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 _____	C 09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR HILLS CENTER FOR NURSING AND REHABILITATION	3905 CLEMMONS ROAD CLEMMONS, NC 27012

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F 000	INITIAL COMMENTS An onsite complaint investigation survey was conducted from 8/28/2024 through 8/30/2024. Additional information was obtained offsite from 9/17/2024 to 9/20/2024. Therefore, the exit date was changed to 9/20/2024. Event ID# 20GW11. The following intakes were investigated NC00221922, NC00221925, NC00221324, NC00221289, NC00221117, and NC00220778. 6 of 12 complaint allegations resulted in deficiency.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2)	F 580		10/11/24

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

Electronically Signed | 10/07/2024

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F 580	Continued From page 1 is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, observations, Nurse Practitioner, and staff interviews the facility failed to report the results of a urinalysis received on 8/8/2024 to the Nurse Practitioner until 8/12/2024, failed to report pain and distention of the lower abdomen to the Nurse Practitioner on 8/5/2024, and failed to report being unable to flush a urinary catheter for 1 of 1 Resident (Resident #1) reviewed for urinary catheter care. Findings included: Resident #1 was admitted to the facility on	F 580	Resident #1 urinalysis results were reported to the Nurse Practitioner on 8/12/24. Nurse Practitioner was notified of pain and distention in the lower abdomen as well as being unable to flush the urinary catheter on 8/5/24. Residents residing in the facility have the potential to be affected. A review of urinalysis results for the last 30 days was conducted to ensure Nurse Practitioner was notified of results. A review of pain assessments and progress notes for last	

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F 580	Continued From page 2 8/20/2024 with diagnoses of end stage renal disease, neuropathic bladder, and Parkinson's disease. A quarterly Minimum Data Set (MDS) assessment dated 7/24/2024 indicated Resident #1 was cognitively intact and had a urinary catheter in place. Resident #1's Physician's Orders indicated he had a Urinalysis with Culture if indicated ordered 8/5/2024 due to discolored urine. Review of a urinalysis laboratory result obtained 8/8/2024 indicated Resident #2 had a mixed flora and collection of a new urinary sample was suggested by the laboratory. On 8/28/2024 at 11:10 am an interview was conducted with Resident #1 and he stated on 8/5/2024 at 3:30 am Nurse #3 flushed his suprapubic urinary catheter because he was not having much urine output, his lower abdomen was distended, and he was having lower abdominal pain. Resident #1 stated when Nurse #3 flushed his suprapubic urinary catheter the flush liquid did not return. Attempts made to call Nurse #3 for an interview were unsuccessful. Nurse #2 was interviewed on 8/28/2024 at 1:19 pm and stated she worked on 8/5/2024 on the 7:00 am to 7:00 pm shift and was assigned to Resident #1. Nurse #2 stated on 8/5/2024 in morning report the 7:00 pm to 7:00 am nurse, Nurse #3, had flushed Resident #1's catheter at 3:30 am and Nurse #3 told her none of the fluid returned from the flush. She stated Nurse	F 580	30 days to make sure all pain has been reported to the Nurse Practitioner if not a successful intervention in place. A review of documentation for residents with urinary catheters with flushes was conducted to ensure that the flush was successful and if not the Nurse Practitioner/Medical Director was notified. Education was completed with the nurses by the Director of Nursing in regards to notification to the Nurse Practitioner/Medical Doctor when there is a change in condition, an order is not able to be completed and/or there are complications. Furthermore results of laboratory tests are reported to the Nurse Practitioner/Medical Doctor. Nurses that have not received the education by 10/4/24 will not be able to work until the education has been completed. Newly hired nurses will receive the education during orientation from the Director of Nursing. The Director of Nursing or designee will audit 5 laboratory results three times a week for four weeks, then 5 laboratory results a week for eight weeks to ensure that laboratory results have been given/acknowledged by the Medical Doctor/Nurse Practitioner. The Director of Nursing will audit 5 residents progress notes/medication administration record three times a week for four weeks, then 5 residents progress notes/medication administration medication record twice a week for eight weeks for pain, change in condition and/or inability to flush a urinary	

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F 580	Continued From page 3 Practitioner (NP) #1, who was in the facility ordered a Urinalysis with Culture if indicated, and she obtained the urine sample for the Urinalysis with Culture and placed it in the refrigerator to go to the laboratory. Nurse #2 stated she did not report to NP #1 that Nurse #3 told her she had flushed Resident #1's suprapubic urinary catheter on 8/5/2024 at 3:30 am and did not get any liquid returned. Nurse #2 stated the Responsible Party called on 8/6/2024 and asked for the results of the Urinalysis with Culture and when Nurse #2 could not locate the results, she called the laboratory, and they had not picked up the urine sample that was obtained 8/5/2024. Nurse #2 stated she checked the refrigerator, and the urine sample was still in the refrigerator. Nurse #2 stated she called the laboratory back, asked them to pick up the urine sample, and they picked it up on 8/8/2024. Nurse #2 stated she did not report the Urinalysis with Culture not being sent on 8/5/2024 to NP #1 or that the Urinalysis with Culture was not sent to the laboratory until 8/8/2024. Nurse #2 stated she did not remember getting the results for the Urinalysis with Culture on 8/8/2024 and did not realize they had not been reported to NP #1 until the Responsible Party called on 8/12/2024 and said Resident #1 had called her and stated he was in pain. Nurse #2 stated she should have looked for the results of the Urinalysis with Culture on 8/8/2024 and reported the results to NP#1. Nurse #2 indicated the facility's laboratory findings are faxed to them by the laboratory, and she did not know why Resident #1's urinalysis findings were not sent. Nurse #1 stated Resident #1 had not reported any pain to her on 8/12/2024. \ On 8/30/2024 at 11:10 am a telephone interview was conducted with NP #1 and she stated she	F 580	catheter. The Director of Nursing is responsible for forwarding the results of the audits to the Quality Assurance Performance Improvement Committee monthly for three months. The Quality Assurance Performance Improvement Committee will review the audit to determine trends and/or issues that may need further interventions put into and to determine the need for further and/or frequency of monitoring. Completion Date: 10/11/24	

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F 580	Continued From page 4 was not called regarding Resident #1 having pain and distention of his abdomen on 8/5/2024. NP #1 stated no one reported to her on 8/5/2024 that Resident #1's catheter was flushed on 8/5/2024 at 3:30 am and the fluid from the flush did not return. NP#1 stated she ordered the Urinalysis with Culture to rule out an infection on 8/5/2024. NP#1 stated she was not notified of the urinalysis with culture not being sent out on 8/5/2024 and she was not notified of the results of the urinalysis with culture on 8/8/2024 which showed Resident #1 had a urinary infection until Resident #1 was sent out to the hospital on 8/12/2024. NP#1 stated the facility should have reported the Urinalysis with Culture was not completed on 8/5/2024 when it was ordered, and they should have reported the Urinalysis with Culture results on 8/8/2024 so that Resident #1's infection would have been treated. During an interview with Director of Nursing (DON) #2 on 8/30/2024 at 1:40 pm she stated Nurse #2 should have notified her and NP #1 on 8/5/2024 of the Urinalysis with Culture not being picked up by the laboratory and Nurse #2 should have notified her and NP#1 the Urinalysis with Culture was not sent until 8/8/2024. The Administrator was interviewed on 8/30/2024 at 1:42 pm and she stated she was not aware of the NP #1 not being notified of the results of the urinalysis with culture on 8/8/2024. The Administrator stated Nurse #1 should have ensured the results were reported to NP #1 on 8/8/2024.	F 580		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4)	F 609		10/11/24

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F 609	Continued From page 5 §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews the facility failed to report an allegation of abuse to Adult Protective Services for 1 of 3 residents (Resident #6) who alleged staff to resident abuse which occurred on 7/25/2024 and was reported to the Administrator on 7/26/2024 but was not reported to Adult Protective Services until 8/1/2024.	F 609	Resident #6 no longer resides in the facility. Adult Protective Services (APS) was notified on 8/1/24 of the allegation involving resident #6. Residents residing in the facility that have an allegation of abuse have the potential to be affected by the deficient practice.	

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F 609	Continued From page 6 Findings included: The facility's Abuse, Neglect and Exploitation Policy reviewed on 1/1/2024 stated the facility would report all alleged violations to the Adult Protective Services and all other required agencies with 24 hours if the event that caused the allegation did not result in abuse or serious bodily injury. Resident #6 was admitted to the facility on 11/13/2023 with diagnoses of hemiplegia and epilepsy. A quarterly Minimum Data Set (MDS) assessment dated 8/9/2024 indicated Resident #6 was severely cognitively impaired and required total assistance with bed mobility and transfers. According to the facility's investigation dated 7/26/2024 at 2:45 pm a Family Member reported Resident #6 told her a male nurse slapped him in the face on 7/25/2024 or 7/26/2024. The investigation indicated the accused was suspended pending an investigation, and the police were notified of the allegation. The facility unsubstantiated the allegation. During an interview with the Administrator on 8/29/2024 at 12:24 am she stated she was notified of the allegation of abuse by Resident #6's Family Member on 7/26/2024 and she notified Adult Protective Services on 8/1/2024. The Administrator stated Resident #6's Family Member reported someone had slapped Resident #6, and she realized now she should have reported the allegation within 24 hours of her being made aware of the allegation of abuse..	F 609	The Administrator conducted an audit of the facility reported incidents alleging abuse for the last 30 days to ensure APS was notified. Education was completed with the Administrator and Director of Nursing by the Regional Director of Operations on 10/1/24 regarding reporting allegations of abuse to APS. The Administrator was instructed to notify APS while completing the 24 hour report for the State Agency and including the APS notification in the report. The Administrator will audit facility reportables alleging abuse for proper notification to APS weekly for twelve weeks. The Administrator is responsible for forwarding the results of the audits to the Quality Assurance Performance Improvement Committee monthly for three months. The Quality Assurance Performance Improvement Committee will review the audit to determine trends and/or issues that may need further interventions put into and to determine the need for further and/or frequency of monitoring. Completion Date: 10/11/24	

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F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on record review and resident,	F 690	Resident #1 remains in the facility.	10/11/24

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F 690	Continued From page 8 Responsible Party, and Nurse Practitioner interviews the facility failed to have a Urinalysis with Culture sample collected on 8/5/2024 tested at the laboratory that same day. The Urinalysis with Culture was not completed and reported to the facility until 8/8/24. In addition, the facility failed to follow through on 8/8/24 when the laboratory suggested a new urine sample when the results for the 8/5/24 indicated the sample was contaminated. The deficient practice occurred for 1 of 1 resident (Resident #1) reviewed for suprapubic catheter care. Findings included: Resident #1 was admitted to the facility on 8/20/2024 with diagnoses of end stage renal disease, neurogenic bladder which required a suprapubic catheter, and Parkinson's disease. A quarterly Minimum Data Set (MDS) assessment dated 7/24/2024 indicated Resident #1 was cognitively intact and had a urinary catheter in place. A Nurse Practitioner's Progress Note dated 8/7/2024 indicated she saw Resident #1 on 8/5/2024 in the facility and Resident #1 brought to her attention his urine was purple. The Nurse Practitioner's Progress Note further stated Resident #1 had no abdominal distention and did not complain of pain, fever or chills; and she ordered a Urinalysis with Culture to rule out infection on 8/5/2024. Resident #1's Physician's Orders indicated he had a Urinalysis with Culture ordered 8/5/2024 due to discolored urine. A Urinalysis laboratory result obtained 8/8/2024 indicated Resident #2's urine had mixed bacteria,	F 690	Resident #1 received antibiotics for urinary tract infection. Resident #1 has had no further urinary issues. Residents residing in the facility that have orders for urinalysis have the potential to be affected by the deficient practice. An audit of the last 30 days urinalysis orders was conducted to ensure labs were collected as ordered and if a suggestion of recollect was made secondary to contamination the Nurse Practitioner/Medical Doctor was notified and/or recollect completed. Education was provided to the nurses by the Director of Nursing regarding the collection of labs as ordered by the Nurse Practitioner/Medical Director. In addition, the nurses were educated to review results for a suggestion of recollection secondary to contamination. Nurses that did not receive the education by 10/7/24 will not be allowed to work until education is received. Newly hired nurse will receive education during orientation from the Director of Nursing. The Director of Nursing or Unit Managers will audit laboratory orders three times a week for four weeks and then twice a week for eight weeks to ensure labs are being collected as order and if recollection was suggested was it addressed. The Director of Nursing is responsible for forwarding the results of the audits to the QAPI Committee monthly for three months. The QAPI Committee will review	

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F 690	Continued From page 9	F 690		

which indicated the sample was contaminated, and collection of a new urine sample was suggested by the laboratory.

On 8/28/2024 at 11:10 am an interview was conducted with Resident #1 and he stated on 8/5/2024 at 3:30 am Nurse #3 flushed his suprapubic urinary catheter because he was not having much urine output, his lower abdomen was distended, and he was having lower abdominal pain. Resident #1 stated when Nurse #3 flushed his suprapubic urinary catheter the flush liquid did not return. Resident #1 stated Nurse #2 got a sample of his urine on 8/5/2024 for a Urinalysis with Culture, but they did not get the results. Resident #1 stated he went out to the hospital on 8/12/2024 due to decreased output and lower abdominal pain.
Attempts were made to call Nurse #3, who attempted to flush Resident #1's suprapubic urinary catheter at 3:30 am on 8/5/2024, on 8/28/2024 at 7:24 pm, 8/29/2024 at 9:28 am, and 8/30/2024 at 11:50 am. A message was left for Nurse #3 with each attempt, and she did not return the calls.

On 8/28/2024 at 1:13 am a phone interview was conducted with the Responsible Party and she stated on 8/5/2024 another Family Member who visited Resident #1 told her Resident #1's urine was purple, which she knew indicated he had an infection. The Responsible Party stated Resident #1 told the Family Member the nurse had flushed his catheter at 3:30 am that morning and nothing came back out and he was having lower abdominal pain, and his lower abdomen was distended. The Responsible Party stated she called back to the facility on 8/7/2024 to check on the results of Resident #1's urinalysis that was

the audit to determine trends and/or issues that may need further interventions put into and to determine the need for further and/or frequency of monitoring.

Completion Date: 10/11/24

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F 690	Continued From page 10	F 690		

ordered on 8/5/2024 and was told the urine sample was not sent to the laboratory and the staff could not tell her why it was not sent. She stated on 8/12/2024 she received a phone call from Resident #1, he stated he needed help, and the Responsible Party stated she called emergency services.

Nurse #2 was interviewed on 8/28/2024 at 1:19 pm and stated she worked on 8/5/2024 on the 7:00 am to 7:00 pm shift and was assigned to Resident #1. Nurse #2 stated on 8/5/2024 in morning report the 7:00 pm to 7:00 am nurse, Nurse #3, stated she had flushed Resident #1's catheter at 3:30 am and none of the fluid returned from the flush. Nurse #1 stated she asked Resident #1 if he wanted to go to the hospital, but he said no. She stated Nurse Practitioner (NP) #1, who was in the facility on 8/5/2024, noticed Resident #1 had purple urine and ordered a urinalysis with culture if indicated. Nurse #2 stated she obtained the urine sample for the Urinalysis with Culture and placed it in the refrigerator to go to the laboratory. Nurse #2 stated the Responsible Party called on 8/6/2024 and asked for the results of the Urinalysis with Culture and when Nurse #2 could not locate the results, she called the laboratory and discovered they had not picked the urine sample that was obtained 8/5/2024. Nurse #2 stated she checked the refrigerator 8/6/24, and the urine sample was still in the refrigerator. Nurse #2 stated she called the laboratory back on 8/6/24 and asked them to pick up the urine sample. The laboratory did not pick up the Urinalysis with Culture sample until 8/8/2024. Nurse #2 stated she cared for Resident #1 on the 7:00 am to 7:00 pm shift on 8/6/2024, 8/7/2024, and 8/8/2024 and he did not complain of pain or discomfort and did not have

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abdominal distention. Nurse #2 stated she returned to work on 8/12/2024 received a call from the Responsible Party and the Responsible Party said Resident #1 had called her complaining of pain and told her he needed help. Nurse #2 stated she did not remember getting the results of the Urinalysis with Culture on 8/8/2024 and she did not report them to NP#1 until the Responsible Party called her on 8/12/24 to say she had called Emergency Medical Services for Resident #1. Nurse #2 stated Resident #1 had not complained of any discomfort or abdominal distention on 8/12/2024.

Medication Aide #1 was interviewed on 8/28/2024 at 8:35 pm by phone and she stated she cared for Resident #1 on 8/9/2024 on the 7:00 am to 7:00 pm shift and he did not complain of any pain or discomfort, and his urine was a light orange color, which was normal for him.

An interview was conducted with Nurse #13 on 8/28/2024 at 7:36 pm by phone and she stated she cared for Resident #1 on 8/11/2024 from 7:00 am to 11:30 pm and he did not have any complaints of pain or discomfort, and his urine was not discolored.

A hospital Admission Note dated 8/12/2024 indicated Resident #1 had a history of Parkinson's disease with neurogenic bladder which required a suprapubic catheter which was placed in 11/2023. He reported pain from his suprapubic catheter yesterday, 8/11/2024, but he stated it was draining urine. The Admission Note also stated Resident #1 did not have any chills or fever. The plan of care on the Admission Note for Resident #1 indicated he would be admitted and receive intravenous antibiotics, and his

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suprapubic catheter was changed to a larger size.

A Hospital Discharge Summary dated 8/20/2024 indicated Resident #1 had a history of Parkinson's disease and neurogenic bladder. He was treated in the hospital for 7 days with an intravenous antibiotic and returned to the facility after the completion of his antibiotics for a urinary tract infection due to a clogged catheter.

On 8/30/2024 at 11:10 am a telephone interview was conducted with NP #1 and she stated Resident #1 had not complained of pain or distention on 8/5/2024 when she ordered the Urinalysis with Culture if indicated, and the only symptom had been that Resident #1's urine was purple. She stated she ordered the Urinalysis with Culture to rule out a urinary infection. NP #1 stated she was not aware Nurse #1 had flushed Resident #1's catheter at 3:30 am on 8/5/2024 and the liquid not returning after the flush could have been a sign his catheter was blocked. She stated she was not aware the Urinalysis with Culture was not completed until 8/8/2024 and she was not made aware of the results of the Urinalysis with Culture until 8/12/2024 when Resident #1 was sent to the hospital. NP #1 stated the facility should have reported the Urinalysis with Culture was not completed on 8/5/2024 when it was ordered, and they should have reported the Urinalysis with Culture results on 8/8/2024 so that Resident #1's infection would have been treated.

During an interview with Director of Nursing (DON) #2 on 8/30/2024 at 1:40 pm she stated she was not made aware of Resident #1's Urinalysis with Culture sample not being sent to the laboratory on 8/5/2024 or the results not being

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F 690	Continued From page 13 reported to NP #1 on 8/8/2024 when they were sent to the facility by the laboratory. DON #2 stated the Urinalysis with Culture sample should have been sent when it was ordered on 8/5/2024 and the results should have been reported to NP #1 on 8/8/2024. DON #2 stated Nurse #2 completed a laboratory order for the Urinalysis with Culture on 8/5/2024 so the laboratory would have been aware the Urinalysis with Culture sample should be picked up. DON #2 stated the laboratory would have faxed Resident #1's laboratory findings to the facility and the nurses were responsible for reporting them to the Nurse Practitioner or Physician. The Administrator was interviewed on 8/30/2024 at 1:42 pm and she stated she was not aware of the Urinalysis with Culture not being sent to the laboratory when it was ordered on 8/5/2024 or NP #1 not being notified of the results of the Urinalysis with Culture on 8/8/2024. The Administrator stated Nurse #1 should have ensured the Urinalysis with Culture was sent on 8/5/2024 and the results were reported to NP #1 on 8/8/2024.	F 690		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff, Pharmacy Consultant and Nurse Practitioner	F 697	Resident #9 no longer resides in the facility.	10/11/24

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F 697	Continued From page 14 interviews the facility failed to administer pain medication as ordered for 1 of 3 residents (Resident #9) reviewed for pain management. Findings included: Resident #9 was admitted to the facility on 8/28/2024 with diagnoses of left knee replacement. A Physician's Order dated 8/28/2024 at 6:45 pm indicated Resident #9 should receive Oxycodone/Acetaminophen 5/325 milligrams, a narcotic pain medication, for pain every 4 hours for pain rated at 4 or more on a pain scale of 1 to 10. An admission Minimum Data Set (MDS) had not been completed for Resident #9. A late entry note written on 8/29/2024 at 5:25 am by Nurse #6 indicated Resident #9 arrived at the facility 8/28/24 at 5:45 pm with an incision to his left knee which was covered with a bandage. His vital signs were normal, he was alert and oriented with some confusion, and he was resting. A progress note written by Nurse #7 on 8/28/24 at 9:34 pm indicated Resident #9 reported his pain was a 6 on a scale of 1 to 10 and he was experiencing muscle spasms to his left lower extremity. A progress note dated 8/28/2024 at 9:37 pm written by Nurse #7 indicated Resident #9's pain medications were not available. Review of Resident #9's Medication Administration Record for 8/28/2024 indicated he	F 697	Residents residing in the facility with pain medication ordered have the potential to be affected by the deficient practice. Nurse management completed an audit of current residents medication administration record for the last 30 days to verify pain medication was administered as ordered. The Director of Nursing educated the nurses and medication aides on administering pain medication as ordered. The education included notification to the Nurse Practitioner/Medical Doctor should the medication not be available for an alternate order. Nurses were educated on the emergency back up system. Nurses that have not received the education by 10/7/24 will be unable to work until education is completed. Newly hired nurses will receive education during orientation from the Director of Nursing. The Director of Nursing or designee will audit 5 residents medication administration records three times a week for four weeks and then 5 residents medication administration records two times a week for eight weeks to ensure that pain medications are being administered as ordered. The Director of Nursing is responsible for forwarding the results of the audits to the Quality Assurance Performance Improvement Committee monthly for three months. The Quality Assurance Performance Improvement Committee will	

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F 697	Continued From page 15 did not receive any pain medication when his pain rated at a 6, on a scale of 1 to 10. A Packaging and Delivery Slip from the pharmacy indicated Resident #9's Oxycodone/Acetaminophen 5/325 milligrams was delivered to the facility on 8/29/2024 at 7:12 pm. An interview was conducted by phone on 9/17/2024 at 12:52 pm with Nurse #6 and she stated she worked on 8/28/2024 at 7:00 pm until 8/29/2024 at 7:00 am and admitted Resident #9 to the facility. She stated Resident #9 arrived at the facility at 5:45 pm on 8/28/2024 and she did not get his admission orders faxed to the pharmacy until sometime between 7:00 pm and 11:00 pm. Nurse #6 stated she gave Resident #9 Acetaminophen from the standing orders on 8/28/2024 at 6:00 pm for mild pain but failed to document she had given it. Nurse #6 stated she checked on Resident #9 three or four times the night of 8/28/2024 and he did not complain of pain. She stated she filled his ice pack machine that was on his knee each time she was in his room. Nurse #7 was interviewed by phone on 9/18/2024 at 8:35 am and she stated she cared for Resident #9 on 8/28/2024 from 7:00 pm until 8/29/2024 at 7:00 am but she does not remember Resident #9. She stated the medications were delivered to the facility at 7:00 pm on 8/29/2024. She stated she could not remember if she was able to give him anything that night (8/28/2024) for pain and could not recall documenting the resident's pain was 6 on 8/28/2024. On 8/29/2024 at 5:37 pm an observation of Resident #9 revealed he was in bed with his eyes	F 697	review the audit to determine trends and/or issues that may need further interventions put into and to determine the need for further and/or frequency of monitoring. Completion Date: 10/11/24	

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F 697	Continued From page 16	F 697		

closed and he did not answer when his name was called.

On 9/17/2024 at 12:42 pm the Consultant Pharmacist was interviewed by phone, and she stated the hard script for Resident #9's Oxycodone/Acetaminophen 5/325 milligrams was not faxed to the pharmacy until 8/29/2024 at 8:06 am and it was delivered to the facility on 8/29/2024 at 7:12 pm. The Consultant Pharmacist stated there were two doses of the Oxycodone/Acetaminophen 5/325 milligrams taken from the electronic emergency backup medications on 8/29/2024 at 4:11 pm by the Corporate Nurse Consultant.

On 9/18/2024 at 11:05 am an interview by phone was conducted with Nurse Aide (NA) #3 and she stated on 8/28/2024 on the 3:00 pm to 11:00 pm shift she was not assigned to Resident #9, but she did help NA #9 change him at 6:30 pm and 9:00 pm but she did not go back into his room after 9:00 pm. NA #3 stated Resident #9 complained of pain when she was in his room with Nurse Aide #9 at 6:30 pm and 9:00 pm. She stated he was not crying or moaning but he did state he was having pain.

Nurse Practitioner (NP) #2 was interviewed by phone on 9/18/2024 at 1:41 pm and she stated she was the on-call provider for 8/28/2024 to 8/31/2024 when Resident #9 was admitted to the facility. NP #2 stated a resident that was only two days post op like Resident #9 would definitely need a narcotic pain medication and would be having moderate to severe pain.

During an interview with Director of Nursing (DON) #2 on 8/30/2024 at 1:30 pm she stated

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F 697	Continued From page 17 she was not made aware of any issues with pain medications not being available to Resident #9. DON #2 stated the Nurse should have checked the emergency backup for the medication and if it was not available, she should have ordered the pain medication stat (to arrive immediately) from the pharmacy and notified the Physician to inquire if a pain medication that was available could be administered. DON #2 stated Nurse #7 should have reported to her that Resident #9's pain medication was not available. DON #2 stated she did not know why Resident #9's pain medications were not delivered until 8/29/2024. The Administrator was interviewed on 8/30/2024 at 1:34 pm and she stated Resident #9's pain medication should have been given from the emergency backup supply and if it was not available from the emergency backup Nurse #7 should have been sent a stat (immediate delivery) order to the pharmacy to send the pain medication immediately and the Physician should have been notified the medication was not available.	F 697		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures	F 755		10/11/24

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F 755	Continued From page 18 that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to have pain medication available as ordered by the Nurse Practitioner on admission to the facility and provide nursing staff access to the electronic emergency backup medication storage for 1 of 3 residents reviewed for pain management (Resident #9). Findings included: Resident #9 was admitted to the facility on 8/28/2024 with diagnosis of left knee replacement. A Physician's Order dated 8/28/2024 at 6:45 pm indicated Resident #9's admission medication orders included Oxycodone/Acetaminophen	F 755	Resident #9 no longer resides at the facility. Residents residing in the facility that have orders for pain medications have the potential to be affected by the deficient practice. The Director of Nursing and Regional Nurse Consultant reviewed pain medications on the eMARs and confirmed the pain medication was available in the medication cart or emergency back-up. Director of Nursing educated the nurses regarding availability of pain medication and knowing how to retrieve ordered pain medication from the emergency medication backup. Nurses were	

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F 755	Continued From page 19 5/325 milligrams, a narcotic pain medication, which was ordered every 4 hours as needed for pain rated at 4 or more on a scale of 1 to 10. A Nurse's Progress Note written 8/28/2024 at 9:34 pm written by Nurse #7 stated Resident #9 reported his pain was a 6 on a scale of 1 to 10 and he was experiencing muscle spasms to his left lower leg. An interview was conducted by phone on 9/17/2024 at 12:52 pm with Nurse #6 and she stated she worked on the 3:00 pm to 11:00 pm shift on 8/28/2024 and the 11:00 pm to 7:00 am shift on 8/28/2024 and admitted Resident #9 to the facility. Nurse #6 stated she faxed the hard script for Resident #9's Oxycodone/Acetaminophen 5/325 milligrams to the pharmacy between 7:00 pm and 11:00 pm and she did not receive the medication the in the medication that night. Nurse #6 stated she gave Resident #9 Acetaminophen 350 milligrams (2 tablets) per the facility's standing orders between 5:00 pm and 6:00 pm but she did not remember anyone telling her he had pain after 6:00 pm on 8/28/2024. Nurse #6 stated she was aware the order for Resident #9's pain medication indicated he should have Oxycodone/Acetaminophen 5/325 milligrams, 1 tablet, for pain rated at 4 or more on a scale of 1 to 10. Nurse #6 stated she did not have access to the electronic emergency backup medications but she had not needed it since Resident #9 did not complain of pain after receiving the Acetaminophen at 6:00 pm. On 8/28/2024 at 9:37 pm Nurse #7 wrote another Nurse's Progress Note which stated Resident #9's pain medication was not available. The Nurse's Progress Note did not include if the	F 755	instructed that in the event they do not have the ordered pain medication available they are to notify the Nurse Practitioner/Medical Doctor and let him/her know what is available for pain in the back up. Nurses that have not received the education by 10/7/24 will be unable to work until the education is completed. Newly hired nurses will receive the education during orientation from the Director of Nursing. The Director of Nursing or designee will audit 5 residents a week for twelve weeks to ensure that pain medication was available. The Director of Nursing is responsible for forwarding the results of the audits to the Quality Assurance Performance Improvement Committee monthly for three months. The Quality Assurance Performance Improvement Committee will review the audit to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring. Completion Date: 10/11/24	

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Nurse Practitioner was made aware of the medication not being available.

Nurse #7 was interviewed on 9/18/2024 at 8:35 am and stated she worked at the facility on 8/29/2024 on the 7:00 pm to 7:00 am shift. Nurse #7 stated she did not remember Resident #9 and she did not remember anyone complaining of pain on 8/29/2024 when she worked. Nurse #7 stated if she signed the pain medication out for Resident #9 that night then she gave it and if his pain had not been relieved she would have called Director of Nursing #2 and then the physician if she did not have the pain medication that was prescribed. Nurse #7 stated she nor the other nurses working on 8/29/2024 had access to the electronic emergency backup system.

On 8/30/2024 at 1:30 pm Director of Nursing (DON) #2 was interviewed and stated she was not made aware of Resident #9's pain medication not being available on 8/28/2024. DON #2 stated Nurse #7 should have checked the emergency backup for the medication and if it was not available, she should have called the physician or nurse practitioner to see if a medication that was available could have been administered for Resident #7's pain. DON #2 stated she did not know why Resident #9's admission medications did not arrive, and the orders should have been sent to the pharmacy as soon as Resident #9 was admitted and admission medication orders were received.

During an interview with the Administrator on 8/30/2024 at 1:34 pm she stated Resident #9's pain medication should have been given from the emergency backup supply and if it was not available Nurse #7 should have sent a stat order

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F 755	Continued From page 21 to the pharmacy to send his medications immediately. The Administrator also stated the Physician or Nurse Practitioner should have been made aware Resident #9 did not have pain medication.	F 755		
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and staff, Pharmacist, Nurse Practitioner, and Resident interviews the facility failed to administer antiseizure medication and pain medication for 2 of 3 residents (Resident #8 and Resident #9) reviewed for providing pharmaceutical services to meet residents' needs. administration. Resident #8 did not receive her antiseizure medication on 7/15/2024 and 7/16/2024, and Resident #9 was admitted with a left total knee replacement and did not receive pain medication when admitted to the facility. Findings included: 1. Resident #8 was admitted to the facility on 7/15/2024 with diagnoses malignant neoplasm to the brain resulting in seizures and brain necrosis due to radiation therapy. Resident #8's Physician's orders included an order written 7/15/2024 for Lamotrigine 200 milligrams twice daily; Lamotrigine 25 milligrams (2 tablets) at bedtime for seizures; and Levetiracetam 1000 milligrams (2 tablets) two	F 760	Resident #8 and resident #9 no longer reside in the facility. Residents residing in the facility have the potential to be affected by the deficient practice. Resident eMARS were reviewed to ensure that the medications ordered were available. Director of Nursing provided the nurses education regarding order entry and re-ordering timely as needed. Furthermore, the nurses were educated regarding the use of the backup medication system in the facility. In the event the medication ordered is not available the nurse was instructed to call the Nurse Practitioner/Medical Director to receive new orders for an alternate available in the back up system. Nurses that have not received the education by 10/7/24 will be unable to work until the education is completed. Newly hired nurses will receive the education during orientation from the Director of Nursing.	10/11/24

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	345131	A. BUILDING _____ B. WING _____	C 09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR HILLS CENTER FOR NURSING AND REHABILITATION	3905 CLEMMONS ROAD CLEMMONS, NC 27012

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F 760	Continued From page 22 times a day for seizures. Resident #8's Medication Administration Record (MAR) for 7/2024 was reviewed and the following medications ordered by the Physician were not documented as administered: Lamotrigine 200 milligrams, Lamotrigine 25 milligrams, or Levetiracetam 1000 milligrams were not signed on the MAR as given at 9:00 pm on 7/15/2024. Lamotrigine 200 milligrams and Levetiracetam 2000 milligrams were not signed on the MAR as given at 9:00 am on 7/16/2024. The Packing and Delivery Slips for Resident #8's Lamotrigine 200 milligrams, Lamotrigine 25 milligrams, and Levetiracetam 1000 milligrams indicated the medication was not delivered to the facility until 7/16/2024. On 8/29/2024 at 4:26 pm a phone interview was conducted with Resident #8 and she stated she was admitted to the facility on 7/15/2024 and did not get her antiseizure medication the day she was admitted or the next morning. During an interview with Nurse #1 on 8/30/2024 at 4:02 pm she stated she cared for Resident #8 on the 7:00 pm to 7:00 am shift on 7/15/2024. Nurse #1 stated Resident #8's antiseizure medication did not arrive from the pharmacy during her shift, and she did not administer it. Nurse #1 stated she arrived for her shift at 7:00 pm and the when the pharmacy medication delivery arrived, after 7:00 pm, Resident #8's medications were not in the delivery. Nurse #1 stated she did not call the pharmacy to request a	F 760	The Director of Nursing or designee will audit 5 residents eMAR a week for twelve weeks to ensure the medication was administered as ordered based on availability. The Director of Nursing is responsible for forwarding the results of the audits to the Quality Assurance Performance Improvement Committee monthly for three months. The Quality Assurance Performance Improvement Committee will review the audit to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring. Completion Date: 10/11/24	

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F 760	Continued From page 23	F 760		

stat order for the seizure medications or notify the Nurse Practitioner #1 of the medication not being available.

An admission Minimum Data Set (MDS) assessment dated 7/19/2024 indicated Resident #8 was cognitively intact.
Resident #8's Care Plan dated 7/29/2024 indicated she had a seizure disorder, and the interventions included administer seizures medication as ordered and monitor for effectiveness.

Director of Nursing (DON) #1, who no longer was employed at the facility, was interviewed by phone on 8/30/2024 at 2:49 pm and she stated Resident #8's antiseizure medications were not available from the pharmacy on the day she admitted, 7/15/2024, and they were not delivered that evening. DON #1 stated her antiseizure medications were not delivered until 7/16/2024. DON #1 stated Resident #8's medications should have been ordered from the pharmacy stat (to arrive as soon as possible) so that she would not miss doses of her antiseizure medication, and she had not been made aware the medication did not arrive from the pharmacy until the day after she was admitted to the facility.

On 8/30/2024 at 2:13 pm the Pharmacist was interviewed by phone and stated Resident #8 not receiving the prescribed antiseizure medications on the evening of 7/15/2024, when she was admitted, and the missed dose on the morning of 7/16/2024 contributed to her having seizures. The Pharmacist stated when a medication is not available from the emergency back-up medications, they should be ordered stat (immediate delivery) from the pharmacy to arrive

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F 760	Continued From page 24	F 760		

as soon as possible.

During an interview with the Administrator on 8/30/2024 at 1:42 pm she stated she was not made aware of Resident #8 not getting her antiseizure medications on the night she was admitted 7/15/2024 and the next morning 7/16/2024. The Administrator stated she was aware Resident #8 had a history of a brain tumor and seizures. She stated Resident #8's medications should have been ordered from the pharmacy as soon as she was admitted, to ensure they arrive as soon as possible if they were not available in the emergency backup medications.

2. Resident #9 was admitted to the facility on 8/28/2024 with diagnoses of left knee replacement, kidney disease, and heart disease.

An Admission Minimum Data Set (MDS) had not been completed for Resident #9.

A Physician's Order dated 8/28/2024 at 6:45 pm indicated Resident #9 should receive Oxycodone/Acetaminophen 5/325 milligrams, a narcotic pain medication, for pain every 4 hours for pain rated at 4 or more on a pain scale of 1 to 10.

A Nurse's Progress Note written on 8/28/2024 at 5:45 pm by Nurse #6 indicated Resident #9 arrived at the facility at 5:45 pm with an incision to his left knee which was covered with a bandage. His vital signs were within normal range, and he was resting.

On 8/28/2024 at 9:34 pm Nurse #7 wrote a Nurse's Progress Note that indicated Resident #9

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F 760	Continued From page 25	F 760		

reported his pain was a 6 on a scale of 1 to 10 and he was experiencing muscle spasms to his left lower extremity.

A Nurse's Progress note dated 8/28/2024 at 9:37 pm written by Nurse #7 indicated Resident #9's pain medications were not available.
A Packaging and Delivery Slip from the pharmacy indicated Resident #9's Oxycodone/Acetaminophen 5/325 milligrams was delivered to the facility on 8/29/2024.

On 8/30/2024 at 1:05 pm an attempt was made to reach Nurse #7, who worked the 7:00 pm to 7:00 am shift on 8/29/2024 when Resident #9 was admitted with no return call from Nurse #7.

During an interview with Director of Nursing (DON) #2 on 8/30/2024 at 1:30 pm she stated she was not made aware of any issues with medications not being available to Resident #9. DON #2 stated the Nurse should have checked the emergency backup for the medication and if it was not available, she should have ordered the medication stat (to arrive immediately) from the pharmacy and notified the Physician to inquire if a medication that was available could be ordered. DON #2 stated Nurse #7 should have reported to her that Resident #9's pain medication was not available. DON #2 stated she did not know why Resident #9's medications were not delivered until the day after he was admitted to the facility.

The Administrator was interviewed on 8/30/2024 at 1:34 pm and she stated Resident #9's pain medication should have been given from the emergency back up supply and if it was not available from the emergency back up the pharmacy should have been sent a stat order to

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F 760	Continued From page 26 send the medication immediately and the Physician should have been notified the medication was not available.	F 760		