PRINTED: 12/21/2023 FORM APPROVED OMB NO. 0938-0391

74101 2741 0	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345131	B. WING		C 11/17/2023	
	PROVIDER OR SUPPLIER	RSING AND REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 3905 CLEMMONS ROAD CLEMMONS, NC 27012	,	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE	
E 000	Initial Comments		E 00			
F 000	investigation survey through 11/17/23. T compliance with the Emergency Prepare	certification and complaint was conducted on 11/12/23 the facility was found in requirement CFR 483.73, dness. Event ID # 1Q8811.	F 00			
	survey was conductor 11/17/23 . Event ID: intakes were investig NC00207516, NC00 NC00209106,NC002 NC00206124, NC00	l complaint investigation ed from 11/12/23 through # 1Q8811. The following gated NC00209542, 207028, NC00206949, 209518, NC00209123, 2044820, NC00207355, 208368 and NC00205849.				
F 558 SS=E	deficiency. Reasonable Accomr	int allegations resulted in modations Needs/Preferences	F 55	В	12/15/23	
	services in the facilit accommodation of repreferences except endanger the health other residents. This REQUIREMEN by: Based on observati interviews, and staff to place residents of #15 and #40) within residents to request for 4 of 4 residents rof needs.	•		The statements included in this plan of correction are not an admission and do not constitute agreement with the alleg deficiencies herein. The plan of correct is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal a state regulations, the center has taken	o ged tion e nd	

Electronically Signed 12/16/2023

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.

STATEMENT OF DEFICIENCIES (X'AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345131	B. WING		C	
NAME OF D	ROVIDER OR SUPPLIER	040101		STREET ADDRESS, CITY, STATE, ZIP CODE	11/17/2023	
NAME OF FI	NOVIDER OR SUFFLIER					
CEDAR H	LLS CENTER FOR NURS	SING AND REHABILITATION		3905 CLEMMONS ROAD		
				CLEMMONS, NC 27012		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 558	Continued From page	e 1	F 558	8		
	The findings included	:		will take the actions set forth in the		
	Ŭ			following plan of correction. The follow	ving	
	1) Resident #12 was	admitted to the facility on		plan of correction constitutes the cent	er⊡s	
	03/26/21 with diagnos	ses that included Vascular		allegation of compliance. An alleged		
	Dementia, anxiety dis	order, orthostatic		deficiency cited has been or will		
	hypertension, osteoar	thritis, and hearing loss.		completed by the dates indicated.		
	The quarterly Minimu	m Data Set (MDS)				
		/04/23 indicated Resident		Resident # 12, 19, 15, and 40 □s call	bell	
		everely impaired. She had		was placed within reach on 11/16/23		
	no behavior and no re			the Unit Manager.		
	required extensive as			All call bells were audited for each		
	mobility, dressing, toil		resident who are able to use them on			
			12/13/23 by the Activities Director. A	ny		
		of her lower extremities.		call bells not in reach of residents who		
				can use them, were immediately place	ed	
	Resident #12's active	care plan, last revised on		within reach.		
	04/14/23, indicated sh	ne was at risk for falls due to		The Director of Nursing (DON) initiate	d an	
	a history of falls and o	decreased mobility. The		in-service on 12/14/23 for proper		
		l provide a working and		placement of call bells with all staff to		
	reachable call light.			include all contract staff (to include		
				therapy, housekeeping, dietary and		
		onducted on 11/13/23 at		agency, certified nursing assistants,		
		12 's call bell was located		licensed nurses, social worker,		
		ad of the bed. Resident		maintenance, admissions, business		
	indicated she could no	ot locate her call bell.		office, payroll, activities, transportation		
	A : £: .	alice at a selectific Normal.		medical records, and scheduler. Any	statt	
	An interview was con	· ·		who did not receive the in-service by	4:1	
		11/15/23 at 11:15 AM. She		12/15/23 will not be allowed to work u		
		direct care NA for Resident		the in-service has been completed. T		
		got sidetracked and forgot to n the residents ' reach prior		education was included in the new hir orientation by the DON on 12/15/23.		
	T	She further stated she went		The Administrator or Designee will		
	_	dent and forgot to come		conduct call bell audits daily on 10		
	back.	aon ana lorgot to come		residents x 4 weeks. Then the audits	will	
	DGOIN.			be 5 residents 3 days a week and the		
	An observation and in	nterview with Resident #12		residents weekly x 4 weeks.		
		1/15/23 at 12:35 PM. Call		The Administrator will be responsible	for	
		the floor between bed A and		bringing the call bell audit results to the		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345131	B. WING				C 17/2023
NAME OF PE	ROVIDER OR SUPPLIER	0.010.	1	STE	REET ADDRESS, CITY, STATE, ZIP CODE	11/	17/2023
NAME OF T	TO VIDEIX OIX SOI I EIEIX				05 CLEMMONS ROAD		
CEDAR HI	LLS CENTER FOR NURS	SING AND REHABILITATION			EMMONS, NC 27012		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 558		e 2 d she used her call bell	F 5	58	Quality Assurance Performance		
					Quality Assurance Performance		
		mething from staff. She			Improvement (QAPI)meeting x 3		
		oor and stated, "I can't use it			consecutive months. At this time, the		
		though, I can't reach it." She			QAPI committee will determine the nee	a	
		call bell to call the Nursing			to continue the call bell audits.		
	Assistant (NA) or nurs	se for assistance.			Date of Compliance: 12/15/23		
	An observation was o	onducted on 11/16/23 at					
		ng Resident #12 ' s room					
		A) #2 was exiting the room.					
		pell was observed on the					
	floor between bed A a						
	verified she was the of #12's room. Na #2 v bell was located on the and stated, "I haven't she checked call bell the rooms. NA #2 veri utilize her call bell for the call bell up from the	ducted with Nursing 11/16/23 at 8:50 AM. She lirect care NA for Resident erified Resident #12 's call le floor between bed A and B done her yet". She indicated placement prior to leaving ified Resident #2 does assistance. She then picked he floor and laid it onto the anket and then exited the					
	Nursing (DON) on 11/ DON stated the call b within the resident's						
	08/22/19 with diagnos	admitted to the facility on ses that included Dementia, ler, and congestive heart					
		m Data Set (MDS) /05/23 indicated Resident everely impaired. She had					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345131	B. WING_		_	11/	7/2023
	ROVIDER OR SUPPLIER	SING AND REHABILITATION		STREET ADDRESS, CITY, ST 3905 CLEMMONS ROAD CLEMMONS, NC 27012		1 11/	1772023
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORRECT CROSS-REFEREI	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 558	mobility eating. She is 1 with dressing and processing and encourage assistance as needed response to all requesting and encourage and	ejection of care. She ssistance of 1 for bed required limited assistance of personal hygiene. e care plan, last revised on the was at risk for falls f falls, confusion (diagnosis lance problems, tychoactive drug use. ls. The interventions included sident's call light was within the the resident to use it for d. Resident needs a prompt	F 5	558			
	were conducted on 1 call bell was located and B. Resident #19 uses her call bell for An observation was 10:50 AM. Resident clipped on to the bac against wall. Not with An interview was cor Assistant (NA) #3 on verified she was the #19. She stated she put the call bells with to leaving the room. to assist another resiback. An observation was 8:46 AM. Upon enter	1/13/23 at 10:15 AM. Her on the floor between bed A indicated she sometimes assistance. conducted on 11/15/23 at #19 's call bell was located k side of the privacy curtain nin residents ' reach.					

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING			DATE SURVEY COMPLETED		
		345131	B. WING _			C 11/17/2023
NAME OF PROVIDER OR SUPPLIER CEDAR HILLS CENTER FOR NURSING AND REHABILITATION STREET ADDRESS, CITY, STATE, ZIP CODE 3905 CLEMMONS ROAD CLEMMONS, NC 27012		E	11111/2020			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 558	Continued From page	ge 4 I bell was observed clipped to	F 5	58		
		e against the headboard, out				
	Assistant (NA) #2 o verified she was the #19 's room. Na #2 bell was located on the headboard. She bell placement prior NA #2 verified Residell at times for assicall bell up from the Resident #19 's top An interview was conversing (DON) on 1	anducted with the Director of 1/16/23 at 11:17 AM. The				
	within the resident ' 3. Resident #15 was 12/31/22 with diagn	s admitted to the facility on osis that included Vascular hotic disturbance, history of				
	assessment dated (#15's cognition was behavior and no rejo extensive assistance	num Data Set (MDS) 08/18/23 indicated Resident severely impaired. He had no ection of care. He required e of 2 for bed mobility, nal hygiene. He had 2 or juries.				
	08/21/23, indicated to impaired mobility and the use of psyc	ive care plan, last revised on he was at risk for falls related , lower extremity amputee, hotropic medications. The ed for staff to be sure				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345131	B. WING			C	
NAME OF PROVIDER OR SUPPLIER CEDAR HILLS CENTER FOR NURSING AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIF 3905 CLEMMONS ROAD CLEMMONS, NC 27012	11/17/2023 P CODE			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN (X (EACH CORRECTIVE AI CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
F 558	encourage the resineeded. Resident is requests for assistate An observation and were conducted or bell was located whom the wall out of Resident #15 indice where he could reauses the call bell for An observation and with Nurse #1 on 1 was observed at the Resident #15's rebell was not within stated call bells shoreach at all times and Nursing Assistants placement. An observation and 11/15/23 at 12:38 February #1. When entering bell was on the flood She verified the case were some times for assistate the top blanket who it. An interview was conversely for the case within the resident within the resident within the resident within the resident who is needed.	was within reach and dent to use it for assistance as needs a prompt response to all ance. If interview with Resident #15 in 11/13/23 at 11:16 AM. His call rapped around the call bell box desident #15 is reach, ated the call bell was not ach it and he stated at times he or assistance. If interview were conducted 1/15/23 at 10:01 AM. Call bell e top of the mattress not within ach. Nurse #1 verified the call reach for Resident #15. She bould be within the residents ind that she had reminded the (NA) yesterday about call bell interview were conducted on PM with Nursing Assistant (NA) resident #15 is room his call for on the left side of his bed. If bell was not within his reach, and #15 does use the call bell on the reresident #15 could reach conducted with the Director of 11/16/23 at 11:17 AM. The if bell device should always be	F	558			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345131	B. WING _				C 17/2023	
NAME OF P	ROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE	1		
CEDAR HI	LLS CENTER FOR NUR	SING AND REHABILITATION			CLEMMONS ROAD MMONS, NC 27012			
(X4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	×	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE	
F 558	Continued From page	e 6	F 5	558				
	12/31/22 with diagno s Disease and Ogilvio	sis that included Parkinson ' e Syndrome.						
	#40's cognition was so behavior and no reject total assistance for be personal hygiene. Resident #40 's activity 11/12/22, indicated here to gait and balance pour The interventions incorresident's call bell was encourage the resident needed. Resident ne	o/02/23 indicated Resident severely impaired. He had no ction of care. He required ed mobility, dressing, and re care plan, last revised on e was at risk for falls related roblems and incontinence luded for staff to be sure as within reach and ent to use it for assistance as eds a prompt response to all						
	were conducted on 1 bell was located on fl Resident #40 's readyes and no simple quhis head side to side asked if he used his of An observation and in were conducted on 1	nterview with Resident #40 1/13/23 at 10:30 AM. His call oor at head of bed out of th. Resident #40 answered testions to include nodding for yes. He stated yes when call bed. nterview with Resident #40 1/15/23 at 10:55 AM. His call						
	An observation and in 11/15/23 at 12:38 PM #1. When entering rebell was on the floor She verified the call but She verified Resident	oor at head of bed out of h. Interview were conducted on I with Nursing Assistant (NA) sident #40 's room his call on the right side of his bed. bell was not within his reach. It #40 does use the call bell ut the call bell on the top						

		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULT IDENTIFICATION NUMBER: A. BUILDIN		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345131	B. WING		C 11/17/2023	
	ROVIDER OR SUPPLIER	RSING AND REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 3905 CLEMMONS ROAD CLEMMONS, NC 27012		
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F 558	An interview was co	ent #40 could reach it. Inducted with the Director of 1/16/23 at 11:17 AM. The bell device should always be	F 55	8		
F 584 SS=B	CFR(s): 483.10(i)(1) §483.10(i) Safe Environment of the resident has a recomfortable and hor but not limited to recomports for daily living the facility must prospossible. (i) This includes ensured receive care and serphysical layout of the independence and cii) The facility shall of the protection of the or theft. §483.10(i)(2) House services necessary that comfortable interesident in good condition; §483.10(i)(4) Private services necessary that it is serviced to the services necessary that it is serviced to the services necessary that it is serviced to the servic	ronment. ight to a safe, clean, nelike environment, including eiving treatment and ing safely. vide- , clean, comfortable, and nt, allowing the resident to nal belongings to the extent uring that the resident can vices safely and that the e facility maximizes resident loes not pose a safety risk. exercise reasonable care for resident's property from loss keeping and maintenance to maintain a sanitary, orderly,	F 58-		12/15/23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345131	B. WING _			C /17/2023	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 11/	17/2023	
				3905 CLEMMONS ROAD			
CEDAR HI	LLS CENTER FOR NUR	SING AND REHABILITATION		CLEMMONS, NC 27012			
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F 584	Continued From page	e 8	F 5	84			
	§483.10(i)(5) Adequate levels in all areas;	ate and comfortable lighting					
	levels. Facilities initia	table and safe temperature illy certified after October 1, a temperature range of 71 to					
	sound levels. This REQUIREMENT by: Based on observation	maintenance of comfortable Γ is not met as evidenced ons and interviews with		Room 312 was cleaned on 11/1			
		ne facility failed to maintain spills and debris for two		the Housekeeper. The area of the hardened substance was scrapp			
	rooms (Room 312 an	nd 318) This deficient		cleaned on 11/16/23 by the Hou	sekeeping		
	practice affected 1 of	3 resident halls (300 Hall).		Director. Room 318 was cleane	ed on		
	The findings included	d:		11/16/23 by the Housekeeper. All residents have the potential taffected by rooms not properly of			
	1. An observation of	room 312 on 11/13/23 at		All rooms were audited by the			
		container of dental floss on		Administrator, Maintenance Dire			
		and B, a donut shaped tan		Housekeeping Supervisor on 12			
		tance approximately 12 x 12		list of rooms requiring additional			
		tween bed A and B, and food		cleanliness was developed and			
		ne room floor. Room 312 was		were completed on 12/14/23 by	tne		
	occupied with 2 resid	ents at the time of survey.		Housekeeping Director. The Administrator and the Hous	ekeeping		
	An observation of roo	om 312 on 11/15/23 at 10:50		Supervisor provided education of	on room		
		r remained in the same		cleanliness, picking up trash in r			
		I substance and crumbs		reporting any spills not able to b	•		
	throughout.			up by staff to include all contract include therapy, housekeeping,			
	An observation of roo	om 312 on 11/16/23 at 8:46		and agency, certified nursing as	•		
		r remained in the same		licensed nurses, social worker,	olotaino,		
		I substance and crumbs		maintenance, admissions, busin	ess		
	throughout.	. Januarios ana siambo		office, payroll, activities, transpo			
				medical records, and scheduler.			
	An interview with Hou	usekeeper #1 on 11/16/23 at		who did not receive the in-service	•		

NAME OF PROVIDER OR SUPPLIER CEDAR HILLS CENTER FOR NURSING AND REHABILITATION (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE C 11/17/202 STREET ADDRESS, CITY, STATE, ZIP CODE 3905 CLEMMONS ROAD CLEMMONS, NC 27012 (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
Anime of Provider or Supplier CEDAR HILLS CENTER FOR NURSING AND REHABILITATION (A4) ID PREFIX TAG CEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 584 Continued From page 9 3:26 PM was conducted. She explained daily cleaning of resident rooms involved sweeping, mopping, wiping furniture down, and cleaning the bathroom. She verified that she was the housekeeper for room 312 and that she had already cleaned room 312 today (11/16/23). An observation was conducted with Housekeeper #1 and Housekeeper #2 of the area of tan dried hardened substance on the floor. She stated she tried to clean the area up but could not get it up because she did not have anything to scrape the hardened substance of fthe floor. The dental floss and crumbs were no longer on the floor. An interview with the Housekeeping Manager on STREET ADDRESS, CITY, STATE, ZIP CODE 3905 CLEMMONS ROAD CLEMMONS, NC 27012 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 1 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 1 PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 1 2/15/23 will not be allowed to work until the in-service has been completed. This education was included in the new hire orientation by the DON on 12/15/23. The Housekeeping Supervisor added a new housekeeping orientation on 12/15/23. The Administrator or designee will conduct 10 room inspections weekly x 4 weeks for cleanliness, then 5 rooms weekly x 4 weeks. The Administrator will be responsible for bringing the room cleanliness audit results to the Quality Assurance Performance Improvement (QAPI) meeting x 3							С	
CEDAR HILLS CENTER FOR NURSING AND REHABILITATION (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 584 Continued From page 9 3:26 PM was conducted. She explained daily cleaning of resident rooms involved sweeping, mopping, wiping furniture down, and cleaning the bathroom. She verified that she was the housekeeper for room 312 and that she had already cleaned room 312 today (11/16/23). An observation was conducted with Housekeeper #1 and Housekeeper #2 of the area of tan dried hardened substance on the floor. She stated she tried to clean the area up but could not get it up because she did not have anything to scrape the hardened substance off the floor. The dental floss and crumbs were no longer on the floor. An interview with the Housekeeping Manager on D PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPT) PREFIX TAG PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 12/15/23 will not be allowed to work until the in-service has been completed. This education was included in the new hire orientation by the DON on 12/15/23. The Housekeeping Supervisor added a new housekeeping orientation on 12/15/23. The Administrator or designee will conduct 10 room inspections weekly x 4 weeks for cleanliness, then 5 rooms weekly x 4 weeks for cleanliness, then 5 rooms weekly x 4 weeks for cleanliness, then 5 rooms weekly x 4 weeks. The Administrator will be responsible for bringing the room cleanliness audit results to the Quality Assurance Performance Improvement (QAPI)meeting x 3			345131	B. WING _			11/	17/2023
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the spill would have to be scrapped or scrubbed up off the floor. She was unaware the area was there. She further stated that most of the housekeeping staff were recently hired, and she was in the process of training them. The Housekeeping Manager stated Housekeeper #3 was the housekeeper that cleaned room 312 from 11/13/23-11/15/23. She further stated Housekeeper #3 did not report the area on the floor in room 312. Attempted to interview Housekeeper #3 on three separate occasions were unsuccessful. An interview with the Administrator on 11/16/23 at 4:01 PM was conducted. She stated that most of the housekeeping staff were recently hired, and the Dietary Manager was in the process of training them. She indicated it was her expectation that housekeeping was to thoroughly clean each room and common areas. 2. An observation of room 318 on 11/13/23 at	F 584	3:26 PM was condicleaning of residen mopping, wiping fu bathroom. She veri housekeeper for ro already cleaned roo observation was condicted to clean the albecause she did not hardened substant and crumbs were in the spill would have up off the floor. She there. She further shousekeeping staff was in the process Housekeeping Mar was the housekeep 11/13/23-11/15/23. Housekeeper #3 difloor in room 312. Attempted to intervise parate occasions. An interview with the 4:01 PM was conditing the housekeeping staff was in the process Housekeeping Mar was the housekeep #3 difloor in room 312.	trooms involved sweeping, rniture down, and cleaning the fied that she was the om 312 and that she had om 312 today (11/16/23). An inducted with Housekeeper #1 #2 of the area of tan dried the on the floor. She stated she trea up but could not get it up to thave anything to scrape the tree off the floor. The dental floss to longer on the floor. The Housekeeping Manager on the was conducted. She stated to be scrapped or scrubbed to was unaware the area was stated that most of the were recently hired, and she of training them. The training them. The training them the area on the stated do not report the area on the see the Administrator on 11/16/23 at fucted. She stated that most of staff were recently hired, and the training them the area on the see were unsuccessful.	F	584	the in-service has been completed. The education was included in the new hire orientation by the DON on 12/15/23. The Housekeeping Supervisor added a new housekeeping orientation on 12/15/23. The Administrator or designee will conduct 10 room inspections weekly x weeks for cleanliness, then 5 rooms weekly x 4 weeks then 2 rooms weekly 4 weeks. The Administrator will be responsible for bringing the room cleanliness audit resto the Quality Assurance Performance Improvement (QAPI)meeting x 3 consecutive months. At this time, the QAPI committee will determine the need to continue the room cleanliness audits.	is ne v 4 x x or ults	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345131	B. WING _			C 1/17/2023	
NAME OF PROVIDER OR SUPPLIER CEDAR HILLS CENTER FOR NURSING AND REHABILITATION		JRSING AND REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CO 3905 CLEMMONS ROAD CLEMMONS, NC 27012	•	11/11/2020	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 584	administration cup. A bed and one besconditioner (PTAC unit and on the floor An observation of AM revealed two 3 administration cup. A bed and one besconditioner (PTAC unit and on the floor An observation of Resident #4 was can AM. Observation of American administration administration administration administration of American administration of American administration cup. A hed and one besconditioner (PTAC unit and on the floor An interview with the tall 1/16/23 at 3:33 P daily cleaning of resweeping, mopping cleaning the bathrosterican and one besconditioner (PTAC unit and on the floor An interview with the tall 1/16/23 at 3:33 P daily cleaning of resweeping, mopping cleaning the bathrosterican and one besconditioner (PTAC unit and on the floor tall 1/16/23 at 3:33 P daily cleaning of resweeping, mopping cleaning the bathrosterican and the floor tall 1/16/23 at 3:33 P daily cleaning the bathrosterican and the floor tall 1/16/23 at 3:33 P daily cleaning the bathrosterican and the floor tall 1/16/23 at 3:33 P daily cleaning the bathrosterican and the floor tall 1/16/23 at 3:33 P daily cleaning the bathrosterican and the floor tall 1/16/23 at 3:33 P daily cleaning the bathrosterican and the floor tall 1/16/23 at 3:33 P daily cleaning the bathrosterican and the floor tall 1/16/23 at 3:33 P daily cleaning the bathrosterican and the floor tall 1/16/23 at 3:33 P daily cleaning the bathrosterican and the floor tall 1/16/23 at 3:33 P daily cleaning the bathrosterican and the floor tall 1/16/23 at 3:33 P daily cleaning the bathrosterican and the floor tall 1/16/23 at 3:33 P daily cleaning the bathrosterican and the floor tall 1/16/23 at 3:33 P daily cleaning the bathrosterican and the floor tall 1/16/23 at 3:33 P daily cleaning the bathrosterican and the floor tall 1/16/23 at 3:33 P daily cleaning the bathrosterican and the floor tall 1/16/23 at 3:33 P daily cleaning the bathrosterican and the floor tall 1/16/23 at 3:33 P daily cleaning the floor tall 1/16/23 at 3:33 P daily cleaning the floor tall 1/16/23 at 3:33 P dai	I two 30ml clear medication son floor, one under the foot of side the packaged terminal air unit. Crumbs on top of PTAC or throughout room. Toom 318 on 11/15/23 at 11:22 Oml clear medication son floor, one under the foot of side the packaged terminal air unit. Crumbs on top of PTAC or throughout room. Toom 318 and interview with conducted on 11/16/23 at 8:40 evealed two 30ml clear stration cups on floor, one bed and one beside the air conditioner (PTAC) unit. PTAC unit and on the floor she stated her floor was always ands and trash on the floor. She usekeepers don 't sweep and or when they enter the room. Toom 318 on 11/16/23 at 9:12 Oml clear medication son floor, one under the foot of side the packaged terminal air unit. Crumbs on top of PTAC or throughout room. The Housekeeping Manager on Manager on Manager on She was unaware the kept this week. She indicated	F	584			

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345131	B. WING		C 11/17/2023	
	ROVIDER OR SUPPLIER	SING AND REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 3905 CLEMMONS ROAD CLEMMONS, NC 27012	11/11/2023	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION	
F 641 SS=D	to her attention. She the housekeeping stashe was in the proces. An interview with the 4:01 PM was conducted the housekeeping state the Dietary Manager training them. She in expectation that houselean each room and Accuracy of Assessm CFR(s): 483.20(g). §483.20(g) Accuracy The assessment must resident's status. This REQUIREMENT by: Based on observation record review the fact Minimum Data Set (If failed to accurately a and participation in the setting, and for insulance Resident #184 and Fresidents reviewed for 1. Resident #185 was 10/28/23 with diagnor renal disease and definition of the setting o	e room had not been brought further stated that most of aff were recently hired, and so of training them. Administrator on 11/16/23 at sted. She stated that most of aff were recently hired, and was in the process of dicated it was her sekeeping was to thoroughly a common areas.	F 54	Residents #185, 184, and 54, Minimi Data Set (MDS) was modified on 12/1 by the MDS Nurse. On 12/15/23, an MDS accuracy audit residents for cognition status, and an MDS accuracy audit for residents receiving insulin was conducted by the MDS Consulting Group. Any residen had inaccurate coding in cognition or insulin was modified by the MDS Coordinator on 12/15/23. The MDS Consultant educated the M nurse on proper coding on the MDS. education was completed on 12/15/23.	for e t who DS This 3.	
		are plan dated 10/28/23 185 was alert and oriented se and situation).		The Regional Clinical Reimbursemen Consultant will conduct 10 MDS audit MDS accuracy related to cognition ar insulin injections x 4 weeks, then 5 au	is for nd	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345131	B. WING			·	C 47/2022	
NAME OF P	ROVIDER OR SUPPLIER	0.40101	1		TREET ADDRESS, CITY, STATE, ZIP CODE	11/	17/2023	
		RSING AND REHABILITATION		39	005 CLEMMONS ROAD LEMMONS, NC 27012			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 641	11/01/23 documenter was not assessed, a revealed his memory. An interview with the 12:58 pm indicated a facility and was not it cognition section. Showing a section section is facility and do the state cognition section showith Resident #185 kso. 2. Resident #184 was 10/27/23 with diagnor obstructive pulmonar disease, and peripher revealed Resident # communicate with staff. Review of baseline or revealed Resident # communicate with staff. Review of Resident assessment dated 1 Resident's cognition assessment indicated. An interview with the 12:58 pm indicated a facility and was not it cognition section. Shown on the complete of the MDS was not complete, slipping and was not complete.	sion MDS assessment dated d Resident #185 cognition and staff assessment was ok. MDS Nurse on 11/16/23 at the worked remotely for the interpretation to the facility to do the neindicated when she and if the cognition section he would talk with staff in the aff section. She stated the build have been completed because he was able to do as admitted to the facility on the interpretation of the facility on the sis that included chronic may disease, coronary artery the eral vascular disease. The provided the facility on the facility on the sis that included chronic may disease, coronary artery the eral vascular disease. The provided the facility on the facility on the sis that included chronic may disease, coronary artery the eral vascular disease.	F	641	weekly x 4 weeks then 1 MDS weekly weeks. The Administrator will be responsible for bringing the MDS accuracy audit result the Quality Assurance Performance Improvement (QAPI)meeting x 3 consecutive months. At this time, the QAPI committee will determine the neet to continue the MDS accuracy audits. Date of Compliance: 12/15/23	or s to		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345131	B. WING _			C 1/17/2023	
	ROVIDER OR SUPPLIER	RSING AND REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP COI 3905 CLEMMONS ROAD CLEMMONS, NC 27012		1/1//2023	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 641	Continued From pag	ge 13	F 6	41			
	•	ould have been completed because he was able to do					
	Nursing on 11/16/23 she expected the MI completed with the r cognition accurately 3. Resident #54 was	nducted with the Director of at 2:30 pm and she indicated DS assessments to be esidents to reflect their initially admitted to the with diagnoses that included					
	assessment dated 9 #54 received one inj	erly Minimum Data Set (MDS) /23/23 indicated Resident ection of insulin during the ed at for the 9/23/23					
	(MAR) for September received dulaglutide to improve blood sugmilligram (mg) subcubetween the skin and Review of the MAR Resident #54 receivinjectable insulin) on 9/17/23, 9/18/23, 9/2	eations Administration Record er 2023 showed Resident #54 (once a week injection used gar) an injection of 0.75 utaneously (under the skin, d muscle) on 9/21/23. for September 2023 showed ed insulin lispro (fast acting a the following days: 9/16/23, 20/23, 9/21/23, and 9/22/23.					
	P.M. with the MDS N reviewed the quarter inaccurate. MDS Nu looked at Resident # medication dulaglutic enough down the MA	Nurse #2 . MDS Nurse #2 rly MDS and confirmed it was rse #2 stated when she #54's MAR she only saw the de and did not scroll far AR to see Resident #54 had ro. The MDS nurse stated it					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345131	B. WING		C 11/17/2023
	ROVIDER OR SUPPLIER	RSING AND REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 3905 CLEMMONS ROAD CLEMMONS, NC 27012	11/11/2023
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 641	P.M. with the Direct the interview, the Di assessment should unable to provide a insulin injections was Develop/Implement CFR(s): 483.21(b)(1) The fill should be shou	conducted on 11/16/23 at 2:32 or of Nursing (DON). During ON stated the MDS be accurate, and she was reason why the number of as not accurate. Comprehensive Care Plan 11/(3) Comprehensive person-centered esident, consistent with the corth at §483.10(c)(2) and includes measurable frames to meet a resident's and mental and psychosocial tified in the comprehensive comprehensive care plan must are to be furnished to attain dent's highest practicable and psychosocial well-being as 3.24, §483.25 or §483.40; and the would otherwise be required 3.25 or §483.40 but are not resident's exercise of rights uding the right to refuse 33.10(c)(6). Services or specialized es the nursing facility will	F 64		12/15/23
	findings of the PASA rationale in the resid	If a facility disagrees with the ARR, it must indicate its dent's medical record.			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345131	B. WING _		,	C 11/17/2023
	ROVIDER OR SUPPLIER	RSING AND REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 3905 CLEMMONS ROAD CLEMMONS, NC 27012	<u>'</u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	JMMARY STATEMENT OF DEFICIENCIES ID DEFICIENCY MUST BE PRECEDED BY FULL PREFIX ATORY OR LSC IDENTIFYING INFORMATION) TAG		PROVIDER'S PLAN OF CORRECTIVE ACTION SH ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 656	desired outcomes. (B) The resident's pr future discharge. Fa whether the resident community was asse local contact agencie entities, for this purp (C) Discharge plans plan, as appropriate requirements set for section. §483.21(b)(3) The se by the facility, as out care plan, must- (iii) Be culturally-con This REQUIREMEN by: Based on record re- interviews, the facilit individualized and co interventions after fa resident at risk for pr incontinence (Reside plan a wanderguard 3 of 20 residents wh reviewed. The findings include 1. Resident #15 was 12/31/22 with diagno Dementia with psych of falls. The quarterly Minimi assessment dated 0	ative(s)- pals for admission and reference and potential for cilities must document respect to return to the ressed and any referrals to researd/or other appropriate researd/or other researd/or ot	F6	Resident #15 care plan was upon interventions for all falls since 6-This was completed by the Minims Set (MDS) Nurse on 12/15/23. Resident #14 care plan was upon 12/15/23 by the MDS Nurse for work and wander guard. Resident #14 care plan was upon 12/15/23 by the MDS Nurse for work and wander guard. Resident care plans were audite pressure risk, urinary incontinent wander risk, wander guard. This was completed on 12/15/23 by the MDS Nurse for work and wander guard. This was completed on 12/15/23 by the MDS con Any care plan(s) that were incorrected by the MDS Nurse on The MDS Consultant educated the Nurse on accurate care planning residents. This education was consultant education.	28-23. mum Data Resident 2/15/23 essure ce. ated on wander d for falls, ce and s audit ne nsultant. rect, were 12/15/23. he MDS y for all	

NAME OF PROVIDER OR SUPPLIER CEDAR HILLS CENTER FOR NURSING AND REHABILITATION (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 656 Continued From page 16 behavior and no rejection of care. He required extensive assistance of 2 for bed mobility, dressing, and personal hygiene. He had 2 or more falls with no injuries. Resident #15 's active care plan, last revised on 08/21/23, included a focus for Resident #15 being at risk for falls related to impaired mobility, lower extremity amputee, and the use of psychotropic medications. (Initiated: 01/14/23) included for staff to be sure resident's call bell was within reach and encourage the resident to use it for	TEMENT OF DEFICIE PLAN OF CORRECT	`	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	IPLE CONSTRUCTION	(X3) DATE : COMPL	
AMME OF PROVIDER OR SUPPLIER CEDAR HILLS CENTER FOR NURSING AND REHABILITATION (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 656 Continued From page 16 behavior and no rejection of care. He required extensive assistance of 2 for bed mobility, dressing, and personal hygiene. He had 2 or more falls with no injuries. Resident #15's active care plan, last revised on 08/21/23, included a focus for Resident #15 being at risk for falls related to impaired mobility, lower extremity amputee, and the use of psychotropic medications. (Initiated: 01/14/23). The interventions (Initiated: 01/14/23) included for staff to be sure resident's call bell was within reach and encourage the resident to use it for			3/5131	B WING			
CEDAR HILLS CENTER FOR NURSING AND REHABILITATION CLEMMONS, NC 27012			343131	B. WING_		11/1	17/2023
CLEMMONS, NC 27012 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 656 Continued From page 16 behavior and no rejection of care. He required extensive assistance of 2 for bed mobility, dressing, and personal hygiene. He had 2 or more falls with no injuries. Resident #15's active care plan, last revised on 08/21/23, included a focus for Resident #15 being at risk for falls related to impaired mobility, lower extremity amputee, and the use of psychotropic medications. (Initiated: 01/14/23) The interventions (Initiated: 01/14/23) included for staff to be sure resident's call bell was within reach and encourage the resident to use it for	ME OF PROVIDER O	ROVIDER OR SUPPLIER			, , ,		
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F 656 Continued From page 16 behavior and no rejection of care. He required extensive assistance of 2 for bed mobility, dressing, and personal hygiene. He had 2 or more falls with no injuries. Resident #15 's active care plan, last revised on 08/21/23, included a focus for Resident #15 being at risk for falls related to impaired mobility, lower extremity amputee, and the use of psychotropic medications. (Initiated: 01/14/23). The interventions (Initiated: 01/14/23) included for staff to be sure resident's call bell was within reach and encourage the resident to use it for					CLEMMONS, NC 27012		
behavior and no rejection of care. He required extensive assistance of 2 for bed mobility, dressing, and personal hygiene. He had 2 or more falls with no injuries. Resident #15's active care plan, last revised on 08/21/23, included a focus for Resident #15 being at risk for falls related to impaired mobility, lower extremity amputee, and the use of psychotropic medications. (Initiated: 01/14/23). The interventions (Initiated: 01/14/23) included for staff to be sure resident's call bell was within reach and encourage the resident to use it for on 12/15/23. The MDS Consultant will audit 5 resident care plans weekly x 4 weeks for fall interventions, pressure risk, urinary incontinence and wandering or wander guard, then 3 resident care plans weekly x 4 weeks then 1 resident care plan weekly x 1 week. The Administrator will be responsible for bringing the care plan audit results to the Quality Assurance Performance Improvement (QAPI)meeting x 3 consecutive months. At this time, the	PREFIX ((EACH DEFICIENCY N	MUST BE PRECEDED BY FULL	PREFIX	((EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	BE	(X5) COMPLETION DATE
assistance as needed. Residents need a prompt response to all requests for assistance, follow facility fall protocol, and Physical Therapy (PT) to evaluate and treat as ordered. An intervention for staff to offer to get resident out of bed upon rising (initiated on 08/18/23). The care plan revealed no focus for Resident #15 having actual falls. Incident reports revealed Resident #15 had six falls between 06/28/23 and 09/14/23 without injuries. Incident report dated 06/13/23 revealed Resident #15 slid out of bed onto the floor. No focus or interventions were added to the care plan. An incident report dated 07/26/23 revealed he attempted to transfer himself from bed unassisted and fell. No focus or interventions were added to the care plan. An incident report dated 08/02/23 revealed he was located on the floor in his room. No focus or interventions were added to the care plan. An incident report dated 08/02/23 revealed Resident #15 rolled out of bed while sleeping. No focus or interventions were added to the care plan. An incident report dated 08/18/23 revealed Resident #15 rolled out of bed while sleeping. A focus that read	behavior extensive dressing more far the last of the extremit medical interver staff to reach a assistant responsifacility for evaluate staff to (initiated focus for last of the extensive focus for last of the extensive focus of plan. And he attern unassist were acted to the extensive focus of plan and last of the extensive focus of the extensive foc	behavior and no rejectic extensive assistance of dressing, and personal more falls with no injurious (No. 1/23), included a focat risk for falls related to extremity amputee, and medications. (Initiated: interventions (Initiated: staff to be sure resident reach and encourage the assistance as needed. response to all requests facility fall protocol, and evaluate and treat as of staff to offer to get reside (initiated on 08/18/23). focus for Resident #15 Incident reports revealed falls between 06/28/23 injuries. Incident report Resident #15 slid out of focus or interventions with plan. An incident report he attempted to transfe unassisted and fell. No were added to the care dated 07/28/23 revealed floor in his room. No focat added to the care plan. 08/02/23 revealed Resignal while sleeping. No focula added to the care plan. report dated 08/18/23 r	ion of care. He required of 2 for bed mobility, I hygiene. He had 2 or ies. care plan, last revised on ocus for Resident #15 being to impaired mobility, lower d the use of psychotropic 01/14/23). The 01/14/23) included for at's call bell was within the resident to use it for Residents need a prompt is for assistance, follow d Physical Therapy (PT) to ordered. An intervention for dent out of bed upon rising The care plan revealed no having actual falls. ded Resident #15 had six and 09/14/23 without to dated 06/13/23 revealed of bed onto the floor. No were added to the care to dated 07/26/23 revealed for bed onto the floor. No were added to the care to dated 07/26/23 revealed for bed onto the floor. An incident report ded he was located on the cus or interventions were. An incident report dated ident #15 rolled out of bed as or interventions were. An incident revealed Resident #15	F 6	on 12/15/23. The MDS Consultant will audit 5 residence plans weekly x 4 weeks for fall interventions, pressure risk, urinary incontinence and wandering or wander guard, then 3 resident care plans week 4 weeks then 1 resident care plan week x 1 week. The Administrator will be responsible bringing the care plan audit results to Quality Assurance Performance Improvement (QAPI)meeting x 3 consecutive months. At this time, the QAPI committee will determine the new to continue the care plan audits.	er kly x ekly for the	

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345131	B. WING _			11/1	; 17/2023
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	, ZIP CODE	1 11/	172020
CEDAR H	LLS CENTER FOR NUR	SING AND REHABILITATION		3905 CLEMMONS ROAD CLEMMONS, NC 27012			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION TE ACTION SHOULD BI D TO THE APPROPRIA CIENCY)		(X5) COMPLETION DATE
F 656	Continued From page		F	656			
	intervention that read out of bed upon rising Incident report dated #15 slid out of bed or interventions were ac. The Director of Nursi on 11/16/23 at 11:15 aware of Resident #1 but was unaware the planned. She also staduring the morning m Data Set (MDS) nurs plan according to the Nurse #1 had been on had not been present DON indicated she will during the time Minim #1 was out on matern she should have care falls and felt it was ar not added to the care care plans should be have included Reside interventions. The Administrator was 3:57 PM, and stated care plan to be person included Resident #1 2. Resident #78 was 09/08/23 with diagno obstructive pulmonar infarction, and chronical intervention.	ng (DON) was interviewed AM. She indicated she was 5 having a couple of falls falls had not been care ated falls were discussed leetings and the Minimum e would update the care root cause of the fall. MDS at on maternity leave and at for morning meetings. The ras to update the care plans from Data Set (MDS) Nurse for morning meetings. The ras to update the care plans from Data Set (MDS) Nurse for planned Resident #15 's an oversite that the falls were a plan. She then indicated the person centered and should ent #15's falls and sinterviewed on 9/13/23 at it was her expectation for the in centered and should have 5's falls with interventions. admitted to the facility on sees including chronic y disease, history of cerebral					
	(MDS) dated 09/18/2	3 revealed Resident #78 and needed extensive					

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345131	B. WING _			11/) 17/2023
	ROVIDER OR SUPPLIER	SING AND REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP 3905 CLEMMONS ROAD CLEMMONS, NC 27012	CODE	, .,,	11/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN O X (EACH CORRECTIVE AC	TION SHOULD BE THE APPROPRIA		(X5) COMPLETION DATE
F 656	assistance with 1-per mobility, 1-person ph supervision with setu supervision with 1-per toilet use. Further reverses and the supervision with 1-per toilet use. Further reverses and the supervision with 1-per toilet use. Further reverses and the supervision with 1-per toilet use. Further reverses and the supervision was at was incontinent of blain dicated pressure ultincontinence were as a supervision of the compression was at 10-1 per supervision was correctly and should have been she worked as needed care plans completed. 3. Resident #14 was 12/16/22 with diagnor disease, dementia was 12/16/22 with diagnor disease, dementia wand anxiety. Resident #14'a physical read "wanderguard of and function every niplacement order was 12/12/23 showed cognitively impaired, behaviors, and he usualarm daily. Review of Resident #14 was 12/12/23 showed cognitively impaired, behaviors, and he usualarm daily.	rson physical assist with bed hysical assist with transfers, phelp with eating, and erson physical assist with view of the MDS revealed risk for pressure ulcers and adder. Section V of the MDS cer risk and urinary didressed in the care plan. The prehensive care plan for ead no care plans for pressure incontinence was developed. The prehensive care plan for ead no care plans for pressure incontinence was developed. The prehensive care plan for ead no care plans for pressure incontinence was developed.	F	656			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345131	B. WING _		11	C / 17/2023
	ROVIDER OR SUPPLIER	SING AND REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 3905 CLEMMONS ROAD CLEMMONS, NC 27012		71172020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SI	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 656	Continued From page	e 19	F 6	56		
		o disoriented to place. The er care area was initiated on				
	P.M. with the MDS not reviewed the quarter and confirmed Residurequired to be updated order was created or dated 5/12/23 was conceeded the confirmed resident #14 used a reviewed at the model of the mo	ducted on 11/16/23 at 12:45 urse. The MDS nurse ly assessment dated 5/12/23 ent #14's care plan was ed either when the physician when the MDS assessment ompleted and showed wanderguard. The MDS provide a reason Resident not updated.				
F 677 SS=E	P.M. with the Directo DON stated care plan timely manner. The D Resident #14 had the April 2023, his care p updated at that time further explained who assessment dated 5/ Resident #14's care p updated to reflect his	or Dependent Residents	F 6	77		12/15/23
	out activities of daily services to maintain personal and oral hyd This REQUIREMENT by: Based on observation interviews, and staff	dent who is unable to carry living receives the necessary good nutrition, grooming, and giene; is not met as evidenced on, record review, resident interviews, the facility failed or dependent residents		Residents # 15, 19, and 40, na cleaned, trimmed and filed on 1 the floor nurse. Resident #64□s	1/16/23 by	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
				_		(С
		345131	B. WING _			11/	17/2023
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CEDAR U	LLC CENTED FOR NUI	DOING AND DELIABILITATION		39	905 CLEMMONS ROAD		
CEDAR HI	LLS CENTER FOR NUI	RSING AND REHABILITATION		С	LEMMONS, NC 27012		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	•	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	<	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 677	Continued From page	ge 20	F 6	677			
	(Resident #15, #19,	esident #15, #19, and #40) and failed to wash washed on 11/14/23 by a floor certified					
	a dependent residents (Resident #64) hair. This				nursing assistant.		
		dents reviewed for activities of			All in house residents were assessed for	or	
	daily living (ADL).				nail care on 12/13/23 by the Activities		
	Director or assistant. Any resident four		nd				
	The findings include	ed:			to have long, unclean, or jagged nails,		
	were cleaned, filed and trimmed to		were cleaned, filed and trimmed to				
	1. Resident #15 was admitted to the facility on			resident preference. This was completed			
		osis that included Vascular			by the Director of Nursing (DON) on		
		hotic disturbance, history of			12/13/23. All in house residents□ hair \	vas	
	falls, and type 2 diabetes.				audited for cleanliness on 12/13/23 by		
		Activities. Any resident who needed					
	The quarterly Minim	` ,			his/her hair washed; this was complete	a	
		08/18/23 indicated Resident severely impaired. He had no			on 12/15/23 by nursing staff. The Director of Nursing initiated an		
	_	ection of care. He required			in-service on nail care and washing		
		e of 2 for personal hygiene.			residents□ hair to all licensed nurses, a	and	
		o of 2 for porconar myglone.			certified nursing assistants. This	ario	
	Resident #15 's act	ive care plan, last revised on			in-service was completed on 12/15/23.		
		he had an ADL self-care			No staff was allowed to work after		
	performance deficit				12/15/23 if the in-service on nail care a	nd	
	impairment, weakne	•			hair washing was not completed. This		
		ed for staff to check nail			in-service was added to the new hire		
		an on bath day and as			orientation by the Director of Nursing o	n	
	necessary. Report a	any changes to the nurse. The			12/15/23.		
	•	tensive to total care of one			The Administrator or Designee will		
	staff with personal h	ygiene and			conduct 20 resident audits on nail care		
	bathing/showering.				and hair washing weekly x 4 weeks, the		
					10 residents weekly x 4 weeks then on	е	
		t #15's nursing progress			resident monthly x 1 month.		
		3 to 11/17/23 revealed resident			The Administrator will be responsible for		
		on 10/03/23 and 09/13/23. No			bringing the nail care and hair washing		
	refusals of nail care	аоситениеа.			audit results to the Quality Assurance Performance Improvement		
	An observation and	interview with Resident #15			(QAPI)meeting x 3 consecutive months		
		11/13/23 at 11:16 AM. The			At this time, the QAPI committee will	·.	
		d Resident #15 's fingernails			determine the need to continue the nail		
	on his left and right				care and hair washing audits.	'	
		o 1/2 of an inch beyond his			Date of Compliance: 12/15/23		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
		345131	B. WING			C 11/17/2023
	ROVIDER OR SUPPLIER	RSING AND REHABILITATION		STREET ADDRESS, CITY, STATE 3905 CLEMMONS ROAD CLEMMONS, NC 27012	E, ZIP CODE	11/1//2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTI) CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIA FICIENCY)	
F 677		fingernails on the left and	F 6	577		
	an interview with Re	own/black substance. During sident #15 he stated he but the staff have not cut				
	were conducted on observation revealed	interview with Resident #15 11/15/23 at 9:12 AM. The d Resident #15 's fingernails rty. Resident stated no one clean his nails.				
	with Nurse #1 on 11, observation revealed were still long and di Resident #15's fing She stated Nursing A care when doing she a resident refused the she would call the R them know and then nurse's notes. She refused baths/showere	interview were conducted (15/23 at 10:01 AM. The discrete High Properties of the High Prope				
	11/15/23 at 12:38 PM #1. NA #1 was not the had worked with Resiste performed nail coare, showers/baths stated Resident #15 can be combative at his nails needed to be when she last gave to the state of	interview were conducted on M with Nursing Assistant (NA) ne direct care NA this shift but sident #15 often. She stated are when performing ADL and as needed. She also refused care at times and times. She had not realized be cut. She could not recall him a shower.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345131	B. WING _				C 17/2023
NAME OF P	ROVIDER OR SUPPLIER			STREE	T ADDRESS, CITY, STATE, ZIP CODE	1 11/	11/2020
CEDABL	II I & CENTED FOR NUE	RSING AND REHABILITATION		3905 C	CLEMMONS ROAD		
CEDAK H	ILLS CENTER FOR NUP	SING AND REHABILITATION		CLEM	IMONS, NC 27012		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 677	Continued From pag	ne 22	F 6	677			
	stated nail care was	1/16/23 at 11:17 AM. She to be looked at daily and on at nails should be cleaned					
	08/22/19 with diagno	admitted to the facility on oses that included Dementia, order, and congestive heart					
	#19's cognition was no behavior and no	9/05/23 indicated Resident severely impaired. She had rejection of care. She ssistance of 1 with bathing					
	08/25/23, indicated s ADL's related to uns safety awareness. T	e care plan, last revised on she needed assistance with teady gait and impaired he interventions included for ent #19 with personal hygiene week and prn.					
	notes from 06/20/23	t #19's nursing progress to 11/15/23 revealed resident on 10/03/23. No refusals of d.					
	were conducted on observation revealed on her left and right approximately 1/4 to fingertips. Right hand An observation was 10:50 AM of Resider	interview with Resident #19 11/13/23 at 10:15 AM. The d Resident #19 's fingernails hands extended 1/2 of an inch beyond her d middle finger was jagged. conducted on 11/15/23 at nt #19. The observation 19 's fingernails were still					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345131	B. WING			C
	ROVIDER OR SUPPLIER	SING AND REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP COE 3905 CLEMMONS ROAD CLEMMONS, NC 27012		11/17/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 677	verified she was the #19. She indicated sh morning but did not to stated she did not reaneeded to be cut. Sh care when doing sho An interview was cor Assistant (NA) #2 on verified she was the #19's room. She stamorning care with reaneded to be cut. Sh care when doing sho An interview was cor Nursing (DON) on 11 stated nail care was shower days and tha and cut as needed. 3. Resident #40 was 12/31/22 with diagnos Disease. A review of Resident notes from 05/26/23 had no refusals for boof nail care documen. The admission Minimassessment dated 10	ducted with Nursing 11/15/23 at 11:15 AM. She direct care NA for Resident ne bathed Resident #19 this rim or file her nails. She alize Resident #19 's nail e stated she performed nail wers/baths and as needed. ducted with Nursing 11/16/23 at 8:50 AM. She direct care NA for Resident atted she had just completed sident #19. NA #2 verified sident #19. NA #2 verified sident were long and needed to she did not realize her nails e stated she performed nail wers/baths and as needed. ducted with the Director of /16/23 at 11:17 AM. She to be looked at daily and on at nails should be cleaned admitted to the facility on sis that included Parkinson ' #40's nursing progress to 11/17/23 revealed resident ath/showers and no refusals ted.	F6	777		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345131	B. WING _				C 17/2023
NAME OF PI	ROVIDER OR SUPPLIER	<u> </u>		STREET ADD	DRESS, CITY, STATE, ZIP CODE	1 117	1772020
CEDAR H	ILLS CENTER FOR NUR	SING AND REHABILITATION		3905 CLEMN	MONS ROAD		
OLDARII	ELO GENTER I GIVINON	SING AND REMADILITATION		CLEMMON	IS, NC 27012		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E ROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 677	Continued From pag	e 24	F 6	677			
		ction of care. He required aths/showers and personal					
	11/12/22, indicated h performance deficit r impairment, weaknes interventions include length, trim and clear necessary. Report ar	es and debility. The d for staff to check nail n on bath day and as ny changes to the nurse. d extensive to total care of					
	were conducted on 1 observation revealed on his left and right h approximately 1/4 to fingertips. During an	nterview with Resident #40 1/13/23 at 10:30 AM. The Resident #40 's fingernails ands extended 1/2 of an inch beyond his interview with Resident #40 asked if he wanted his nails					
	with Nurse #1 on 11/ observation revealed were still long and di Resident #40 's fing Nursing Assistants (I doing showers/baths refused the NA would call the Responsible and then document t notes.	ernails were long. She stated NAs) perform nail care when and as needed. If a resident d notify her and she would Party (RP) to let them know he refusal in the nurse 's					
	11/15/23 at 12:38 PN	nterview were conducted on I with Nursing Assistant (NA) e direct care NA this shift but					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345131	B. WING _			C 11/17/2023	
	ROVIDER OR SUPPLIER	SING AND REHABILITATION		STREET ADDRESS, CITY, STATE, 3905 CLEMMONS ROAD CLEMMONS, NC 27012	ZIP CODE	11111112020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE O TO THE APPROPRIA CIENCY)		
F 677	she performed nail care, showers/baths realized Resident #4 She could not recall shower. An interview was corn Nursing (DON) on 11 stated nail care was shower days and that and cut as needed. 4. Resident #64 was 3/24/23 with diagnos and hemiparesis follosubarachnoid hemornon-dominant side, The quarterly Minimum.	ident #40 often. She stated are when performing ADL and as needed. She had not 0 's nails needed to be cut. when she last gave him a adducted with the Director of /16/23 at 11:17 AM. She to be looked at daily and on the nails should be cleaned admitted to the facility on its that included Hemiplegia owing nontraumatic rhage affecting left at the part of the part o	F	677			
	hygiene. Resident #64 's active 09/18/23, indicated so performance and requestion of one/two staff with bathing/showering, not toileting, transfer, and on shower days, and nurse. Further review that Resident #64 was anxiety. Review of Resident #	n of Resident getting her hair					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345131	B. WING _			C 11/17/2023
	ROVIDER OR SUPPLIER	RSING AND REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 3905 CLEMMONS ROAD CLEMMONS, NC 27012	'	111112929
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 677	Continued From page	ge 26	F 6	77		
		tesident #64 was conducted pm. Resident's hair observed				
	conducted on 11/14 #64 and she indicat	on, an interview was /23 at 1:30 pm with Resident ed her hair had not been veeks. Resident #64's hair				
	conducted of NA #6 Resident #64. The #6 asked Resident	am an observation was i, perform ADL care on ADL care was completed, NA did she wanted her hair isident stated no because it eded to be washed.				
	11/15/23 at 9:40 am #64 did not want he facility did not have #6 stated that Resid as she can for herse hair washed because hand hair dryer or a	and she indicated Resident or hair washed because the a hair dryer to dry her hair. NA dent #64 wants to do as much elf but did not like to have her se the facility did not have a hairdresser that could do her d the facility did not have a				
		ne shower room were 23 at 9:30am, revealed no hair				
	11/16/23 at 2:30 pm hair had not been w the facility did not ha	onducted with Resident #64 on n. Resident #64 indicated her rashed since 9/23/23 because ave a hand hair dryer and they e to do ethnic hair. Resident				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345131	B. WING		C 11/17/2023	
	ROVIDER OR SUPPLIER	SING AND REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 3905 CLEMMONS ROAD CLEMMONS, NC 27012		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION	
F 677	Continued From page #64 stated she would	e 27 I love to get her hair done.	F 6	77		
		was conducted on 11/17/23 ent #64. Resident's hair				
F 684 SS=D	indicated her expecta ADL care daily, include	nducted with the 17/23 at 2:36 pm and she ation for residents to receive ding their hair being washed by the staff in the facility.	F 6	84	12/15/23	
	applies to all treatme facility residents. Bas assessment of a resident residents receive accordance with prof practice, the compredicare plan, and the resident resident resident resident resident reviewe the physician's order and for a skin tear to a Resident #78). The findings included Resident #78 was ad 09/08/23 with diagno	Indamental principle that Int and care provided to It is ded on the comprehensive Ident, the facility must ensure It is treatment and care in It is essional standards of Inensive person-centered Is is not met as evidenced In is, record review, resident, It is facility failed to obtain a It perform dressing changes It is in the perform for 1 It is in the facility on It is including chronic It is indicated to the facility on It is including chronic It is indicated to determine the provided to the facility on It is including chronic It is indicated to the facility on It is including chronic It is included the included the including chronic It is included the including chronic It is included the i		Resident #78 s skin tear was healed when dressing was ren the floor nurse on 11/15/23. No dressing was required at that t Medical Director (MD) was not healed skin tear. No new order All in house residents were obany skin tears, order from the dressing and dressing change completed. This audit was cor 12/14/23 by the Director of Nu (DON). Any resident who had an order was verified or receiv	noved by o order for ime. iffied of rs given. served for MD for a s nducted on rsing a skin tear,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF D	ROVIDER OR SUPPLIER	0.0.0.	1		STREET ADDRESS, CITY, STATE, ZIP CODE	111/	17/2023	
NAME OF T	TOVIDER OR SOLT EIER				, , ,			
CEDAR H	LLS CENTER FOR NUR	SING AND REHABILITATION		3905 CLEMMONS ROAD				
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F 684	(MDS) dated 09/18/2 was cognitively intact assistance with 1-per mobility, 1-person physupervision with setu supervision with 1-pet toilet use. A review of progress 10:28 am read in part resident's bathroom leboth knees bent. Resat time of incident. Reorientation, pain, and (alert and oriented to situation) able to make tear to left elbow note implemented by wour distress currently. Sk treatment implemented. An observation was called a dirty gas #78's left upper arm with A review of Resident orders was conducted for skin tear to left up standing orders for skin t	sion Minimum Data Set 3 revealed Resident #78 and needed extensive son physical assist with bed ysical assist with transfers, p help with eating, and rson physical assist with note written on 11/08/23 at t, "Resident found on floor in aying in front of toilet with ident wearing nonskid socks esident assessed for injuries. Resident A&Ox4 person, place, time and te needs known. The skin ed, cleansed and treatment and care nurse. No c/o pain or in tear cleansed and ed, neuro checks initiated." conducted on 11/12/23 at tize dressing to Resident with the date of 11/08/23. #78's current physician d, and no order was noted per arm. There were no kin tears. n 11/12/23 at 4:19 pm with orted he had a fall the other and got a "cut". He stated, Resident #78 indicated he e exact day the fall	F	584	entered the resident chart. The dressin was put in place, changed, or discontinued by DON on 12/15/23. The Director of Nursing initiated an in-service on 12/14/23 for all licensed nurses to enter orders from the MD into the resident chart for skin tear dressing and to change the dressing as indicate the order. No nurse was allowed to wo after 12/15/23 if the in-service had not been completed. DON added this education to the new hire orientation of 12/15/23. The DON will conduct 5 resident observations x 4 weeks for residents whave skin tears with dressing to verify a order is in place in the resident chart at that the dressing has been changed, the 3 resident observations x 4 weeks. The Director of Nursing will be responsible for bringing the skin tear of and dressing change audit results to the Quality Assurance Performance Improvement (QAPI)meeting x 3 consecutive months. At this time, the QAPI committee will determine the need to continue the skin tear order and dressing change audits. Date of Compliance: 12/15/23	o gs d in rk n and nen n 1		
	happened, or which r on his left upper arm.	nurse put the gauze dressing						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION	, , ,	TE SURVEY MPLETED
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F 684	Continued From բ	page 29	F	584		
	of 11/08/23 remai upper arm. An interview was pm with the Wour indicated she was had sustained a significant of a skin tear and gauze dressing to indicated the Nurse	y gauze dressing with the date ned on Resident #78's left conducted on 11/14/23 at 1:00 and Care Nurse and she not aware that Resident #78 kin tear to his left upper arm. Sident #78 did not have an order dishe was not aware he had a phis left upper arm. She se should have called the				
	The Wound Care standing orders to On 11/15/23 at 9: conducted with N went to assist the bathroom floor an Resident's left up Nurse came into I immediately treat stated, "I thought she put the dress had not worked w 11/08/23 fall and visited or the standing of the standing or the standi	tained an order for the skin tear. Nurse indicated there were no or treat skin tears. 16 am an interview was surse #4, and she indicated she NA get Resident #78 off the dobserved a skin tear on per arm. She stated the Wound Resident's room and led the skin tear. Nurse #4 she wrote the orders because ing on it." She indicated she was not aware that there was reder for the skin tear to Resident				
	conducted with the stated she did not #78's skin tear but and if she did put Resident. It was N	am a follow up interview was e Wound Care Nurse, and she t remember dressing Resident t was busy the day of his fall the gauze dressing on Nurse #4's for notifying the tting the order in the computer.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		L IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 684	(DON) on 11/16/23 a was her expectation skin tear the Nurse w and get an order and treatment record.	vith the Director of Nursing t 12:13 pm, she indicated it when a resident sustained a vas to notify the Physician transcribe the order to the	F 68		40.45.400	
F 689 SS=D	CFR(s): 483.25(d)(1) §483.25(d) Accidents The facility must ens §483.25(d)(1) The re as free of accident ha §483.25(d)(2)Each re supervision and assis accidents. This REQUIREMENT by: Based on observation record review the fact cause for six falls and interventions to prevent This was for 1 of 7 re accidents. The findings included Resident #15 was acc 12/31/22 with diagnor Dementia with psych of falls. The quarterly Minimulassessment dated 08 #15's cognition was servers.	sident environment remains azards as is possible; and esident receives adequate stance devices to prevent is not met as evidenced on, staff interviews, and sility failed to identify the root d implement effective ent six falls (Resident #15). Esidents reviewed for dimitted to the facility on sis that included Vascular otic disturbance and history	F 68	Resident #15 care was corrected 12/15/23 by the Director of Nursir for fall interventions based on roo analysis. All in house residents who had fa last 30 days, the falls were review root cause analysis and fall interventions by the DON on 12/14/23. Any result who did not have a root cause an and intervention, was corrected on 12/15/23 by DON. The Director of Nursing initiated in-servicing on 12/14/23 to all lice nurses on root cause analysis and interventions. Any licensed nurse not receive this education by 12/14 was not allowed to work until this completed. The Director of Nursi	ng (DON) bit cause Ils in the wed for ventions sident halysis an ensed d fall e who did 15/23 was	

NAME OF PROVIDER OR SUPPLIER CEDAR HILLS CENTER FOR NURSING AND REHABILITATION (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 689 Continued From page 31 extensive assistance of 2 for bed mobility, dressing, and personal hygiene. He had 2 or more falls with no injuries. Resident #15 's active care plan, last revised on 08/21/23, included a focus for Resident #15 being at risk for falls related to impaired mobility, interventions (Initiated: 01/14/23). The interventions (Initiated: 01/14/23) included for staff to be sure resident's call bell was within reach and encourage the resident to use it for	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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CEDAR HILLS CENTER FOR NURSING AND REHABILITATION (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 689 Continued From page 31 extensive assistance of 2 for bed mobility, dressing, and personal hygiene. He had 2 or more falls with no injuries. Resident #15's active care plan, last revised on 08/21/23, included a focus for Resident #15 being at risk for falls related to impaired mobility, lower extremity amputee, and the use of psychotropic medications. (Initiated: 01/14/23). The interventions (Initiated: 01/14/23) included for staff to be sure resident's call bell was within reach and encourage the resident to use it for			345131	B. WING _			11/17/2023		
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extensive assistance of 2 for bed mobility, dressing, and personal hygiene. He had 2 or more falls with no injuries. Resident #15 's active care plan, last revised on 08/21/23, included a focus for Resident #15 being at risk for falls related to impaired mobility, lower extremity amputee, and the use of psychotropic medications. (Initiated: 01/14/23). The interventions (Initiated: 01/14/23) included for staff to be sure resident's call bell was within reach and encourage the resident to use it for added this to the new hire orientation for licensed nurses on 12/15/23. The Director of Nursing or designee will review all falls weekly for root cause analysis and fall interventions x 12 weeks. The Director of Nursing will be responsible for bringing these audit results to the Quality Assurance Performance Improvement Committee improvement Committee will determine	PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	×	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		COMPLETION	
assistance as needed. Residents need a prompt response to all requests for assistance, follow facility fall protocol, and Physical Therapy (PT) to evaluate and treat as ordered. An intervention for staff to offer to get resident out of bed upon rising (initiated on 08/18/23). The care plan revealed no focus for Resident #15 having an actual fall. a. A incident report dated 06/13/23 revealed Resident #15 was observed sitting on his buttocks on the floor beside his bed with no injuries. The resident 's description was that he slid out of bed onto the floor. No focus or interventions were added to the care plan. No investigation to include root cause of fall noted. b. A incident report dated 07/26/23 revealed Resident #15 was observed sitting on floor, leaning against his bed with no injuries. The resident 's description was that he thought he might get up but did not know that he was not strong enough. No focus or interventions were added to the care plan. No investigation to include root cause of fall noted. c. A incident report dated 07/28/23 revealed Resident #15 was observed on floor in his room	F Case riii s raa r f e s () f a F Liii s iii Li F III r r s a iii c c	extensive assistance dressing, and person more falls with no injunct and person more falls with no injunct falls with no injunct falls with no injunct falls related and trisk for falls related extremity amputee, a medications. (Initiate interventions (Initiate fall to be sure reside reach and encourage assistance as needed response to all requestable for an and treat as staff to offer to get response to facility fall protocol, a evaluate and treat as staff to offer to get response for Resident #15 was obtout for the floor injuries. The resident #15 was obtout for the floor injuries. The resident fall out of bed onto the floor injuries. The resident #15 was obtout for the floor injuries were according to the floor injuries. A incident report definition of the floor injuries were according to the floor injuries were according to the floor include the floor injuries. A incident report definition of the floor injuries were according to the floor injuries were according to the floor include to the care plate include root cause of the floor injuries. A incident report definition of the floor injuries were according to the floor injuries. The resident #15 was obtouched to the care plate include root cause of the floor injuries. A incident report definition of the floor injuries were according to the floor injuries were according	e of 2 for bed mobility, all hygiene. He had 2 or uries. We care plan, last revised on focus for Resident #15 being do to impaired mobility, lower and the use of psychotropic do: 01/14/23). The ed: 01/14/23) included for ent's call bell was within the enteresident to use it for do. Residents need a prompt ests for assistance, follow and Physical Therapy (PT) to so ordered. An intervention for esident out of bed upon rising B). The care plan revealed no also having an actual fall. Final do: 06/13/23 revealed beserved sitting on his beside his bed with no to the care plan. No doe root cause of fall noted. Final do: 07/26/23 revealed beserved sitting on floor, ed with no injuries. The on was that he thought he not know that he was not book or interventions were an. No investigation to fall noted.	F 6	689	licensed nurses on 12/15/23. The Director of Nursing or designee wireview all falls weekly for root cause analysis and fall interventions x 12 week. The Director of Nursing will be responsible for bringing these audit results to the Quality Assurance Performance Improvement Committee meeting x 3 consecutive meetings. The Quality Assurance Performance Improvement Committee will determine the need for continued monitoring or additional education.	ill eks. ee		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
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F 689	interventions were ad investigation to include d. A incident report of Resident #15 was obtroom adjacent to be resident 's description bed while sleeping. It were added to the calinclude root cause of e. A incident report of Resident #15 was oblying on his side with description was that	with no injuries. No focus or dded to the care plan. No de root cause of fall noted. ated 08/02/23 revealed observed on the floor in his d, lying on left side. The on was that he rolled out of No focus or interventions are plan. No investigation to fall noted. ated 08/18/23 revealed observed on floor in his room no injuries. The resident 's he slid off his bed. A focus	F 6	89			
	with an intervention to get him out of bed up 08/18/23). No investion of fall noted. f. A incident report do Resident #15 was with onto the floor. No injuinterventions were actinivestigation to include Nurse #1 was intervitive AM. She stated she will a fall she would asset incident report, write the responsible party.	r stated when a resident had ess for injuries, complete a a progress note, and notify					

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F 689	but was unaware the planned. She also staduring the morning me Data Set (MDS) nursiplan according to the Nurse #1 had been of had not been present DON indicated she was during the time Minin #1 was out on matern she should have care falls and felt it was an not added to the care care plans should be have included Reside interventions. The Administrator was 3:57 PM, and stated care plan to be person included Resident #1 Dialysis CFR(s): 483.25(I) §483.25(I) Dialysis. The facility must ensire quire dialysis receive with professional star comprehensive person the residents' goals at This REQUIREMENT by: Based on observation interview, staff intervifacility failed to provid dialysis resident on 1	at the state of th	F 68		-	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 698	Continued From page	e 34	F6	98				
	1residents reviewed	for dialysis (Resident #185).			audited for receiving a meal or bag to g	jo		
	Findings included:				with to dialysis on 12/14/23 by the Administrator. All dialysis residents we found to be receiving a meal or a bag t			
	10/28/23 with diagnos	dmitted to the facility on ses that included end stage pendence on dialysis.			go. The Director of Nursing initiated an in-service on providing early meals or be to go with dialysis resident to dialysis or	oag		
	(MDS) assessment d Resident #185 cognit staff assessment indi	on Minimum Data Set ated 11/01/23 revealed ion was not assessed, and cated his memory was ok. d Resident #185 was able to d was understood.			12/14/23 to the Dietary Manager, cook and dietary aides, certified nursing assistants, and all licensed nurses. Anyone who did not receive this educa by 12/15/23 was not allowed to work up this education was completed. The Director of Nursing added this to the new and the present the second seco	s, tion ntil		
	5:06 pm and he state breakfast meal either since his admission of went to dialysis on Tu Saturday. He explair was 6:15 am and he between 5:30 am to 6 He indicated he was bag lunch on dialysis think he needed to te because they knew he because he left the face	desident #185 on 11/12/23 at d, he had not gotten a at the facility or bag to go on 10/28/23. He reported he lesday, Thursday, and hed his chair time at dialysis was usually transported 6:00 am each dialysis day. In the staff at the facility e did not eat breakfast or a cility before breakfast.			hire orientation on 12/15/23. The Director of Nursing or designee wi audit all dialysis residents 1 x a week for 12 weeks to ensure they are receiving meal prior to or a bag to go with them to dialysis. The Director of Nursing is responsible to bringing the dialysis meal or bag audit the Quality Assurance Performance Improvement Committee meeting x 3 consecutive meetings. The Quality Assurance Committee will determine the need for changes or continued monitor Date of Compliance: 12/15/23	III or a o for to		
	pm with the Dietary M bags of food were proon the evening shift a nursing staff to come dialysis. On 11/16/23 at 2:54 pconducted with Nurse	ducted on 11/15/23 at 1:00 Manager and it was indicated epared for dialysis residents and put in the refrigerator for get for residents before om an interview was at #3, and she indicated she in shift and has cared for						

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F 698	Resident #185 havi dialysis. An interview was compm with NA #4 and with Resident #185 indicated Resident when he went to dialysis when he went to dialy what was in it. She a bag out of the kito. An interview was compm with NA #5 who Resident #185 at le reported Resident # bag to take with him was in the bag. She bag with food from breakfast before go goes before breakfad in ot know I was to eat before dialysis. On 11/16/23 at 3:34 Resident # 185 and attendance, and the not send any meals Resident # 185 stat anything, I didn't thi	e reported she did not recall ng breakfast sent with him to onducted on 11/16/23 at 3:01 she indicated she had worked on the night shift. NA #4 #185 usually had a bag ready alysis, but she did not know stated, "I have not gone to get then for him." Inducted on 11/16/23 at 3:03 reported she worked with ast 3 nights a week. She end that she had a little duffle in, but she did not know what a indicated she never got a the kitchen, and he did not eat ing to dialysis because he ast came out. NA #5 stated," I to go and get anything for him	F 6	,			
	something on his st machine." An interview was co am with the Adminis was her expectation	on get sick if he doesn't have omach before getting on the onducted on 11/17/23 at 10:23 strator and she indicated it in that staff ensure residents from kitchen before going to					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	must use the service least 8 consecutive h §483.35(b)(2) Except paragraph (e) or (f) or must designate a reg director of nursing or service director or service director of nursing or service director or service director of nursing or service director or service director or serv	Full Time DON -(3) ed nurse t when waived under f this section, the facility s of a registered nurse for at fours a day, 7 days a week. It when waived under f this section, the facility fistered nurse to serve as the fina full time basis. Trector of nursing may serve filly when the facility has an funcy of 60 or fewer residents. This is not met as evidenced fiew and staff interviews the fulle a Registered Nurse fulle a Registered Nurse finance of the service of th	F 698	3	I the
	through 11/12/23 rev scheduled for the foll 10/19, 10/20, 10/23, 11/1, 11/2, 11/6, 11/7	taffing sheets from 10/12/23 ealed there was no RN owing days, 10/13, 10/18, 10/24, 10/27, 10/28, 10/29, 11/10, 11/11, and 11/12. with the Scheduler on who indicated she had only		Registered Nurse in the facility for 8 consecutive hours for a day, 7 days a week. The Director of Nursing and/or design will audit schedule to ensure a Regist Nurse is in the facility for 8 consecutive hours for a day, 7 days a week weekl weeks. The Director of Nursing will be responsible for bringing the Registered.	nee ered ve y x 8

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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		345131	B. WING _			11/	17/2023
NAME OF PR	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
CEDAR III	LLC CENTED FOR NUR	CINC AND DELIABILITATION		39	05 CLEMMONS ROAD		
CEDAR HI	LLS CENTER FOR NUR	SING AND REHABILITATION		CLEMMONS, NC 27012			
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI) TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 727	Continued From page	: 37	F 7	727			
		r 6 weeks. She revealed			Nurse audit to the Quality Assurance		
		ledge of not being able to			Performance Improvement Committee	x 3	
		Nursing (DON) as the RN on			consecutive meetings. The Quality		
		as not present. Scheduler			Assurance Committee will determine if		
	acknowledge many d	ays of no RN.			further auditing will be required. Date of Compliance: 12/15/23		
	The Administrator was	s interviewed on 11/16/23 at					
	4:58pm. The Adminis	trator acknowledged the					
	days the facility did no						
		N was present and she had					
	been the RN for that of						
	Administrator acknow	ledge that DON cannot					
	serve as RN now.						
F 759 SS=D	Free of Medication Er CFR(s): 483.45(f)(1)	ror Rts 5 Prcnt or More	F 7	759			12/15/23
	§483.45(f) Medication	Erroro					
	The facility must ensu						
	8483 45(f)(1) Medicat	ion error rates are not 5					
	percent or greater;						
	-	is not met as evidenced					
	by:	is not met as evidenced					
	Based on observation	ns, record reviews.			Medication Aide# 1 received immediat	e	
	interviews with staff a				education on medication administration		
		nt, the facility failed to have			the Unit Coordinator on 11/15/23 to	,	
	a medication error rat	-			include swish and spit with water to rin	se	
	evidenced by 3 medic				mouth after Advair Diskus aerosol,		
		g in a medication error rate			following physician orders for applying		
		esidents (Resident #45 and			ointments, and not leaving medications	at	
		ed during the medication			bedside.		
	administration observ	•			All current residents have the potential be affected.	to	
	The findings included	:			The Director of Nursing initiated an in-service on medication administration	n on	
	1. a. Resident #45 wa	is admitted to the facility on			12/14/23 to all licensed nurses and		
		tive diagnosis included			medication aides. This in-service include	ded	
		Pulmonary Disease (COPD).			rinsing mouth with water or	.54	
		2.22.20 (00. 2).					

NAME OF PROVIDER OR SUPPLIER CEDAR HILLS CENTER FOR NURSING AND REHABILITATION CEMMONS, NC 27012 (X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 759 Continued From page 38 A review of Resident #45 active Physician Orders included a current order for Advair Diskus Aerosol Powder Breath Activated 250-50 MCG/DOSE, 1 inhalation inhale orally one time a day for SOB (initiated 11/10/23). Advair Diskus Aerosol is an	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER CEDAR HILLS CENTER FOR NURSING AND REHABILITATION (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 759 Continued From page 38 A review of Resident #45 active Physician Orders included a current order for Advair Diskus Aerosol Powder Breath Activated 250-50 MCG/DOSE, 1 inhalation inhale orally one time a day for SOB (initiated 11/10/23). Advair Diskus Aerosol is an							С
CEDAR HILLS CENTER FOR NURSING AND REHABILITATION (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 759 Continued From page 38 A review of Resident #45 active Physician Orders included a current order for Advair Diskus Aerosol Powder Breath Activated 250-50 MCG/DOSE, 1 inhalation inhale orally one time a day for SOB (initiated 11/10/23). Advair Diskus Aerosol is an 3905 CLEMMONS ROAD CLEMMONS, NC 27012 DPROVIDER'S PLAN OF CORRECTION OF COMPLETION (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTION SHOULD BE (EACH CORRECTI			345131	B. WING _			11/17/2023
CLEMMONS, NC 27012 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 759 Continued From page 38 A review of Resident #45 active Physician Orders included a current order for Advair Diskus Aerosol Powder Breath Activated 250-50 MCG/DOSE, 1 inhalation inhale orally one time a day for SOB (initiated 11/10/23). Advair Diskus Aerosol is an CLEMMONS, NC 27012 D PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (EACH CORE	NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	DE	
(X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 759 Continued From page 38 A review of Resident #45 active Physician Orders included a current order for Advair Diskus Aerosol Powder Breath Activated 250-50 MCG/DOSE, 1 inhalation inhale orally one time a day for SOB (initiated 11/10/23). Advair Diskus Aerosol is an (X5) PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 759 Coaching/instructing resident to swish and spit water after Advair Discus, applying ointments per physician orders and not leaving medications at bedside. Any licensed nurse or medication aide who did not receive the in service by 12/15/23	CEDAD U	II I S CENTED EOD NII	IDSING AND DEHABILITATION		3905 CLEMMONS ROAD		
F 759 Continued From page 38 A review of Resident #45 active Physician Orders included a current order for Advair Diskus Aerosol Powder Breath Activated 250-50 MCG/DOSE, 1 inhalation inhale orally one time a day for SOB (initiated 11/10/23). Advair Diskus Aerosol is an F 759 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 759 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 759 (Continued From page 38 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 759 (Continued From page 38 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 759 (Continued From page 38 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	CEDAR III	ILLS CENTER FOR NO	RSING AND REHABILITATION		CLEMMONS, NC 27012		
coaching/instructing resident to swish and spit water after Advair Discus, applying ointments per physician orders and not Powder Breath Activated 250-50 MCG/DOSE, 1 inhalation inhale orally one time a day for SOB (initiated 11/10/23). Advair Diskus Aerosol is an coaching/instructing resident to swish and spit water after Advair Discus, applying ointments per physician orders and not leaving medications at bedside. Any licensed nurse or medication aide who did not receive the in service by 12/15/23	PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	N SHOULD BE E APPROPRIATE	COMPLETION
A review of Resident #45 active Physician Orders included a current order for Advair Diskus Aerosol Powder Breath Activated 250-50 MCG/DOSE, 1 inhalation inhale orally one time a day for SOB (initiated 11/10/23). Advair Diskus Aerosol is an spit water after Advair Discus, applying ointments per physician orders and not leaving medications at bedside. Any licensed nurse or medication aide who did not receive the in service by 12/15/23	F 759	Continued From pa	ge 38	F 7		to swish and	
included a current order for Advair Diskus Aerosol Powder Breath Activated 250-50 MCG/DOSE, 1 inhalation inhale orally one time a day for SOB (initiated 11/10/23). Advair Diskus Aerosol is an ointments per physician orders and not leaving medications at bedside. Any licensed nurse or medication aide who did not receive the in service by 12/15/23		A review of Resider	nt #45 active Physician Orders				
Powder Breath Activated 250-50 MCG/DOSE, 1 inhalation inhale orally one time a day for SOB (initiated 11/10/23). Advair Diskus Aerosol is an leaving medications at bedside. Any licensed nurse or medication aide who did not receive the in service by 12/15/23							
inhalation inhale orally one time a day for SOB (initiated 11/10/23). Advair Diskus Aerosol is an licensed nurse or medication aide who did not receive the in service by 12/15/23		Powder Breath Activ	vated 250-50 MCG/DOSE, 1				
		inhalation inhale ora	ally one time a day for SOB			•	
		(initiated 11/10/23). Advair Diskus Aerosol is an inhaled medication containing a combination of two medications, fluticasone (a corticosteroid)			not receive the in service by	12/15/23	
						until the in	
, , , , , , , , , , , , , , , , , , , ,					·		
and Salmeterol (a long-acting bronchodilator). The Director of Nursing or designee will							
Used to treat Chronic Obstructive Pulmonary audit 5 licensed nurses or medication		_					
Disease (COPD). aides weekly x 8 weeks for proper		Disease (COPD).				roper	
medication administration. The Director of Nursing will be		On 11/15/22 at 0:22	2 AM Madiantian Aida (MA) #1				
On 11/15/23 at 8:22 AM, Medication Aide (MA) #1 was observed as she prepared and administered The Director of Nursing will be responsible for bringing the medication					_		
16 medications to Resident #45. The administration audits to the Quality			• •				
administered medications included one Advair Assurance Performance Improvement						-	
Diskus Aerosol Powder Breath Activated 250-50 Committee x 3 consecutive meetings.					-		
MCG/DOSE 1 inhalation inhale orally. The The Quality Assurance Committee will		MCG/DOSE 1 inhal	lation inhale orally. The			-	
resident was observed as she inhaled one puff of determine if further auditing or education							
the aerosol medication. The MA did not prompt is needed.		the aerosol medicat	tion. The MA did not prompt		is needed.		
the resident to rinse her mouth out with water; no Date of Compliance: 12/15/23		the resident to rinse	her mouth out with water; no		Date of Compliance: 12/15/2	3	
water was offered to the resident so she could							
rinse and spit out the water after the Advair							
Diskus inhaler was used.		Diskus inhaler was	used.				
A review of the full prescribing information from		A review of the full p	prescribing information from				
the manufacturer 's website for Advair Diskus		the manufacturer 's	s website for Advair Diskus				
Aerosol Powder inhaler (Revised 01/19) included			,				
the following administration information, in part:		_	The state of the s				
Advair Diskus Aerosol should be administered;							
use 1 inhalation of Advair Diskus 2 times each							
day. Use Advair Diskus at the same time each		1					
day, about 12 hours apart. Advair Diskus can							
cause serious side effects, including fungal							
infection in your mouth or throat (thrush). Advair		_	, ,				
Diskus specified the following administration guidelines: "Rinse your mouth with water and spit							
the water out after each dose of Advair Diskus to							
help reduce your chance of getting thrush."							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		OATE SURVEY COMPLETED	
		345131	B. WING _			C 11/17/2023
	ROVIDER OR SUPPLIER	RSING AND REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 3905 CLEMMONS ROAD CLEMMONS, NC 27012	'	1111112020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 759	Continued From page	ge 39	F 7	59		
	AM with Medication interview, the MA cowater or coaching/ir	Aide (MA) #1. During the onfirmed she did not provide nstruction to Resident #45 to nout swallowing after using whaler.				
	AM with the facility's During the interview had recently been p	dministered per the				
	09/13/23. Her cumu	was admitted to the facility on llative diagnosis included mbar region intervertebral				
	included a current of External Cream 10	nt #45 active Physician Orders order for Aspercreme/Aloe %, apply to right shoulder and r times a day for pain.				
	was observed as shall medications to Radministered medical Aspercreme/Aloe Eright shoulder and le					
	AM with Medication	onducted on 11/15/23 at 8:34 Aide (MA) #1. During the onfirmed she did not apply the				

345131 B. WING C 11/17/202	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	
NAME OF PROVIDER OR SUPPLIER CEDAR HILLS CENTER FOR NURSING AND REHABILITATION STREET ADDRESS, CITY, STATE, ZIP CODE 3905 CLEMMONS ROAD CLEMMONS, NC 27012		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETED FOR TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	PRÉFIX	
F 759 Continued From page 40 Aspercreme to Resident #45 's left hip. An interview was conducted on 11/16/23 at 11:17 AM with the facility's Director of Nursing (DON). During the interview, the DON reported education had recently been provided to nurses and Medication Aide 's related to medication administration. She further expected all medications to be administered per the physicians' orders. 2. Resident #11 was admitted to the facility on 03/08/18. Her cumulative diagnosis included constipation. A review of Resident #11 active Physician Orders included a current order for Lokelma Packet 10 gram (GM) (Sodium Zirconium Cydosilicate) Give 10 gram by mouth one time a day. Which is used for the treatment of hyperkalemia (high potassium) in adults. On the packet of Lokelma medication it read to administer Lokelma orally as a suspension in water. Empty the entire contents of the packet(s) into a drinking glass containing approximately 3 tablespoons of water or more, if desired. Stir well and drink immediately if powder remains in the glass, add water, stir, and drink immediately. Repeat until no powder remains in the glass, add water, stir, and drink immediately. On 11/15/23 at 8:22 AM, Medication Aide (MA) #1 was observed as she prepared and administered 4 medications to Resident #11. MA #1 mixed the 10 GM packet of Lokelma with approximately 3 tablespoons of water and took the Lokelma and other medications to Resident #11. The resident was observed to partially complete the cup of	F 759	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		ATE SURVEY OMPLETED	
		345131	B. WING			C 11/17/2023
	ROVIDER OR SUPPLIER	SING AND REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 3905 CLEMMONS ROAD CLEMMONS, NC 27012		11/1//2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	FULL PREFIX (EACH CORRECTIVE ACTION SHOWN		HOULD BE	(X5) COMPLETION DATE
F 759	other medications. The approximately 2 tables water mixed solution exited the room. An interview was con AM with Medication A interview, the MA conformation of the Loke solution in a cup on the medication was justified to the interview was conformation. An interview was conformation of the loke solution in a cup on the medication was justified to the lower than the medication was justified to the lower than the lower tha	ne MA left the cup with espoons of Lokelma and on the bedside table and ducted on 11/15/23 at 8:45 kide (MA) #1. During the	F7	759		
F 761 SS=E	had recently been promedication Aide 's readministration. She formedications to be adophysicians 'orders. A phone interview was 10:19 AM with the fact Consultant. She states should not be left at bresidents may be ableated to be also stated Lokelmas and should be consultabel/Store Drugs and CFR(s): 483.45(g)(h) §483.45(g) Labeling of Drugs and biologicals	elated to medication further expected all ministered per the as conducted on 11/17/23 at cilities Pharmacist ad Lokelma medication bedside where other as to have access to it. She should be mixed with water med right away. ad Biologicals as used in the facility must be as with currently accepted as, and include the ay and cautionary	F	761		12/15/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345131	B. WING		C 11/17/2023	
	ROVIDER OR SUPPLIER	SING AND REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 3905 CLEMMONS ROAD CLEMMONS, NC 27012		171772020
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECT (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOU REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROD		SHOULD BE	(X5) COMPLETION DATE		
F 761	§483.45(h)(1) In according Federal laws, the factor biologicals in locked temperature controls personnel to have according for the factor of the factor of the Comprehensive In Control Act of 1976 a abuse, except when package drug distributed quantity stored is mindered for the Equipment of the Comprehensive In Control Act of 1976 a abuse, except when package drug distributed quantity stored is mindered for the Equipment of the facility medications and failed the following for the facility medication storage for medication cart and failed the following for the facility medication cart and failed the following for the facility medication cart and failed the following for the facility medication cart and failed the following for the facility medication cart and failed the following for the failed for the fai	ordance with State and dility must store all drugs and compartments under proper and permit only authorized cess to the keys. cility must provide separately affixed compartments for drugs listed in Schedule II of Drug Abuse Prevention and nd other drugs subject to the facility uses single unit ution systems in which the simal and a missing dose can is not met as evidenced iew, observation and staff of failed to remove expired do to remove loose pills from the sire of the serviewed and failed to	F 7	Expired medications and loos medications on 300B medications on 300B medications. The expired medication the 200-hall medication storag were removed on 11/15/23 by Manager. All medication carts and medications were audited for expire medications on 12/15/23 by the Manager. Any expired or loos medications were discarded be Director of Nursing on 12/15/27. The Director of Nursing initiate in-service on medication storal include removing expired medication carts for the in-service also included the	ion cart the floor as located in ge room the Unit cation d or loose as Unit se by the 23. ed an age, to lications and loose pills.	

PRINTED: 12/21/2023 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		345131	B. WING _		1	C 11/17/2023	
	ROVIDER OR SUPPLIER	URSING AND REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP COE 3905 CLEMMONS ROAD CLEMMONS, NC 27012	•		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 761	expired September - One bottle of Mu 2023. MA #3 indicated the 300B medication of unaware that the result indicated that both from the medication indicated that night for checking and result in the medication carrooms. The Director of Nu on 11/15/2023 at 1 medication that was medication cart or available for use be further indicated the responsible for enemedications. 1b. An observation was conducted on presence of Nurse cart contained 10 colors and sizes ladrawers. Nurse #1 indicated responsible for cleans and sizes ladrawers.	of Magnesia liquid that	F 7	nurses and certified medicati to check medication carts nig expired medications and loos certified medication aides, all nurses and central supply on Any certified medication aide nurse or central supply who describe the in service by 12/1 not allowed to work. This ed added to the new hire oriental Director of Nursing on 12/15/2. The Director of Nursing or desaudit all medication carts and storage rooms weekly x 4 we biweekly x 4 weeks then more The Director of Nursing will be responsible for bringing the new storage audits to the Quality Performance Committee medications are performance Combe responsible for determining for additional audits. Date of Compliance: 12/15/2	ghtly for se pills to all I licensed a 12/14/23. e, licensed did not 15/23 were ucation was ation by the /23. esignee will d medication eeks, the enthly x 1. be enedication Assurance eeting x 3 Quality enmittee will ag the need		

Facility ID: 923335

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	, ,	OATE SURVEY OMPLETED	
		345131	B. WING _			C 11/17/2023
	ROVIDER OR SUPPLIER	RSING AND REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 3905 CLEMMONS ROAD CLEMMONS, NC 27012	'	2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 761		ne 44 Inducted with the DON on m. The DON indicated night	F 7	61		
	shift nurses should omedications carts, a	clean, organize the nd discard any loose pills.				
	storage room was co 12:47pm in the preso revealed the followin	the 200-hall medication onducted on 11/15/2023 at ence of Nurse #2 and MA #4, and medications as expired ication storage room and				
	-Two bottles of One-Daily Multivitamin dietary supplement 1000 tablets with an expiration date of August 2023.					
	MA #4 indicated the	medications were expired.				
	Multivitamin in the 20 room were expired a medications must be available for use. Nu night shift nurses we and removing expire	he two bottles of One-Daily 00-hall medication storage and indicated that both removed and not made arse #2 further indicated that are responsible for checking d medications in the medication storage rooms.				
	on 11/15/2023 at 1:4 medication that was medication cart or m available for use but further indicated that responsible for ensu	ing (DON) was interviewed 1pm and indicated expired should not be in the edication storage room should be discarded. She t the night shift nurses were ring the medication carts and rooms had no expired				
F 804 SS=E		ar, Palatable/Prefer Temp)(2)	F 8	04		12/15/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345131	B. WING			C 11/17/2023	
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>		STRE	EET ADDRESS, CITY, STATE, ZIP CODE	1 11/1	11/2023
CEDAR III	LLC CENTED FOR NUE	ICINIC AND DELIABILITATION	3905 CLEMMONS ROAD		CLEMMONS ROAD		
CEDAR HI	LLS CENTER FOR NUR	SING AND REHABILITATION		CLE	MMONS, NC 27012		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 804	Continued From pag	e 45	F8	304			
	§483.60(d) Food and	l drink					
		es and the facility provides-					
		prepared by methods that					
	conserve nutritive value, flavor, and appearance;						
	§483.60(d)(2) Food and drink that is palatable,						
	attractive, and at a sa	•					
	temperature.						
	this REQUIREMEN by:	Γ is not met as evidenced					
	-	bservation, record reviews,			One on one education was provided to	,	
		esidents and staff the facility			he Dietary Manager on 12/15/23 by th		
		hat was palatable and at		- 1	Regional Dietary Manager, on palatabi	lity	
		able to 5 of 8 residents			of food and food temperatures.		
	·	latability (Resident #1,			All current residents have the potential	to	
		nt #22, Resident #26, and practice had the potential to		- 1	oe affected by this current deficiency. The Regional Dietary Manager initiated	d an	
	affect other residents				n-service to all Dietary staff to include	a an	
					cooks and aides on palatability of food	,	
	Findings included:			- 1	and food temperatures on 12/15/23. A	ny	
	5				dietary staff who did not receive this		
	a. Resident #1 was 09/01/2017.	s admitted to the facility on			education by 12/15/23 are not allowed work until this in-service has been	to	
	03/01/2017.				completed. On 11/17/23 a new food		
	Resident #1 resided	on the 100 hall.		- 1	delivery cart was delivered, and on		
				- 1	12/12/23, 4 additional new food deliver	у	
		num Data Set (MDS) dated		- 1	carts were ordered. On 12/1/23, the		
	8/12/23 revealed Reintact and independe	esident #1 was cognitively		- 1	contract for dietary service was erminated and all dietary staff were		
	assistance with meal				converted to facility staff on 12/2/23. T	his	
	assistantes with mou			- 1	will allow increased education and		
	During an interview v	vith Resident #1 on 11/12/23		- 1	monitoring by the Regional Dietary		
	-	ted she had concerns with		- 1	Manager.		
		old. Resident #1 alleged the			The Regional Dietary Manager or		
		g because the food was			designee will conduct 10 resident		
	often undercooked o	r overcookea.			nterviews for palatability of food and emperatures x 8 weeks. The Regiona		
				'	omporaturos y o meeks. The Neglona	u	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE COMP	SURVEY LETED	
		345131	B. WING _			C 11/17/2023	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	117	1772020
				39	905 CLEMMONS ROAD		
CEDAR H	LLS CENTER FOR NUR	SING AND REHABILITATION			LEMMONS, NC 27012		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 804	Continued From page	e 46	F 8	304			
	A second interview wa	as conducted with Resident			Dietary Manager or designee will cond		
		5 pm, Resident #1 indicated			food temperature audits 5 x a week x 8		
		oday. Resident #1 indicated			weeks.		
		shed potatoes and broccoli			Date of Compliance: 12/15/23		
	i i	food lacked seasoning.					
	and dietary manager	that she had told the staff					
	and dictary manager	about her concern.					
	b. Resident #3 was 02/16/18.	admitted to the facility on					
	Resident #3 resided on the 100 hall.						
	at 4:38pm she indicat all her meals being co	with Resident #3 on 11/12/23 ted she had concerns with old, Resident #2 alleged the g because the food was rovercooked.					
	#3 on 11/15/23 at 1:2 that lunch was cold to that the pork loin, mas were cold, and all the	as conducted with Resident 0 pm, Resident #3 indicated oday. Resident #3 indicated shed potatoes and broccoli food lacked seasoning. It that staff were aware of her id.					
	c. Resident #22 wa 06/22/22.	s admitted to the facility on					
	Resident #22 resided	on the 300 hall.					
	A review of the Minim	num Data Set (MDS) dated					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED		
		345131	B. WING _			C 11/17/2023	
	ROVIDER OR SUPPLIER	RSING AND REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 3905 CLEMMONS ROAD CLEMMONS, NC 27012		11/11/2023	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 804	intact and independer assistance with mean During an interview of the Minimal By 29/23 revealed Reimpaired and independer assistance with mean During an interview of the Minimal Resident #26 resident #26 resident #26 resident #26 resident #26 resident #26 resident #27 review of the Minimal Resident #26	sident #22 was cognitively ent with eating after I set up. with Resident #22 on a she indicated she had eals being cold. Resident #22 as complained before, and no but the meals being cold. ported her complaint to the my times. conducted with Resident # 22, as pm she indicated that the indicated also that her pork y. Mashed potatoes and io. During this interview tray was observed as she may room. Resident #22 had at 40% of her meal during this interview as admitted to the facility on the 300 hall. mum Data Set (MDS) dated sident #26 was moderately indent with eating after I set up.	F8	04			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345131	B. WING _			C I 1/17/2023
	ROVIDER OR SUPPLIER	RSING AND REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP COD 3905 CLEMMONS ROAD CLEMMONS, NC 27012		11/11/2023
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 804	member on 11/14/2: concerns with Resident Resident #38 w 06/15/22. Resident #38 re	with Resident #26's family 3 indicated that family had dent #26. conducted with Resident #26, 0 pm, she indicated that the dry. was admitted to the facility on ed on the 200 hall. mum Data Set (MDS) dated desident #38 was cognitively ent with eating after al set up. with Resident #38 on a she indicated that is cold daily. Resident #38 alked with the Dietary would get better but this have been cold. Resident #38 as complained before about the #38 reported her concerns to and the old Administrator. conducted with Resident #38, 0 pm, she indicated that her and dry, mashed potatoes and	F 8	,		
	kitchen was conduc The food items were	ne meal tray line service in the ted on 11/15/23 at 11:20am. e placed on heated plates r. The plated meals were				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345131	B. WING _		1	C / 17/2023
	ROVIDER OR SUPPLIER	SING AND REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 3905 CLEMMONS ROAD CLEMMONS, NC 27012		71772023
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 804	bottoms. A test meal foods was included in On 11/15/23 at 12:18 300 halls were served the Surveyor observe palatability. The pork potatoes and broccoli participated in the test acknowledged these During an interview of Dietary Manager reveat the facility for two yreceive complaints froquality of the food.	d, dome-shaped lids with tray of the regular textured the meal delivery cart. am, after the residents of the d, the Dietary Manager and did the test meal tray for loin, mashed potatoes, fried it were cold. The DM sting of the meal tray and findings. n 11/16/23 at 1:30pm., the caled he had been working years and did not frequently om residents concerning the	F8	04		
F 867 SS=E	11/16/23 at 1:35pm ir expectation was that good hot food and for During an interview w 11/03/23 at 2:30pm s expectation was that palatable food and te regulations for all resi QAPI/QAA Improvem CFR(s): 483.75(c)(d)(s) §483.75(c) Program f monitoring. A facility must establis policies and procedur collections systems, a adverse event monitoring.	all residents would receive od on time daily. with the Administrator on the indicated that her the dietary staff provide indents. ent Activities (e)(g)(2)(i)(ii) feedback, data systems and sh and implement written	F 8	67		12/15/23

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345131	B. WING _			11/) 17/2023
	ROVIDER OR SUPPLIER	SING AND REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP COD 3905 CLEMMONS ROAD CLEMMONS, NC 27012	ΙΕ		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE		(X5) COMPLETION DATE
F 867	systems to obtain and from direct care staff, resident representation information will be used to a systems to identify, conformation from all donot limited to the facility and evaluation of per including the method development, monito \$483.75(c)(4) Facility and evaluation of per including the method development, monito \$483.75(c)(4) Facility including the method systematically identification and the facility will use the data adverse events in the facility will use the data prevent adverse ever \$483.75(d) Program systemic action.	maintenance of effective duse of feedback and input other staff, residents, and ves, including how such ed to identify problems that tume, or problem-prone, and ovement. maintenance of effective ollect, and use data and epartments, including but ity assessment required at ding how such information op and monitor performance development, monitoring, formance indicators, ology and frequency for such ring, and evaluation. adverse event monitoring, so by which the facility will y, report, track, investigate, and information relating to a facility, including how the tate to develop activities to ints. systematic analysis and cility must take actions as improvement and, after actions, measure its success,	F8	367			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345131	B. WING _			C 11/17/2023
	ROVIDER OR SUPPLIER	RSING AND REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 3905 CLEMMONS ROAD CLEMMONS, NC 27012		1111/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 867	§483.75(d)(2) The faimplement policies at (i) How they will use determine underlying impacting larger systii) How they will dewill be designed to elevel to prevent qual safety problems; and (iii) How the facility of its performance in ensure that improve §483.75(e) Program §483.75(e) (1) The faperformance improve high-risk, high-volund consider the incident of problems in those outcomes, resident stresident choice, and §483.75(e)(2) Performance improvement choice, and implement preventive that include feedbact facility. §483.75(e)(3) As paimprovement activitic distinct performance number and frequence number a	ealized and sustained. acility will develop and addressing: a systematic approach to g causes of problems tems; velop corrective actions that effect change at the systems lity of care, quality of life, or d will monitor the effectiveness inprovement activities to ments are sustained. activities. activities. activities that focus on ne, or problem-prone areas; ce, prevalence, and severity areas; and affect health safety, resident autonomy,	F	367		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		, ,	E SURVEY PLETED
		345131	B. WING _		C 11/17/2023	
	ROVIDER OR SUPPLIER	SING AND REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP COD 3905 CLEMMONS ROAD CLEMMONS, NC 27012		717/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 867	assessment required Improvement project annually a project the problem-prone areas collection and analys (c) and (d) of this see §483.75(g) Quality a §483.75(g)(2) The quassurance committed governing body, or defunctioning as a governing body, or defunctioning as a governing body, or defunctioning as a governing body, or defunctioning as a governing as a governing body, or defunctioning following a complain	as reflected in the facility I at §483.70(e). Is must include at least at focuses on high risk or Is identified through the data asis described in paragraphs action. In the facility is sessment and assurance. I wality assessment and a reports to the facility's a resignated person(s) are reming body regarding its applementation of the QAPI and are paragraphs (a) through are committee must: I wall the facility deficiencies; and analyze data, including and analyze data, including and analyze data are improvements. I is not met as evidenced ans, record review, resident	F8		ance implemented nterventions d on resident and	
	Centered Care Plan Comprehensive Care recertification and co 11/17/23. The facility	Comprehensive Resident (Develop/Implement e Plan) and on the current emplaint survey conducted on 's Quality Assessment and emmittee also failed to		Committee failed to maintain procedures and monitor inter committee put in place follow complaint survey conducted this was evident for 1 deficiencited in the area Comprehens	vention the ring a on 12/17/20. ency that was	

Facility ID: 923335

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
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		345131	B. WING _		11/17/2023	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE	
0504011		UIDOINO AND DELLABILITATION		3905 CLEMMONS ROAD		
CEDAR H	ILLS CENTER FOR N	URSING AND REHABILITATION		CLEMMONS, NC 27012		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ON SHOULD BE COMPLÉTION HE APPROPRIATE DATE	٧
F 867	Continued From p	age 53	F 8	367		
Γ 00/	maintain impleme intervention the coa a complaint surve was evident for 1 area of Quality of recertification and The QAA addition implemented processing interventions the crecertification and 02/26/21. This was were cited in the accomprehensive resurvey conducted additionally failed procedures and mand complaint sur This was evident in the areas of En Care (Dialysis) and Medication Error for current recertificate conducted on 11/2 additionally failed procedures and mand complaint survey conducted on 11/2 additionally failed procedures and mand complaint survey and complaint survey and complaint survey and complaint survey and deficiencies in the Assessment/Accu Comprehensive Relans/Develop/Im	nted procedures and monitor or mittee put in place following y conducted on 1/28/21. This deficiency that was cited in the Care and on the current complaint survey on 11/17/23. ally failed to maintain edures and monitor committee put in place following complaint survey conducted on sevident for 2 deficiencies that areas of Resident esident Centered Care Plan esident Centered Care Plan ent.), and Pharmacy Services on Error Rate of 5 % or more at recertification and complaint on 11/17/23. The QAA to maintain implemented conitor interventions the place following recertification every conducted on 08/23/21. For 3 deficiencies that were cited evironment (homelike), Quality of d Pharmacy Services "Free of Rate of 5 % or more and on the cition and complaint survey 17/23. The QAA committee to maintain implemented conitor intervention the place following recertification every conducted on 07/29/22 and tent recertification and of 11/17/23. This was evident of		Centered Care Plan (Devel Comprehensive Care Plan) current recertification and comprehensive Care Plan) current recertification and complaint to maintain implemented promonitor intervention the complace following a complaint conducted on 1/28/21. This for 1 deficiency that was cit of Quality of Care and on the recertification and complaint 11/17/23. The QAA addition maintain implemented proceedings are cited in the areas of Figure Comprehensive resident Complaint survey conducted in the areas of Figure Comprehensive resident Comprehensive reside	and on the complaint /23. The nt and ee also failed cocedures and mmittee put in survey was evident ed in the area ne current at survey on nally failed to edures and committee put in on and do no 02/26/21. Siencies that tesident entered Care and Pharmacy on Error Rate of crent at survey ee QAA in nd monitor e put in place complaint /21. This was nat were cited at (homelike), nd Pharmacy on Error Rate of crent at survey en Err	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345131	B. WING _			C / 17/2023	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		71772020	
				3905 CLEMMONS ROAD			
CEDAR HI	LLS CENTER FOR NU	RSING AND REHABILITATION		CLEMMONS, NC 27012			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O ((EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 867	implemented proced interventions the co-complaint survey co-was evident for 1 de area of Quality of ca hazards/Supervision current recertification 11/17/23. The duplic federal surveys of refacility's inability to sprogram. Findings included: F584 Based on obs	ally failed to maintain	F 8	implemented procedures intervention the committee following recertification ar survey conducted on 07/2 on the current recertificatic complaint survey of 11/17 evident of 3 deficiencies in Resident Assessment/Acc Assessment and Comprese Resident Centered Care Plans/Develop/Implement Care Plan and Provision of daily living for dependent Quality of Care. The QAA additionally failed to main implemented procedures interventions the committee	e put in place and complaint 29/22 and recited on and 2/23. This was an the areas curacy of hensive t Comprehensive of activities of residents, a committee tain and monitor		
	floors free from drie rooms (Room 312 a practice affected 1 depractice affected 1 deprac	d spills and debris for two and 318) This deficient of 3 resident halls (300 Hall). ation and complaint survey 21 the facility failed to tiles in resident rooms. The atian clean call bell string dent on 2 of 3 resident care		following complaint survey 04/27/23. This was evider deficiency that was cited i Quality of care (Free of Adhazards/Supervision/Devion the current recertificatic complaint survey on 11/17 duplicate citations during surveys of record show a facility's inability to sustain QAA program. Corrective Action: A plan of correction was puthe time of the deficiency of correction included morand review of monitoring to monthly Quality Assurance meetings for a defined peresented to the Quality Accommittee and no further identified throughout the residence of the program of the plan of the committee and no further identified throughout the residence of the plan of the plan of the committee and no further identified throughout the residence of the plan	y conducted on ant for 1 in the area of ocident ices) and recited on and 7/23. The six federal pattern of the an effective out into place at cited. The plan initoring tools, tools during e Committee riod of time. correction was assurance issues were		

Facility ID: 923335

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			JITIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			7 50.125			С		
		345131	B. WING _			11/	17/2023	
	ROVIDER OR SUPPLIER	RSING AND REHABILITATION		39	TREET ADDRESS, CITY, STATE, ZIP CODE 905 CLEMMONS ROAD LEMMONS, NC 27012			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 867	therapeutic diet on the assessment for 1 of nutrition. During the recertification of the conducted on 7/29/2 accurately code the (MDS) for 1 of 25 respectively for 25 res	the Minimum Data Set (MDS) 6 residents reviewed for ation and complaint survey 22 the facility failed to quarterly Minimum Data Set sidents reviewed for MDS. ard review, observations and facility failed to develop an comprehensive care plan or alls (Resident #15), for a ressure ulcers and urinary ent #78) and failed to care at (Resident #14). This was for rose care plans were It survey conducted on failed to develop an erson-centered care plan that entravenous (IV) catheter ard doctor's order for IV fluids reviewed for dehydration. Action and complaint survey Action and Action	F	867	and were discontinued. The Administrator initiated an in-service all administrative staff on 12/6/2023 regarding Quality Assurance Performan Improvement (QAPI) process including identifying and prioritizing quality deficiencies, systemically analyzing causes of quality deficiencies, developing and implementing corrective action or performance improvement activities. The in-service included accuracy of audits, extending audits when appropriate, and reviewing corrective action/performance improvement activities to evaluate the effectiveness of each plan and revise an necessary. All newly hired administrative staff will receive the appropriate education worked until they received appropriate education. The QAPI committee will review the compliance audits to evaluate continue compliance. The committee will make recommendations if any noncompliance identified and reevaluate the plan of correction for possible revisions. This process will continue until the facility has achieved three months of consistent compliance. The Administrator will be responsible for the plan of correction. Date of Compliance: 12/15/23	ing, his d e as ve tion caff		

AND DI AN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345131	B. WING _			C 11/17/2023
	ROVIDER OR SUPPLIER	RSING AND REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 3905 CLEMMONS ROAD CLEMMONS, NC 27012	I	11/1//2023
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F 867	residents and staff, floors free from drie rooms (Room 312 a practice affected 1 decoration of the recertification of the recertification of the recertification of the resident who was daily living resident cleaned glasses, arresidents reviewed F684: Based on obstain a physician's changes for a skin from the resident of the received multiple arressure) medication F689: Based on obstain of the received multiple arressure) medication of the received multiple arrows of the received multiple arro	servations and interviews with the facility failed to maintain d spills and debris for two and 318) This deficient of 3 resident halls (300 Hall). Pation and complaint survey 22 the facility failed to provide dependent on activities of (ADL) washed hair, cut nails, and shaved facial hair for 1 of 7 for ADLs. Pations record review, and the facility failed to a roder and perform dressing the art to a Resident's left upper cent reviewed for skin Interview the facility failed to a resident of the failed to monitor a resident of the failed to monitor a resident of the resident reviewed who antihypertensive (blood)	F	867		

AND DI AN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	(XX	(X3) DATE SURVEY COMPLETED		
		345131	B. WING_			C 11/17/2023	
	ROVIDER OR SUPPLIER	RSING AND REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP 3905 CLEMMONS ROAD CLEMMONS, NC 27012	CODE	11/1//2023	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 867	lost control of the wh 150-foot ramp to the collided with an interfacility. She sustain a pelvic fracture, and The hospital determisurgery to repair her admitted to a hospic measures. This defit three residents reviee F698: Based on obstamily interview, staff review, the facility farmeal to a dialysis resident to a dialysis resident of 11/07/23, 11/09/23, 11/16/23 for 1 of 1 resident reviewed for nutritional recommendialysis center. This resident reviewed for F759: Based on obstinterviews with staff Pharmacist Consultates a medication error residenced by 3 med opportunities, resulting 11.54% for 2 of 3 the medication admit During the recertificate conduct on 2/26/21 to medication error rates.	econd-floor door on her own, reelchair and rolled down a first floor. The resident ior wall on the first floor of the ed bilateral femur fractures, if a laceration to her head, ned she would not survive fractures and she was the house for palliative care cient practice affected one of wed for accident hazards. Bervation, resident interview, finterviews and record filed to provide a lunchtime sident on 11/02/23, 11/04/23, 11/11/23, 11/14/23 and sidents reviewed for dialysis. Between the formulation of the was evident for 1 of 1 or dialysis. Bervations, record reviews, and interview with the facility failed to have the of less than 5% as ication errors out of 26 ong in a medication error rate residents observed during inistration observation.	F	367			

17/2023
(X5) COMPLETION DATE