interviewed. NA #7 stated she was assigned to Resident #10 and had not offered nail care during the bath that morning. NA #7 stated she would provide nail and facial hair care.On 2/10/26 at 10:40 am, Resident #10's family member was interviewed by phone. The family member stated he was visiting the resident during the call. He agreed that the resident's facial hair was long, the resident looked ragged and needed a shave. He also commented that this was the longest he had ever seen the resident's facial hair. The family member stated that his nails looked dirty and needed a trim, especially the right thumb nail which looked sharp. The family member stated he was not informed that the resident had (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	refused care and did not know why the hair and nail care had not been provided. On 02/12/2026 at 11:40 am, an observation was done of Resident #10 with the assigned NA #6. The resident's nails and facial hair remained unchanged from the 2/9/26 observation. The NA stated she had not offered nail or hair care this morning but would cut the resident's fingernails and shave him now. The resident was able to state, yes, and touch his facial hair when the NA asked him. On 2/13/26 at 10:30 am, the Director of Nursing was interviewed. The DON stated the nursing staff was required to provide nail care and facial hair care during bathing as needed or when requested. On 2/13/26 at 2:05 pm Resident #10 was observed to have received nail and facial hair care.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and interview of staff, the physician assistant, and the wound nurse practitioner, the facility failed to change the pressure ulcer dressing as ordered (Resident #30). The deficient practice affected 1 of 5 residents reviewed for pressure ulcers. The findings included:Resident #30 was admitted to the facility on [DATE] with diagnosis which included spina bifida with hydrocephalus, paraplegia, and stage 4 pressure ulcer to the sacrum.The care plan initiated on 08/14/25 revealed Resident #30 had a stage 4 pressure ulcer to the sacral area and a potential for pressure ulcer development related to crushing injury, impaired mobility, spina bifida. The goal was Resident #30's pressure ulcer would show signs of healing and remain free from infection. Interventions included administer medication as ordered, administer treatments as ordered, monitor for effectiveness, educate the resident/family/caregiver as to the causes of skin breakdown, and follow facility policies/protocols for the prevention/treatment of skin breakdown.Review of the initial wound progress note dated 08/19/25 revealed Resident #30 had a stage 4 pressure ulcer to the sacrum, with measurements of 5.5 cm x 5 cm x 3 cm, and undermining (extends under the skin) of 3 cm from 3 o'clock to 10 o'clock. The wound bed was noted to have 40% slough tissue and 60% granulation (new tissue that forms on the wound during healing process) tissue and moderate serosanguinous exudate (light red fluid that leaks out of blood vessels). Review of a wound progress noted dated 08/20/25 revealed Resident #30 had a stage 4 pressure ulcer to the sacrum, with measurements of 5.5 cm x 5 cm x 3 cm and undermining of 3 cm from 3 o'clock to 10 o'clock. The wound bed was noted to have 40% slough tissue and 60% granulation tissue and moderate serosanguinous exudate.The quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #30 was cognitively intact. Further review of the MDS indicated Resident #30 was dependent on staff for toileting and personal hygiene, toilet transfer, and required substantial/maximal assistance with rolling left and right. The MDS also indicated Resident #30 had a stage 4 pressure ulcer at the time of the review. There was no indication of rejection of care.A physician order dated 12/08/25 Dakins (1/2 strength) external solution 0.25% (Sodium Hypochlorite) apply to sacrum topically every evening shift. Clean with normal saline and pat dry. Apply moistened gauze cover with abdominal pad and secure with tape twice daily and as needed.Review of the Treatment Administration Record (TAR) for December 2025 revealed the treatment was not documented as administered on 12/20/25, 12/21/25, 12/22/25, and 12/29/25. An interview was conducted on 02/13/26 at 3:30 pm with Nurse # 4, the nurse responsible for Resident #30's pressure wound treatment on 12/20/25 and 12/21/25. Nurse #4 was unable to provide an explanation for why Resident #30's treatments were not completed on those days.A physician order dated 12/31/25 Dakins (1/4 strength) external solution 0.125% (Sodium Hypochlorite) apply to sacrum topically every day shift. Clean with normal saline and pat dry. Apply collagen powder followed by Dakin's moistened rolled gauze packing and cover with silicone super absorbent dressing daily and as needed and apply to sacrum topically as needed for soiling or removal. Review of the wound care progress note dated 01/07/26 revealed Resident #30 had a stage 4 pressure ulcer to the sacrum, with measurements of 3.0 cm x 2.5 cm x 0.3 cm and undermining of 2.2 cm from 5 o'clock to 9 o'clock. The wound bed was noted to have 100% granulation tissue and moderate serosanguinous exudate.Review of the TAR for January 2026 revealed the treatment was not documented as administered on 01/17/26, 01/21/26, 01/25/26, and 01/28/26.An interview was conducted on 02/12/26 at 10:10 am with Nurse #1, the nurse responsible for Resident #30's pressure wound treatment on 01/17/26. Nurse #1 stated the licensed nurse was expected to administer treatments on the weekends if there was no wound care nurse. When Nurse #1 was asked about Resident #30's pressure wound treatment not being administered some days during (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	weekends. She stated she could not always administer treatments on the weekend and if not, she would not sign off the TAR indicating that it was complete.Review of the wound care progress note dated 01/21/26 revealed Resident #30's stage 4 pressure ulcer to the sacrum had deteriorated that week, with undermining of 6 cm from 6 o'clock to 12 o'clock. The wound bed had a 100% granulation tissue and moderate serosanguinous exudate. An interview was conducted on 02/12/26 at 10:45 am with the Wound Care Nurse. The Wound Care Nurse stated that Resident #30 indicated her pressure ulcer treatment was not getting done some days on the weekends. She reported Resident #30's concern to the previous DON. She stated she did provide wound care for Resident #30 on 01/21/26 and 01/28/26 and she was not sure why it was not signed off on the TAR. The Wound Care Nurse was able to review her progress notes and confirm Resident #30's treatment was administered on those days. An interview was attempted multiple times with Nurse #7, the nurse responsible for completing Resident #30's pressure wound treatment on 01/25/26. Review of the wound care progress noted dated 02/4/26 revealed Resident #30's stage 4 pressure ulcer to the sacrum had deteriorated that week, with measurements of 2.3 cm x 2.4 cm x 0.5 cm and undermining of 6.7 cm from 6 o'clock to 12 o'clock. The wound bed had a 100% granulation tissue and moderated serosanguinous exudate.Review of the TAR for February 2026 revealed the treatment was not documented as administered on 02/08/26. An interview was conducted on 02/13/26 at 3:30 pm with Nurse # 4, the nurse responsible for Resident #30's pressure wound treatment on 02/08/26. Nurse #4 was unable to provide an explanation for why Resident #30's treatments were not completed on that day.An interview was conducted on 02/09/26 at 12 noon with Resident #30. Resident #30 stated she was concerned her pressure ulcer treatment was not being administered on the weekends sometimes. She stated on 02/07/26 that her pressure ulcer treatment was administered, but it was not administered on 02/08/26. Resident #30 stated she would ask the nurse aides about her treatment, and they would let the nurse know that the treatment needed to be done. She stated the nurse aides would return and let her know that the nurses were aware, and they could see what treatments were due on their computer. An interview was conducted on 02/13/26 at 3:30 pm with Nurse # 4, the nurse responsible for Resident #30's pressure wound treatment on 02/08/26. Nurse #4 was unable to provide an explanation for why Resident #30's treatment was not completed on that day.An interview was conducted on 02/12/26 at 9:15 am with Nurse Aide (NA) #10. Nurse Aide #10 stated if a resident inquired about wound treatment, she would let the nurse know. She stated she would then go back and let the resident know that the nurse was made aware.An observation of wound care on 02/12/26 at 10:45 am with Resident #30 revealed a pressure wound to the sacrum, with granulation tissue, and no foul odor.An interview was conducted on 02/12/26 at 1:30 pm with the Physician Assistant (PA). The PA stated pressure wounds are handled by the Wound Nurse Practitioner (NP) and the Wound Care Nurse. He stated if there was an issue he needed to address the Wound NP or Wound Care Nurse would inform him. He stated he was not aware of wound treatments not being administered for Resident #30. He stated if an order was placed it was put in place for a reason. He would have to assume if an order was put in place, it was necessary. He indicated if wound treatments were not being administered, it could have a negative effect on the wound.An interview was conducted on 02/12/26 at 3:40 pm with the wound NP. The NP stated failure to provide dressing changes as ordered could cause the wound to not progress or get worse.An interview was conducted on 02/13/26 10:10 am with the Director of Nursing (DON). The DON was not aware of Resident #30's pressure wound treatment not being administered on the weekends. She stated if the wound care nurse was not a work it was the licensed staff responsibility to administer pressure wound treatments. She stated her expectation would be for treatments to be administered according to physician's order.An interview was conducted with the Administrator on 02/13/26 at 3:00 pm. The Administrator (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was not aware that pressure wound treatments were not being administered some days on the weekends. She stated her expectation would be for staff to administer treatments according to physician's order. She stated it was unacceptable for staff not to administer treatments.

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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** Based on record review, physician assistant, and staff interviews the facility failed to obtain ordered urine analysis and culture sensitivity specimen for 1 of 2 residents. (Resident #30) The facility failed to empty the urinary catheter bag as ordered to maintain free urine flow through an indwelling catheter and failed to keep stool away from urinary catheter and the meatus to prevent urinary tract infections for 1 of 2 resident reviewed for urinary catheter care. (Resident #30)1a. Resident #30 was admitted to the facility on [DATE] with diagnosis which included spina bifida with hydrocephalus, paraplegia, neuromuscular dysfunction of bladder, and urinary tract infection.The care plan initiated on 08/14/25 revealed Resident #30 had a urinary catheter related to neurogenic bladder. The goal was Resident #30 would show no signs or symptoms of urinary tract infection. The interventions included monitor and document intake and output per facility policy, monitor for signs and symptoms of discomfort with urination and frequency, monitor/document for pain/discomfort due to catheter, and monitor/record/report to medical doctor signs and symptoms for urinary tract infection.A physician order dated 09/15/25 to monitor urinary catheter output every day and night shift for monitoring.The quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #30 was cognitively intact. Further review of the MDS revealed Resident #30 had an indwelling catheter in place and was dependent on staff for toileting and personal hygiene.Review of December 2025 Treatment Administration Record (TAR) revealed on day shift the catheter output was not documented on 12/10/25, 12/11/25, 12/15/25, 12/17/25, 12/19/25,12/22/25, 12/23/25, 12/29/25, 12/30/25, and 12/31/25. The nights shift was not documented for 12/8/25, 12/09/25, 12/14/25, 12/17/25, and 12/19/25.Review of January 2026 TAR revealed the catheter output was not documented on 01/19/26 on day shift and 01/30/26 on night shift.Review of February 2026 TAR revealed the catheter output was not documented on 02/01/26, 02/04/26, 02/05/26, 02/09/26, and 02/10/26 on day shift.An interview was conducted on 02/09/26 at 12 noon with Resident #30. Resident #30 stated she was concerned her urinary catheter bag was not emptied at all on some days. She stated she would have to ask staff to empty her urinary catheter bag.An interview was conducted on 02/12/26 at 9:15 am with Nurse Aide (NA) #10. NA #10 stated she would empty urinary catheter bags if a nurse requested, she would do so. She stated she would let the nurse know the amount of urine noted.An interview was conducted on 02/12/26 at 12:40 pm with NA #11. NA #11 stated she empties the catheter bag sometimes and she would let the nurse know the amount of urine noted.An interview was conducted on 02/12/26 at 9:30 am with Nurse #5. Nurse #5 stated she had seen residents with full catheter bags at the beginning of first shift. She stated if the urinary catheter bag is not emptied urine would flow back up to the resident and could cause a urinary tract infection.An interview was conducted on 12/12/26 at 1:30 pm with the Physician Assistant (PA). The PA stated he has seen full urine catheter bags with urine back flowing up to the resident. He stated he would ask staff to empty the urine catheter bag. He stated if the urine flowed back up to the resident it could enter kidneys and cause problems such as bladder distention and urinary tract infections.An interview was conducted on 02/13/26 at 9:10 am with Unit Manager #1. Unit Manager #1 stated the nurse aides are responsible for emptying the urinary catheter bags. She was not aware staff were not emptying the urinary catheter bags as ordered. She stated if the catheter bags are not emptied, urine could rise back up in the tubing.An interview was conducted on 2/13/26 at 9:16 am with Director of Nursing (DON). The DON stated that any nurse aide or nurse could empty the catheter bag. She stated they have received training on how to provide care. She was not sure why the catheter bags were not getting empty. Her expectation would be for the staff to empty the (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	urinary catheter bags as ordered.An interview was conducted on 02/13/26 at 3:00 pm with the Administrator. The Administrator stated nurses should check the urinary catheter bags every time they round. She stated the residents are everybody's responsibility on the hall. She expects staff to do whatever they can do as long as it is within their scope of practice.1.b. A physician order dated 09/15/25 to cleanse with soap and water every day and night shift for monitoring.During an observation on 02/12/26 at 11:00 am dry brown stool was noted to Resident 30's lower buttocks and urinary catheter starting from the resident's meatus up to the middle of the urinary catheter. NA #9 was observed applying an adult brief to Resident #30 without cleaning the dry brown stool off the urinary catheter. An interview was conducted on 02/12/26 at 11:25 am with NA #9. NA #9 stated that while preparing the resident for wound care, Resident #30 already had dry brown stool on her lower buttocks and urinary catheter. She stated the dry brown stool should have been removed before applying the adult brief. NA #9 stated Resident #30 was not on her assignment, but she would go back and provide catheter care.An interview was conducted on 02/12/26 at 11:35 am with Assistant Director of Nursing (ADON). The ADON was made aware of the observation with NA #9 and Resident #30. The ADON stated she would expect NA #9 to provide catheter care for the resident, regardless if Resident #30 was a part of her assignment. The ADON stated she would go and make sure catheter care was provided for the resident. During a follow-up interview on 02/12/26 at 12:20 pm, the ADON stated Resident #30 had received catheter care. She stated NA #9 could not give her an answer to why the care was not provided.An interview was conducted on 12/12/26 at 1:30 pm with the PA. The PA stated if stool is on a urinary catheter and not cleaned properly it could cause a urinary tract infection.An interview was conducted on 02/13/26 at 10:10 am with DON. The DON could not give an explanation to why catheter care was not provided by NA #9. She stated she would expect catheter care to be completed if needed regardless of the staff assignment.An interview was conducted on 02/13/26 at 3:00 pm with the Administrator. The Administrator stated nurses should check the urinary catheter bags every time they round. She stated the residents are everybody's responsibility on the hall. She expects staff to do whatever they can do as long as it is within their scope of practice.1.c. A physician order dated 12/29/25 obtain urine analysis and culture sensitivity specimen one time a day for 3 days. Review of December TAR revealed the urine analysis and culture sensitivity specimen was not documented as done on 12/29/25, 12/30/25 and 12/31/25.Review of urine analysis and culture sensitivity labs obtained on 01/10/26 revealed Resident #30 was positive for Escherichia Coli (bacteria that live in the human intestine)An interview was conducted on 02/12/26 at 9:30 am with Nurse #5. Nurse #5 stated the lab picks up specimens early in the morning. She stated if the physician orders a urine analysis, the urine specimen would not be picked up until the next day. She stated she would attempt to get the specimen three times on her shift. If she could not obtain the specimen, she would report it to the oncoming nurse. She stated if the urine specimen was not obtained by the next morning, she would let the unit manager know.An interview was conducted on 12/12/26 at 1:30 pm with the Physician Assistant (PA). The PA stated that it had been an issue with specimens not being obtained. He stated he has treated urinary tract infections empirically, but it would be ideal to know what he was addressing. He stated he had to re-order the urine analysis a few times before receiving results. He stated it has been a few times he has had to switch the antibiotics to treat urinary tract infections. He stated Resident #30 had to be treated aggressively because of her urinary catheter. He stated Resident was referred to Urology for a suprapubic catheter if the urinary catheter was going to be long term. He stated the urinary catheter would be positioned where the resident would least likely get an infection.An interview was conducted on 02/13/26 at 10:10 am with the Director of Nursing (DON). The DON stated she would expect the (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	specimen to be collected by licensed staff when ordered. She stated if staff could not obtain a specimen, she would expect staff to alert the provider to obtain a new order.An interview was conducted on 02/13/26 at 3:00 pm with the Administrator. The Administrator stated if there was an order in place she would expect the order to be filled as soon as possible. If a specimen was unable to be obtained the PA should be called and asked what they want them to do at that point. The expectation would be to obtain the specimen within 24 hours.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations and staff interviews, the facility failed to remove loose and unsecured pills of various shapes, sizes and colors on 2 of 4 medication carts observed (Hall 300 Medication Cart #1 and Medication Cart #2).The findings included:a. An observation was conducted on 02/11/26 at 10:35 am of Medication Cart #2 on Hall 300 in the presence of Nurse #4. The observation revealed the following medications were stored in the medication cart:-One small round pink unmarked tablet found in the first drawer of the medication cart.-One small round yellow unmarked tablet found in the first drawer of the medication cart.-One medium round brown unmarked tablet found in the second drawer of the medication cart. -One small oblong white unmarked tablet found in the second drawer of the medication cart.-One small round pink tablet with marking E found in the second drawer of the medication cart-One small round bright yellow unmarked tablet found in the third drawer of the medication cart.-One half of a round white unmarked tablet found in the third drawer of the medication cart.-One small round orange unmarked tablet found in the third drawer of the medication cart.An interview was conducted on 02/11/26 with Nurse #4 at 10:35 am. When asked, Nurse #4 confirmed that loose tablets of medication were observed in Medication Cart #2. Nurse#4 was unable to explain why medications were stored without the minimum information including the name of the resident or prescribing information. b. An observation was conducted on 02/11/26 at 11:20 am of Medication Cart #1 on Hall 300 in the presence of Medication Aide (MA) #2. The observation revealed the following medications were stored in the medication cart:-One small oblong pink unmarked tablet found in the first drawer of the medication cart.-One small round orange unmarked tablet found in the first drawer of the medication cart.-One small round purple unmarked tablet found in the first drawer of the medication cart.-One small round white unmarked tablet found in the second drawer of the medication cart.-One medium round white unmarked tablet found in the second drawer of the medication cart.-One small oblong white unmarked tablet found in the second of the medication cart.-One small round white unmarked capsule found in third drawer of the medication cart.-One medium oblong green tablet found in the third drawer of the medication cart.-One extra small white tablet found in the third drawer of the medication cart.An interview was conducted on 02/11/26 at 11:20 am with MA #2. When asked, MA #2 confirmed that the loose tablets of medication were observed in Medication Cart #1. MA #2 was unable to explain why medications were stored without the minimum information required, including the name of the resident or prescribing information.An interview was conducted on 02/11/26 at 11:30 am with the Unit Manager. The Unit Manager stated she would expect staff to conduct an audit of the medication cart during shift change. She stated if staff found any loose medication, she would expect to be made aware. The Unit Manager was unable to give an explanation to why loose medication was observed in Medication Cart #1 and Medication Cart #2.An interview was conducted with the Director of Nursing (DON) on 02/11/26 at 12:30 pm to discuss the concerns that were identified during the medication storage observation. The DON stated that the medication carts were audited by the Unit Managers and Pharmacist. The DON could not give an explanation to why loose tablets of medication were observed on Medication Cart #1 and Medication Cart #2. She stated all the loose pills should be disposed of.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and staff and Physician Assistant interviews, the facility failed to obtain an ordered clostridium difficile test result for a Resident experiencing abdominal tenderness and loose stools (clostridium difficile is a bacterium which can cause diarrhea, abdominal pain and bowel inflammation). The deficient practice occurred on three separate occasions for 1 of 3 residents reviewed for laboratory services (Resident #98).Findings included:Resident #98 was admitted on [DATE] from the hospital setting after diagnoses of declining functional status and pulmonary embolism, with past medical history of vaginal and rectal bleeding secondary to anticoagulant use, past clostridium difficile infection, right hip osteoarthritis, depression, anxiety, obstructive sleep apnea and generalized weakness. A provider note dated 12/29/25 at 8:15 AM indicated Resident #98's physical exam revealed abdominal tenderness with palpation and an order was placed for stool testing to rule out possible clostridium difficile given Resident #98's past history of infection. Review of provider orders revealed a 12/29/25 order to send a stool sample for clostridium difficile testing.A Bowel and Bladder record for December 2025 revealed Resident #98 had a loose stool on 12/31/25. Review of December 2025 staffing revealed Medication Aide (MA) #1 cared for Resident #98 on 12/31/25, which was a day on which a loose stool was documented for Resident #98. Attempts to interview MA #1 were unsuccessful.On 1/2/26, a provider progress note indicated Resident #98 was awake and alert, sitting up in her wheelchair and was in no acute distress. She recently had multiple loose stools per day (dates were not specified) but she stated this had been better. Resident #98 did not complain of abdominal pain. The provider noted Resident #98 had maintained compliance with her medications and reported her abdominal pain had resolved and notation was made of awaiting stool testing for clostridium difficile. January 2026 Bowel and Bladder records revealed Resident #98 had loose stools on 1/4/26 and on 1/6/26. Review of January 2026 staffing schedules revealed Nurse #4 cared for Resident #98 on 1/4/26 and 1/6/26, days on which loose stools were documented for Resident #98.An interview was conducted with Nurse #4 on 2/12/2 at 1:45 PM. Nurse #4 said she could not remember Resident #98 and was unable to recall why a stool sample was not collected on 1/4/26 or 1/6/26 and could not answer any further questions.Review of laboratory results from 12/31/25 through 1/7/26 revealed there was no stool resulted for clostridium difficile testing.Review of provider orders revealed a second order was placed on 1/7/26 for stool to be sent for clostridium difficile testing. Review of laboratory results from 1/7/26 through 1/14/26 revealed there was no stool resulted for clostridium difficile testing. In a progress note dated 1/8/26 the provider noted occasional loose stools with history of diarrhea in the past which was controlled with loperamide. The provider also noted his orders to collect stool to test for clostridium difficile, but the stool had not yet been collected and he had spoken to nursing staff and verbally requested it to be collected. A third order for stool for clostridium difficile testing was placed on 1/11/26. A provider progress note dated 1/15/26 indicated Resident #98 appeared uncomfortable. Resident #98 stated her stomach was hurting prior to bowel movements and was sometimes relieved after bowel movements. The provider noted Resident #98 had continued to have loose stools but had no other new complaints (the dates of those loose stools were not specified). Resident #98 denied bloody stools. On physical exam, her abdomen had dull, nonspecific and poorly localized tenderness. Her bowel sounds were active. Reviewed vital signs were stable with no recent bleeding. The provider further noted Resident #98 was previously seen for diarrhea follow-up on 1/8/2026 with a stool test for clostridium difficile ordered. Review of laboratory test results revealed the stool specimen was collected on 1/15/26 and results on 1/16/26 indicated Resident #98 tested positive for clostridium difficile. A provider note (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dated 1/16/26 revealed notification was made to the provider of the positive clostridium difficile result on 1/16/26 and antibiotic therapy was initiated. The provider noted Resident #98 was deemed clinically stable to remain in-house for ongoing monitoring and treatment for clostridium difficile. On 2/12/26 at 2:40 PM, an interview with Nurse #1 was conducted. Nurse #1 said she did not remember Resident #98 specifically, but said in general, anytime the provider placed an order for clostridium difficile testing of stool, nursing staff should collect the stool sample as soon as they could obtain it. Nurse #1 said she would not skip collection if the stool was solid or formed but would collect it for testing anyway if she received an order to do so. Nurse #1 said if a resident did not have a bowel movement during a given shift, the nurses would inform the oncoming shift that a stool sample still needed to be collected. On 2/12/26 at 1:30 PM, an interview with the Physician Assistant was conducted. The Physician Assistant said he placed an order for stool for clostridium difficile testing on three separate occasions and stool was not collected until the last order. The Physician Assistant said his expectation was a turnaround time of about three days from an order being placed to an order being collected and/or resulted. The Physician Assistant said he would have wanted to begin Resident #98's clostridium difficile treatment earlier. On 2/12/26 at 2:00 PM, an interview with the Director of Nursing (DON) and the Regional Nurse Consultant was conducted. The DON and Regional Nurse Consultant both stated the expectation was for the nursing staff to collect an ordered stool sample for ordered testing as soon as they could. The DON indicated staff usually reported needed labs and orders at shift change and orders that were placed in the electronic medical record were visible to the nursing staff. An interview with the Administrator was conducted on 2/12/26 at 2:10 PM. The Administrator said her expectation would be that if a provider ordered a stool sample to be collected and sent for clostridium difficile testing, the stool sample would be collected and sent for testing as soon as possible.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, record review and staff interviews, the facility failed to ensure the low temperature dishwasher maintained the wash temperature of 120 degrees Fahrenheit (F). These practices had the potential to affect food served to all residents. Findings included: During the initial tour of the kitchen on 2/9/26 at 9:58 a.m., three observations of the operation of the dishwashing machine by Dietary Staff #1 were conducted. The water temperatures ranged from 90 degrees Fahrenheit to 100 degrees Fahrenheit. Dietary Staff #1 continued to send dishware through the dish machine. The Dietary Manager (DM) was not in the dishwashing area of the kitchen during this observation. During an interview on 2/9/26 at 10:05 a.m., Dietary Staff #1 revealed he was unsure if the dishwasher was a high temperature or low temperature machine, then pointed to the manufacturer's instructions for use of the dishwasher located on the top, front of the machine which revealed the water temperature requirement for the low temperature dish machine was 120 degrees Fahrenheit and 50 ppm (parts per million) chlorine (sanitizer) during rinse cycle. He further revealed the water temperature of the dishwashing machine has had fluctuating water temperatures for approximately one week. He stated he reported the issue to the Dietary Manager (DM) when the water temperature would decrease but did not indicate why he continued washing the dishware in the machine. During an interview on 2/9/26 at 10:20 a.m. the DM stated the dishwashing machine was a high temperature machine. The DM acknowledged she was aware of the fluctuating water temperatures of the dishwasher and had submitted an electronic work order request to the facility's maintenance department concerning the problem. The DM did not supply a copy of this work order for review when requested. During a telephone interview on 2/9/26 at 10:25 a.m., the Regional Food Service Consultant confirmed the facility's dishwasher was a low temperature machine, not a high temperature machine as indicated by the DM. She indicated she was not aware the dishwashing machine was not operating correctly and disposable plates, cups, and plastic utensils would be used until the dishwasher was repaired. On 2/13/26 at 10:20 a.m., an interview was conducted with the Maintenance Director. He stated he first learned of the dishwashing machine not maintaining the proper temperature on 2/9/26, after the initial tour of the kitchen. The Maintenance Director revealed he did not receive a verbal or electronic work order request from the dietary department concerning the dishwashing machine. He stated that on inspection of the dishwashing machine, hot water was not getting to the dishwashing machine. As a result, on 2/12/26 both hot water tanks were replaced.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observations and staff interviews, the facility failed to ensure the side doors to trash dumpsters remained closed, failed to contain waste in dumpsters with lids or coverings and failed to maintain a clean garbage area free from litter for 2 of 2 trash dumpsters and 1 of 1 construction container. These practices had the potential to attract pests and rodents.Upon arrival into the parking area of the facility an observation of the dumpster area on 2/9/26 at 9:15 a.m., revealed a long/large open to air construction-type container overflowing with bags of trash with some of the bags on the ground next to one side of building of the facility. There was no covering/tarp over the container or trash bags. On 2/11/26 at 12:07 p.m., accompanied by the Regional Food Service Consultant, an observation of the facility's dumpster area was completed. The large/long open-to-air construction-type container remained in the same condition with an overflow of bags of trash. There were two trash dumpsters surrounded by an unlocked, gated fence located in the back of the parking lot. The doors to both dumpsters were open with trash visible inside. The surrounding area was littered with cardboard pieces, used plastic gloves, plastic cup lids, paper, an office chair lying on its' side, and an upside-down large planter on the ground. There was also a pungent odor within the gated dumpster area. The Regional Food Service Consultant revealed she also made this observation when she arrived at the facility earlier that morning and requested the area be cleaned; but the area still looked the same. On 2/12/26 at 8:45 a.m., during an observation, the construction-type container remained in the same condition with an overflow of multiple bags of trash. During an interview on 2/13/26 at 1:03 p.m., the Dietary Manager revealed the facility shared the dumpsters with the neighboring facility located next to this facility. She stated she was not sure who was responsible for keeping the doors of the two dumpsters closed and the enclosed, surrounding area clean. She did not comment on the construction-type container utilized as a trash dumpster. During an interview on 2/13/26 at 1:10 p.m., the Administrator indicated the concerns with the trash disposal containers and areas would be taken care of immediately.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, record reviews, and staff interviews, the facility failed to implement infection control policies and procedures for enhanced barrier precautions when Nurse Aide (NA) #1 failed to don a gown when starting to provide incontinence care to Resident #105 who had a sacral wound and required surveyor intervention for 1 of 7 staff members observed for infection control practices (NA #1). Findings included:The facility's enhanced barrier precautions last revised in 12/2025, documented it is the policy of this facility to implement enhanced barrier precautions for the prevention of transmissions of multidrug-resistant organisms.An observation of Resident #105's room door and the hallway immediately outside the room on 02/11/26 at 9:25 AM and at 11:24 AM revealed Resident #105's door did not have enhanced barrier precaution signage posted, and there was no personal protective equipment (PPE) available outside of Resident #105's room.On 02/11/26 at 11:34 AM, an observation was made of Nurse Aide (NA) #1 performing incontinence care on Resident #105. NA #1 had donned gloves and retrieved a washcloth to provide the care. While turning Resident #105 over, the surveyor stopped her upon noticing a wound on the resident's sacral area. NA #1 removed her gloves, washed her hands, and left the room. She then reentered wearing PPE (a surgical mask and gown) and donned gloves before turning the resident over. A foam dressing was observed on the sacral area. NA #1 then completed the incontinence care.An interview was conducted with NA #1 on 02/11/26 at 11:40 AM, and she indicated that she would have donned PPE prior to providing care to Resident #105 if the enhanced barrier precaution signage had been posted in the resident's room. NA #1 indicated she was trained that if there was a sign on the door she was to put on the PPE.An interview was conducted with the Assistant Director of Nursing (ADON) on 02/11/26 at 11:57 AM, and she verified Resident #105 had a wound and should have had an enhanced barrier precautions sign on the door and NA #1 should have donned PPE prior to providing care.An interview was conducted with the Administrator on 02/13/26 at 3:58 PM, and she indicated that her expectation was for residents who required enhanced barrier precautions to have signage and PPE accessible prior to providing care.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. Based on facility policy review, record review and staff interviews, the facility failed to implement an antibiotic stewardship program to monitor antibiotic usage in the facility. This practice had the potential to affect 87 of 87 residents in the facility.The findings included:Review of the facility's policy titled, Antibiotic Stewardship Program, effective date 12/2025 revealed the following: The Antibiotic Stewardship Program purpose is to optimize the overall infection prevention program by the treatment of infections while reducing the adverse events associated with antibiotic use. The Infection Preventionist utilizes expertise and data to form strategies to improve antibiotic use to include tracking of antibiotic starts, monitoring adherence to evidence based published criteria during the evaluation and management of treated infections and reviewing antibiotic resistance patterns in the facility to understand which infections are caused by resistant organisms. A review was conducted of the pharmacy services antibiotic user tracking sheets for the months of November 2025, December 2025 and January 2026. The sheet reported for the month of November there were 25 residents on antibiotics, in December there were 37 residents on antibiotics and in January there were 40 residents on antibiotics.During an interview with the Director of Nursing (DON) on 02/13/26 at 12:00 PM, she stated she was responsible for the Infection Prevention and Control program. The DON further stated she had been in the DON position since the end of December 2025, and she was in the process of getting the Antibiotic Stewardship Program in place, but she was unable to locate any information from prior months. When asked had the facility been monitoring and tracking infections within the facility, she stated she was unable to locate any information for the prior months.A telephone interview was conducted on 02/13/26 at 1:17 PM with the previous DON (DON from 9/2025 to 12/2025) and she indicated she did not have an antibiotic stewardship program in place when working in the facility. The previous DON mentioned that nobody provided her with any guidance or instructions.An interview was conducted with the Administrator on 02/13/26 at 4:01 PM and she indicated she expected the antibiotic stewardship program to be in place per the protocol. The Administrator stated they discussed infections during the quality assurance performance Improvement (QAPI) meetings.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to maintain vaccination consents or declination decisions in the residents' medical record and failed to maintain a record of education of the benefits and potential side effects for the influenza and pneumococcal immunizations for 5 of 5 residents reviewed for immunizations (Resident #21, Resident #20, Resident #9, Resident #72 and Resident #33). The findings included:Findings included:a. Resident #21 was admitted to the facility on [DATE].Review of Resident #21's Minimum Data Set (MDS) assessment dated [DATE] revealed she was cognitively intact. Further review of the MDS revealed Resident #21was not offered the influenza vaccine and was offered but declined the pneumococcal vaccine.An interview was conducted with Resident #21 on 02/12/26 at 8:57 am and she indicated she could not recall if she was offered the influenza or pneumococcal vaccines. Review of the medical record revealed Resident #21 declined to have the pneumococcal vaccine. Resident #21's medical record did not include the date of declination. Further review of the medical record revealed no documentation of the influenza vaccination for the current influenza season.The facility was unable to provide documentation that the influenza or pneumococcal vaccines were offered, that Resident #21 or the Responsible Party had the opportunity to accept or decline the vaccines, or that education on the benefits and potential side effects were provided to Resident #21 or their Responsible Party regarding the influenza and pneumococcal vaccines.b. Resident #20 was admitted to the facility on [DATE].Review of Resident #20's MDS assessment dated [DATE] revealed Resident #20 was severely cognitively impaired. Further review of the MDS indicated Resident #20 was not offered the influenza or pneumococcal vaccines.Review of the medical record revealed Resident #20 declined to have the influenza vaccine and pneumococcal vaccine. Resident # 20's medical record did not include the date of declination for either vaccine.The facility was unable to provide documentation that the influenza or pneumococcal vaccines were offered, that Resident #20 or the Responsible Party had the opportunity to accept or decline the vaccines, or that education on the benefits and potential side effects were provided to Resident #20 or their Responsible Party regarding the influenza and pneumococcal vaccines.c. Resident #9 was admitted to the facility on [DATE].Review of Resident #9's MDS assessment dated [DATE] revealed Resident #9 was severely cognitively impaired. Further review of the MDS indicated Resident #9 was not offered the influenza or pneumococcal vaccines.Review of the medical record revealed Resident #9 did not have any documentation for the pneumococcal or the influenza vaccine. The facility was unable to provide documentation that the influenza or pneumococcal vaccines were offered, that Resident #9 or the Responsible Party had the opportunity to accept or decline the vaccines, or that education on the benefits and potential side effects were provided to Resident #9 or their Responsible Party regarding the influenza and pneumococcal vaccines.d. Resident #72 was admitted to the facility on [DATE].Review of Resident #72's MDS assessment dated [DATE] revealed Resident #72 was severely cognitively impaired. Further review of the MDS indicated Resident #72 was not offered the influenza vaccine and the pneumococcal vaccine was up to date.Review of the medical record revealed Resident #72 was administered the pneumococcal vaccine (pneumovax 23) outside of the facility on 01/02/21 and the influenza vaccine was administered outside of the facility on 10/21/24 (previous influenza season). The medical record revealed no documentation of an influenza vaccine for the current influenza season.The facility was unable to provide documentation that the influenza vaccine was offered, that Resident #72 or the Responsible Party had the opportunity to accept or decline the influenza vaccine, or that education on the benefits and potential side effects were provided to Resident #72 or their Responsible Party regarding the influenza vaccines.e. Resident # 33 was admitted to the (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	facility on [DATE].Review of Resident 33's MDS assessment dated [DATE] revealed Resident #33 had moderate cognitive impairment. Further review of the MDS indicated Resident #33 was not offered the influenza or pneumococcal vaccines.Review of the medical record revealed Resident #33 did not have any documentation for the pneumococcal or the influenza vaccines. The facility was unable to provide documentation that the influenza or pneumococcal vaccines were offered, that Resident #33 or the Responsible Party had the opportunity to accept or decline the vaccines, or that education on the benefits and potential side effects were provided to Resident #33 or their Responsible Party regarding the influenza and pneumococcal vaccines.During an interview with the Director of Nursing (DON) on 02/13/26 at 12:00 PM, she stated she was responsible for the Infection Prevention and Control program. The DON further stated she had been in the DON position since the end of December 2025, and she was in the process of gathering information on the immunizations, however had not started them yet. She indicated she was unable to locate any of the vaccine consents and/or the education provided to the residents for prior months.A telephone interview was conducted with the previous DON on 02/13/26 at 1:17 PM and it was revealed that she had not received guidance or instructions regarding resident immunizations and did not know if they were being done while she was working in the facility.An interview was conducted with the Administrator on 02/13/26 at 4:01 PM and she indicated she was unaware immunizations had not been completed or offered and expected residents to receive education and consent per protocol.