STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345131	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/22/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS An onsite revisit was conducted from 4/20/26 through 4/22/26. Tags F578, F582, F655, F656, F686, F690, F770, F812, F814, F880, F881, and F883 were corrected as of 4/22/26. Repeat tags were cited. New tags were also cited as a result of the complaint investigation survey that was conducted at the same time as the revisit. The facility is still out of compliance.	F0000		
F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.	F0550	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice Resident # 16 no longer resides in the facility. Address how the facility will identify other residents having the potential to be affected by the same deficient practice Residents residing in the facility have the potential to be affected by the deficient practice. On 5/11/26 the Social Worker conducted interviews with residents with BIMs of 12 and higher to ensure they felt their right to be treated with dignity was upheld. There were no issues identified. On 5/11/26 the Director of Nursing and Assistant Director of Nursing conducted observation on the residents with a BIMS of 11 or less to ensure staff were treating them with dignity. There were no issues identified. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur On 5/11/26 the Director of Nursing and Assistant Director of Nursing educated all staff, including agency staff, on the resident right to be treated with dignity and respect. The education included providing care during meal tray pass. Staff who have not received the education by 5/13/26 will not be able to work their next shift until education is completed. Newly hired staff will receive the education in orientation from the Assistant Director of Nursing. Indicate how the facility plans to monitor its	05/18/2026

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F0550 SS = D	Continued from page 1 §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and resident and staff interviews, the facility failed to respect a resident's right to dignity when Resident #16 requested assistance to the bathroom and then incontinence care. Assistance was not provided to Resident #16 until after all the meal trays were passed out on the hall and other residents were assisted with eating. This affected 1 of 4 residents reviewed for dignity (Resident #16). Findings included: Resident #16 was admitted to the facility on 4/13/2026 with diagnoses including non-progressive congenital joint contractures and chronic obstructive pulmonary disease. A Brief Interview for Mental Status assessment completed on 4/14/2026 indicated Resident #16 was cognitively intact. A care plan focus area, initiated on 4/16/2026 for Resident #16, documented a self-care performance deficit, with interventions including the need for one-person assistance for toileting and transfers. During an interview and observation conducted on 4/21/2026 at 2:22 PM, with a follow-up interview on 4/22/2026 at 9:41 AM, Resident #16 reported that she had received medication earlier that morning to stimulate a bowel movement. She stated that at 12:15 PM, she activated her call light, requesting assistance to the bathroom because she felt the medication beginning to work and believed she could reach the bathroom with help. She reported that Nurse Aide (NA) #1, whom she did not recognize, responded within five or six minutes. According to Resident #16, she informed NA #1 of her urgent need for assistance and her fear of having a bowel movement in bed. The resident stated that NA #1 turned off the call light and told her she would return, but no one came. The resident	F0550	Continued from page 1 performance to make sure that solutions are sustained The Social Worker or designee will audit through observation throughout the facility ten resident interactions with staff weekly for four weeks, then 8 resident interactions with staff weekly for four weeks, then 5 resident interactions with staff weekly for four weeks to ensure residents are being treated with dignity. Observations will include mealtimes. The Assistant Director of Nursing is responsible for forwarding the results of the audits to the QAPI Committee monthly for three months. The QAPI Committee will review the audit to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring. Completion date: 5/18/26	05/18/2026

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F0550 SS = D	Continued from page 2 reported that she activated her call light again, at which time NA #2 entered the room to deliver her lunch tray. The resident stated she informed NA #2 that she now required incontinence care because no one assisted her to the bathroom. The resident reported that NA #2 also turned off her call light and stated she would return. The resident stated she became angry but waited, activating her call light again at 1:22 PM. Resident #16 reported she was certain of the time because she had both a wall clock and a phone visible and accessible. A clock was observed on the wall, and the resident was holding her phone during the interview. Resident #16 stated that a staff member from the rehabilitation department, identified as the Director of Rehabilitation Services, eventually answered her call light. Resident #16 reported she told this staff member she had been waiting for over an hour and required incontinence care. Resident #16 stated she received assistance only after the rehabilitation staff member notified a nurse aide. Resident #16 confirmed NA #2 did provide care for her, but she was so angry at that point that she did not recall the time. Resident #16 also confirmed she waited until after she received incontinence care to eat her lunch. Resident #16 stated she did not like sitting in her feces and felt frustrated and angry that she did not receive assistance when needed. She stated that at home, she was able to reach the bathroom independently and did not soil herself in an incontinence brief. During an interview on 4/21/2026 at 4:13 PM, NA #1 stated she did not recall the exact time but confirmed that before meal trays were distributed, Resident #16 activated her call light. NA #1 stated she responded to the call light and turned off the call light. NA #1 reported she was not assigned to Resident #16 that day and was unfamiliar with the resident's care needs because the resident was new. NA #1 stated she informed Nurse #2 and NA #2 at the nurses' desk that Resident #16 reported the medication to move her bowels was beginning to work, and she needed help to the bathroom. During an interview on 4/21/2026 at 3:35 PM, NA #2 confirmed that NA #1 informed her that Resident #16 needed assistance to the bathroom. NA #2 stated that the lunch trays were already in the hallway at that time. She reported that it was a long-standing rule that residents could not receive incontinence care or be assisted to the bathroom while meal trays were in the hallway. NA #2 stated that Resident #16 did not eat her lunch while soiled but waited until trays were passed and NA #2 had finished assisting other residents with eating. NA #2 stated she then	F0550		05/18/2026

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F0550 SS = D	Continued from page 3 provided incontinence care and reheated Resident #16's lunch. During an interview on 4/21/2026 at 3:30 PM, Nurse #2 stated that NA #1 informed her and NA #2 around lunchtime that Resident #16 might need incontinence care. Nurse #2 stated Resident #16's call light may have been on for approximately ten minutes before NA #1 answered it, and stated the resident tended to exaggerate waiting times. Nurse #2 reported that meal trays for the adjacent hallway had just been delivered, and trays for her hallway were expected imminently when Resident #16 requested assistance. During an interview on 4/21/2026 at 3:55 PM, the Director of Rehabilitation Services stated she answered Resident #16's call light at lunchtime. She reported that Resident #16 stated she needed to be changed and had been waiting. The Director of Rehabilitation Services stated she notified the Assistant Director of Nursing (ADON) of Resident #16's needs. During an interview on 4/21/2026 at 4:08 PM, the ADON confirmed she was informed by the Director of Rehabilitation Services that Resident #16 required assistance at lunchtime. The ADON stated she located Nurse #2 and informed her that Resident #16 needed to be changed. The ADON stated Nurse #2 told her she would take care of it. During a second interview on 4/21/2026 at 4:47 PM, Nurse #2 stated the ADON texted her at 1:30 PM and informed her that Resident #16 needed to be changed. Nurse #2 stated she was assisting another resident with eating, and when she entered the hallway, NA #2 was already on her way to provide care. Nurse #2 stated that call lights were rarely left on for long because the sound was "very annoying," and therefore she believed Resident #16's call light was not on for an extended period. During an interview on 4/22/2026 at 10:30 AM, the Director of Nursing stated that NA #2 should have assisted Resident #16 to the bathroom when she was informed of her needs. She stated she teaches nurse aide classes and that there has never been a rule prohibiting incontinence care while meal trays are in the hallway. During an interview with the Administrator conducted on 4/22/2026 at 2:45 PM, she reported that residents should receive assistance with toileting and incontinence care even if the meal trays were in the hallway. The Administrator stated that another staff member could have assisted with	F0550		05/18/2026

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F0550 SS = D	Continued from page 4 passing out meal trays while Resident #16 received needed care. The Administrator stated the incident represented a dignity issue and was unacceptable.	F0550		05/18/2026
F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and resident and staff interviews, the facility failed to provide assistance to the bathroom and incontinence care to a resident upon request for 1 of 5 reviewed for the provision of activity of daily living care (Resident #16). Findings included: Resident #16 was admitted to the facility on 4/13/2026 with diagnoses including non-progressive congenital joint contractures and chronic obstructive pulmonary disease. Review of an admission data collection note dated 4/13/2026 revealed Resident #16 was assessed as incontinent of bladder and bowel. A Brief Interview for Mental Status assessment completed on 4/14/2026 indicated Resident #16 was cognitively intact. A care plan focus area, initiated on 4/16/2026 for Resident #16, documented a self-care performance deficit, with interventions including the need for one-person assistance for toileting and transfers. Documentation in a daily skilled physical therapy note completed on 4/20/2026 revealed Resident #16 performed a transfer from the edge of the bed to a forward wheeled walker. Resident #16 then took a few steps, transferred to the wheelchair and then the commode with moderate assistance with verbal cues for hand positioning and pivoting. Resident #16 was noted to end the session back in the wheelchair. During an interview and observation conducted on 4/21/2026 at 2:22 PM, with a follow-up interview on 4/22/2026 at 9:41 AM, Resident #16 reported that she had received medication earlier that morning to stimulate bowel movement. She stated that at 12:15	F0677	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice Resident #16 no longer resides in the facility. Address how the facility will identify other residents having the potential to be affected by the same deficient practice Residents residing in the facility have the potential to be affected by the deficient practice. On 5/11/26 the social worker interviewed residents with BIMs of 12 or greater to ensure their needs were being met with assistance to the bathroom and/or incontinence care. On 5/11/26 the Director of Nursing and Assistant Director of Nursing conducted observations on the residents with a BIMs of 11 and less to ensure assistance to the bathroom or incontinence care was provided. There were no issues identified. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur On 5/11/26 the Director of Nursing and Assistant Director of Nursing educated the certified nurse aides, certified medication aides and nurses, including agency staff on the need to provide assistance to the bathroom and incontinence care upon request of the resident. Staff who have not received the education by 5/13/26 will not be able to work their next shift until education is completed. Newly hired staff will receive the education in orientation from the Assistant Director of Nursing. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained The Director of Nursing or designee will audit ten residents throughout the facility a week for twelve weeks through observation to ensure that their activity of daily living for continence/incontinence care is provided upon request. The Director of Nursing is responsible for forwarding the results of the audits to the QAPI Committee monthly for three months. The QAPI Committee will review the audit to determine trends and/or issues that may need further interventions put into place	05/18/2026

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F0677 SS = D	Continued from page 5 PM, she activated her call light, requesting assistance to the bathroom because she felt the medication beginning to work and believed she could reach the bathroom with help. She reported that Nurse Aide (NA #1), whom she did not recognize, responded within five or six minutes. According to Resident #16, she informed NA #1 of her urgent need for assistance and her fear of having a bowel movement in bed. The resident stated that NA #1 turned off the call light and told her she would return, but no one came. The resident reported that she activated her call light again, at which time NA #2 entered the room to deliver her lunch tray. The resident stated she informed NA #2 that she now required incontinence care because no one assisted her to the bathroom. The resident reported that NA #2 also turned off her call light and stated she would return. The resident stated she became angry but waited, activating her call light again at 1:22 PM. Resident #16 reported she was certain of the time because she had both a wall clock and a phone visible and accessible. A clock was observed on the wall, and the resident was holding her phone during the interview. Resident #16 stated that a staff member from the rehabilitation department, identified as the Director of Rehabilitation Services, eventually answered her call light. Resident #16 reported she told this staff member she had been waiting for over an hour and required incontinence care. Resident #16 stated she received assistance only after the rehabilitation staff member notified a nurse aide. She stated that at home, she was able to reach the bathroom independently and did not soil herself in an incontinence brief. During an interview on 4/21/2026 at 4:13 PM, NA #1 stated she did not recall the exact time but confirmed that before meal trays were distributed, Resident #16 activated her call light. NA #1 stated she responded to the call light and turned off the call light. NA #1 reported she was not assigned to Resident #16 that day and was unfamiliar with the resident's care needs because the resident was new. NA #1 stated she informed Nurse #2 and NA #2 at the nurses' desk that Resident #16 reported the medication to move her bowels was beginning to work, and she needed help to the bathroom. During an interview on 4/21/2026 at 3:35 PM, NA #2 confirmed that NA #1 informed her that Resident #16 needed assistance to the bathroom. NA #2 stated that the lunch trays were already in the hallway at that time. She reported that it was a long-standing rule that residents could not receive incontinence care or be assisted to the bathroom while meal trays	F0677	Continued from page 5 and to determine the need for further and/or frequency of monitoring. Completion date: 5/18/26	05/18/2026

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F0677 SS = D	Continued from page 6 were in the hallway. NA #2 stated that Resident #16 did not eat her lunch while soiled but waited until trays were passed and NA #2 had finished assisting other residents with eating. NA #2 stated she then provided incontinence care and reheated Resident #16's lunch. During an interview on 4/21/2026 at 3:30 PM, Nurse #2 stated that NA #1 informed her and NA #2 around lunchtime that Resident #16 might need incontinence care. Nurse #2 stated Resident #16's call light may have been on for approximately ten minutes before NA #1 answered it. Nurse #2 reported that meal trays for the adjacent hallway had just been delivered, and trays for her hallway were expected imminently when Resident #16 requested assistance. During an interview on 4/21/2026 at 3:55 PM, the Director of Rehabilitation Services stated she answered Resident #16's call light at lunchtime that day. She reported that Resident #16 stated she needed to be changed and had been waiting. The Director of Rehabilitation Services stated she notified the Assistant Director of Nursing (ADON) of Resident #16's needs. During an interview on 4/21/2026 at 4:08 PM, the ADON confirmed she was informed by the Director of Rehabilitation Services that Resident #16 required assistance at lunchtime that day. The ADON stated she located Nurse #2 and informed her that Resident #16 needed to be changed. The ADON stated Nurse #2 told her she would take care of it. During a second interview on 4/21/2026 at 4:47 PM, Nurse #2 stated the ADON texted her at 1:30 PM that day and informed her that Resident #16 needed to be changed. Nurse #2 stated she was assisting another resident with eating, and when she entered the hallway, NA #2 was already on her way to provide care. During an interview on 4/22/2026 at 10:30 AM, the Director of Nursing stated that NA #2 should have assisted Resident #16 to the bathroom when she was informed of her needs. She stated she taught nurse aide classes and that there had never been a rule prohibiting incontinence care while meal trays were in the hallway. During an interview with the Administrator conducted on 4/22/2026 at 2:45 PM, she reported that residents should receive assistance with toileting and incontinence care even if the meal trays were on the hallway. The Administrator stated that another staff member could have assisted in passing	F0677		05/18/2026

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F0677 SS = D	Continued from page 7 out meal trays while Resident #16 received the needed care.	F0677		05/18/2026
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observations and staff interviews, the facility failed to store stock medications securely in the original covered and labeled bottles to prevent errors and possible contamination in 1 of 2 medication carts reviewed for medication storage (300 hall medication cart #1). The findings included: A medication administration observation of the medication cart #1 for the 300-hall occurred on 4/21/26 for Resident #12. This was a continuous observation that occurred from 8:28 AM through 8:54 AM. The observation revealed Nurse #1 did not have a bottle of Vitamin D3 (cholecalciferol) 25 micrograms (mcg)/1000 units (supplement) in her medication cart, nor was the medication available in	F0761	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice Resident #12 still resides in the facility. Resident #12 received medications as ordered by the physician. Address how the facility will identify other residents having the potential to be affected by the same deficient practice Residents residing in the facility have the potential to be affected by the deficient practice. The medication carts on both units were inspected on 5/11/26 by the Director of Nursing and Assistant Director of Nursing to ensure that there were no medications stored outside of their original packaging and stored securely. There were no other issues identified. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur Education was provided to nurses and medication aides on 5/11/26 by the Assistant Director of Nursing and Director of Nursing regarding maintaining medications securely and in the original covered and labeled packaging. Nurses or medication aides that have not received the education by 5/13/26 will not be able to work their next scheduled shift until education is received. Newly hired nurses and medication aides will receive the education during orientation from the Assistant Director of Nursing. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained The Assistant Director of Nursing or designee will audit two medication carts four times a week for four weeks, then two medications carts three times a week for four weeks, then two medication carts two times a week for four weeks for a total of 12 weeks to ensure that medications are stored in their original packaging and stored securely. The Assistant Director of Nursing is responsible for forwarding the results of the audits to the QAPI Committee monthly for three months. The QAPI Committee will review the audit to determine trends and/or issues that may need further interventions	05/18/2026

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F0761 SS = D	Continued from page 8 the medication storage room. Nurse #1 obtained the medication from Unit Manager #1's medication cart #2 which was also assigned to the 300-hall. Unit Manager #1 poured 8 tablets of the Vitamin D3 25mcg/1000 units into a medicine cup, labeled the cup as "Vit D3", and handed the cup to Nurse #1. Nurse #1 went back to her medication cart and placed the medicine cup into the top drawer of her medication cart. Nurse #1 confirmed she placed the Vitamin D3 in a medicine cup for continued use until she was able to get a bottle for her medication cart. A continuous medication administration observation on 4/21/26 from 8:54 AM through 9:08 AM with Nurse #1 revealed she did not have Acetaminophen 500 milligrams (mg) in medication cart #1 on the 300-hall for Resident #10. Nurse #1 obtained the medication from Unit Manager #1's medication cart #2. Unit Manager #1 poured 12 tablets of the Acetaminophen 500mg into a medicine cup and handed the cup to Nurse #1. Nurse #1 went back to medication cart #1 and placed the medicine cup into the top drawer of her cart. The medicine cup was not labeled. Nurse #1 stated she did not have a pen to write the medication name on the cup. Nurse #1 confirmed she placed the Acetaminophen in a medicine cup for continued use until she was able to get a bottle for her medication cart. On 4/21/26 at 9:10 AM, an interview was held with Nurse #1. She stated if a medication was not available in her medication cart, she would see if another cart on her hall had that medication. If the medication was available on that cart, she would get a cup of the medicines to finish her medication pass. If the medication was not available on either cart, she would look in the medication storage room. If the medication was not in the storage room, she would follow up with Central Supply to place an order for that medication. On 4/21/26 at 10 AM, an interview with the Director of Nursing (DON) revealed if a medication was not available on the medication cart, she would check all medication carts and medication storage rooms. If the medication was not available, she would follow up with Central Supply. If they could not obtain the medication, they would contact the provider. Interview and observation of Nurse #1's medication cart #1 with the Director of Nursing (DON) present on 4/21/26 at 10:15 AM revealed the open medicine	F0761	Continued from page 8 put into place and to determine the need for further and/or frequency of monitoring. Completion date: 5/18/26	05/18/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345131	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/22/2026

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

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F0761 SS = D	Continued from page 9 cups that contained 12 tablets of Acetaminophen 500mg and 8 tablets of Vitamin D3 (cholecalciferol) 25mcg/1000 units had been discarded. Nurse #1 stated she received a bottle of Acetaminophen 500mg and Vitamin D3 25mcg/1000 units from the Assistant Director of Nursing (ADON). However, during this observation with the DON and Nurse #1, an open medicine cup of white tablets labeled Magnesium was observed in the top drawer of the medication cart. The small medicine cup was observed to be about half full of tablets. The number of tablets in the cup was unknown as Nurse #1 discarded the pills prior to counting. The DON stated medications were not supposed to be stored open (labeled or unlabeled) in a medicine cup in the medication cart.	F0761		05/18/2026