DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/09/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495153		08/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS HEALTHCARE CENTER	1242 CEDARS CT CHARLOTTESVILLE, VA 22903

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 7/30/19 through 8/1/19. The facility's Emergency Preparedness Plan was reviewed and found to be in compliance with CFR 483.73, the Federal requirements for Emergency Preparedness in Long Term Care facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 7/30/19 through 8/1/19. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. No complaint's were investigated during the survey. The census in this 143 certified bed facility was 131 at the time of the survey. The survey sample consisted of 27 current Resident reviews and 2 closed record reviews.	F 000	The statement made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State regulations, the facility has taken or will take the action set forth in the plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as	F 656	1. The assigned CNA is reading resident #53 menu to her daily as resident will allow while assisting her with menu/meal requests. Assigned CNA is also describing what is on meal tray items and location with resident #53 at each meal. Activities assistant is reviewing the activity calendar with resident #53 daily as resident allows. Resident #1 was evaluated by Occupational Therapy for splint management. Physician orders obtained for splint management and it was entered on residents care plan.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Stephen Reynolds | TITLE: Administrator | (X6) DATE: 8-14-19

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.

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F 656	Continued From page 1 required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and resident interview, the facility staff failed to implement care plan interventions for vision deficit for one of 29 residents, Resident #56; and failed to develop a care plan for a hand splint for one of 28 residents, Resident #1. Findings were: 1. Resident #56 was admitted to the facility on 05/08/2018 with the following diagnoses,	F 656	2. All residents with visual deficits and splints have the potential to be affected by this practice. An audit of all residents with vision deficits will be reviewed to ensure care plan interventions for visual deficits are being implemented. Unit Managers will assess all residents with splints to ensure appropriate physicians orders are in place and care plan is updated. 3. DON/designee will educate current staff on the development and implementation of the comprehensive care plan, to include visual deficit interventions and splint management. 4. DON/designee will audit new admissions orders and care plan for visual deficit interventions and splints to ensure that a comprehensive care plan is developed and implemented. DON/Designee will observe staff to ensure that care plan interventions are being implemented 3x weekly x 4 weeks, weekly x 1 month and monthly x 1 month. Findings will be reported to the QAPI committee for review and further recommendations. 5. Date of compliance: September 10th, 2019	

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F 656	Continued From page 2 included, but not limited to: Major depressive disorder, elevated blood pressure, absolute glaucoma, legal blindness, hypokalemia and diabetes mellitus. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 06/17/2019 assessed Resident #56 as cognitively intact with a summary score of "15". On 07/30/2019 at approximately 12:15 p.m., Resident #56 was observed in her room. After knocking on the door, Resident #56 turned her head to the door and stated, "Who's there?" Resident #56 also stated, "I'm blind...I can see your shape, but that's it." On 07/31/2019 at approximately 8:30 a.m., Resident #56 was observed sitting on the side of her bed eating breakfast. Her cup of coffee and juice were directly in front of her, her plate of food was to her right, at the back of her tray was a plate of fruit covered with plastic wrap. Resident #56 was asked if she knew where everything was on her tray. She stated, "I feel around for it." She was asked if anyone had told her where things were located on her tray, she stated, "No." At approximately 10:00 a.m., Resident #56 was sitting in her room. LPN (licensed practical nurse) # 2 was in the room speaking with her. In the course of the conversation Resident #56 stated that she often got food she didn't like on her trays at meal times. LPN # 2 asked Resident #56 if she filled out her menu each day. Resident #56 stated, "No...I can't see it." Resident #56 was asked if anyone reviewed it with each day. She stated, "No." LPN # 2 looked on Resident #56's	F 656	See Page 1 of 36	

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F 656	Continued From page 3 bedside table, The menu for 07/31/2019 was on the bedside table, no choices had been selected. LPN # 2 was asked if the menus were given to the residents one day in advance. She stated, "Yes." LPN # 2 completed Resident #56's menu for 07/31/2019 and the additional one on her bedside table for 08/01/2019. At approximately 10:15 a.m., a volunteer came in and laid an activities calendar for August on Resident #56's bedside table. Resident #56 asked, "What is that?" The volunteer stated, "It is the calendar of activities for August." Resident #56 was asked (by this surveyor) if she could read the calendar. She stated, "No...I don't know what is going on unless they come in here everyday and tell me." The care plan was reviewed at approximately 11:30 a.m. Interventions on the care plan included, "...Read activities calendar and menu to resident so she can make choices." On 07/31/2019 at approximately 1:40 p.m., the activities assistant (Other Staff #2) came to the conference room. She stated, "We try to go over the activities with (name of Resident #56) but she cuts us off. The CNA (certified nursing assistants) review the menus with her everyday." She was informed of the observations documented above. The administrator and the DON (director of nursing) were informed of the above information during an end of the day meeting on 07/31/2019. No further information was obtained prior to the exit conference on 08/01/2019. 2. Resident # 1 was admitted to the facility 4/4/19 with a readmission date of 5/28/19. Diagnoses	F 656	See Page 1 of 36	

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F 656	Continued From page 4 for Resident # 1 included, but not limited to: chronic congestive heart failure, cortical blindness, spina bifida, diabetes, history of stroke, and hemiplegia/hemiparesis of left side following stroke. The most recent MDS (minimum data set) was a quarterly review dated 7/19/19. Resident # 1 was assessed as being cognitively intact with a total summary score of 13 out of 15. During the initial tour of the facility on 7/30/19 beginning at 10:15 a.m., Resident # 1 was observed with a splint on his left hand. When asked about the splint, Resident # 1 stated "I had a stroke and a heart attack on the operating table; I wear this now because my hand is contracted. I think it's to help straighten out my fingers." Resident # 1 was then asked how many hours per day the splint was worn. Resident # 1 stated "Well, pretty much I wear it all the time..." A review of the clinical record was conducted 7/30/19 at 2:00 p.m. The current POS (physican order summary) did not include any orders for the use of the splint, and there were no therapy orders for management of the splint. A review of the care plan revealed the hand splint was not care planned. On 7/31/19 during an end of the day meeting with facility staff beginning at 4:05 p.m. the DON (director of nursing), when informed of the above findings, and stated "Well, he did come from the hospital to us with the hand splint, but there were no orders for it, so it didn't get put in the system here. That's why it wasn't on the care plan." No further information was provided prior to the	F 656	See Page 1 of 36	

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F 656	Continued From page 5 exit conference.	F 656		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to follow professional standards of care for two of 29 residents in the survey sample, Resident #105 and Resident #42. Resident #105 was administered another resident's medications in error. Nurses failed to clarify a physician's order prior to administration of a medication to Resident #42. The findings include: 1. Resident #105 was originally admitted to the facility on 04/01/19 and readmitted on 05/13/19 with diagnoses that included dysphasia, hypertension, depression, hemiplegia/hemiparesis, muscle weakness, anemia, and complex regional pain syndrome. The minimum data set (MDS) dated 07/03/19 coded the resident as being moderate cognitively impaired for daily decision making with a score of 8 out of fifteen. Resident #105's clinical record was reviewed on 07/31/19 at 9:30 a.m. Resident #105's clinical record documented a nursing note dated 07/04/19 at 11:57 a.m. as follows: "This am	F 658	1. Resident #105 was given medication in error. MD/RP was notified immediately and resident was monitored for adverse effects. No negative outcomes were observed. The responsible LPN received medication administration education and med pass observations. Resident #42 Synthroid order was clarified and updated in the EMR to reflect current physician order. 2. All residents have the potential to be affected by this practice. An audit of current resident's physician orders will be conducted to identify any discrepancies in additional instructions. 3. DON/Designee will educate licensed nurses on medication administration policy to include five rights of medication administration, preparation of medications utilizing infection control practices and providing privacy and dignity during medication administration. DON/Designee will educate licensed nurses on taking transcribing/executing a physician's order to include discontinuing previous orders.	

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F 658	Continued From page 6 (morning) res. (resident) received medication in error, MD notified and will monitor for drowsiness and monitor vs (vitals) q4 24H (every 4 hours for 24 hours). Res (resident) at this time has no ill effects from the medication and is participating with therapy this am (morning), she is alert and pleasant. Res (resident) is aware, attempt to notify daughter no answer to number listed and voice mailbox is full. VS (vitals) at time of incident..." The facility's investigation of Resident #105's medication error dated 07/04/19 at 11:21 a.m. documented, "This resident was coming down the hall with therapy and nurse mistaken her for another resident with similar appearance and administered wrong medication. Res (resident) made comment (I don't take my medications crushed). Error caught and MD's notified. Therapist commented to staff that this is [Name of Resident #105].... Med Error Cause... Did not id resident...mistaken for another resident..." Recommendation: nursing staff to properly identify all residents prior to medication administration." On 07/31/19 at 10:50 a.m., the director of nursing (DON) was interviewed about the documented medication error with Resident #105. The DON stated the nurse did not properly identify the resident and had mistaken her for another resident who looked similar. The DON was asked how nurses identify residents for medication administration. The DON stated the nurse is supposed look at the picture on the electronic medical record (EMR), look at the names on the room and verbally state the resident's name prior to adminstering the medication to ensure they are administering the	F 658	4. DON/Designee will conduct medication administration observations for two licensed nurses weekly x 4 weeks and 5 licensed nurses monthly x 2 months to ensure medication administration policy is followed. DON/Designee will audit physician's orders daily (5x week) in clinical startup to ensure EMR accurately reflects new orders. The findings will be reported to the QAPI committee for review and further recommendations. 5. Date of compliance: Sept 10th, 2019	

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F 658	Continued From page 7 medications to the correct resident. The DON stated the nurse was standing at the med cart near the Resident's room and mistook the resident's identity. On 07/31/19 at 2:50 p.m., the occupational therapist (OS #1) who was transporting Resident #105 to therapy was interviewed regarding the medication error incident on 07/04/19. OS #1 stated she was transporting Resident #105 to therapy when the nurse stopped them and said "let me give her her meds now." OS #1 stated when the nurse gave Resident #105 the medications, that Resident #105 said "I don't take my medications crushed", however Resident #105 did take the medications. OS #1 stated she observed the electronic medical record screen (EMR) and noticed the picture was not Resident #105, rather another resident who looked similar to Resident #105 and told the nurse of her observation. OS #1 stated the nurse said "oh no" and immediately made the calls to notify the appropriate staff of the medication error. A review of the facility's policy titled "Medication Administration" revised on 12/14/17, documents the following: "I. General Procedures.... f. Observe the "five rights" in giving medication: i. the right resident....j. Full attention should be given during preparation of medications. "II. Preparation..... d. Identify the resident by picture and state name. e. Provide privacy and dignity....." These findings were reviewed with the administrator, director of nursing (DON) and	F 658	See Page 6 of 38	

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F 658	Continued From page 8 corporate consultant during a meeting on 07/31/19 at 4:00 p.m. 2. Resident #42 was admitted to the facility on 1/27/15 with a re-admission on 11/18/16. Diagnoses for Resident #42 included cerebral infarction, lymphedema, diabetes, hypothyroidism, atrial fibrillation, obesity and high blood pressure. The minimum data set (MDS) dated 4/26/19 assessed Resident #42 as cognitively intact. A medication pass observation was conducted on 7/31/19 at 7:40 a.m., with licensed practical nurse (LPN #1) administering medication to Resident #42. Among the medications administered to Resident #42 was Synthroid 50 mcg. Resident #42's clinical record documented a physician's order dated 1/7/18 for Synthroid 50 mcg each morning with instructions to give the 50 mcg tablet along with a 12.5 mcg tablet for a total dose of 62.5 mcg. The resident's MAR and the medication label from the pharmacy had the same order/instructions for a 62.5 mcg daily dose. On 7/31/19 at 8:50 a.m., LPN #1 was interviewed about Resident #42's Synthroid dosage. LPN #1 reviewed the MAR and stated the order was confusing and she thought the resident was ordered only the 50 mcg dose. LPN #1 looked through the medication supply and stated there was no Synthroid 12.5 mcg for Resident #42 in the cart. On 7/31/19 at 9:15 a.m., the director of nursing (DON) was interviewed about Resident #42's Synthroid. After researching, the DON stated at one time the resident was prescribed 62.5 mcg	F 658	See Page 6 of 38	

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F 658	Continued From page 9 but that dosage was discontinued and changed to 50 mcg each day. The DON stated when the order was discontinued, the instructions to give with 12.5 mcg for a total dose of 62.5 mcg were not removed from the clinical record or MAR. A copy of the order to discontinue the 62.5 mcg dose was requested. On 7/31/19 at 10:50 a.m., the DON presented a copy of the physician's order dated 1/7/18 to discontinue the 12.5 mcg dose of Synthroid for Resident #42 and give 50 mcg each day. On 7/31/19 at 1:13 p.m., the DON stated the resident had been administered the 50 mcg dose of Synthroid since it was ordered on 1/7/18. The DON stated she checked with the pharmacy and the 12.5 mcg Synthroid dose had not been filled and/or sent from the pharmacy since January 2018. The DON had no explanation of why nurses had not questioned and/or clarified the Synthroid dosage order since January 2018. The facility's policy titled Physician Orders (revised 12/1/18) documented concerning taking/executing a physician's order, "...Write down the order as stated...Discontinue any previous contradicting order (ex: for dose changes, dressing treatments)...Place orders in electronic Medical Record...Contact pharmacy for changes...The nurse that takes the physician order will be responsible for executing the order or provide for the safe hand-off to the next nurse...Update MAR...with changes or new orders..." The Nursing 2017 Drug Handbook on page 1585 documented concerning best practices to avoid medication errors, "...A drug order with incomplete or unclear information can result in	F 658	See Page 6 of 38	

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F 658	Continued From page 10 giving the wrong drug or wrong dose, by the wrong route, or at the wrong time...each order should specify the correct drug name, concentration, dosage, route, and frequency of administration...Clarify all incomplete or unclear orders with the prescriber..." (1) This finding was reviewed with the administrator and director of nursing during a meeting on 7/31/19 at 4:15 p.m. (1) Rader, Janet, Dorothy Terry and Leigh Ann Trujillo. Nursing 2017 Drug Handbook. Philadelphia: Wolters Kluwer, 2017.	F 658	See Page 6 of 38	
F 677 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, staff interview, resident interview, and facility document review, the facility staff failed to provide nail care for one of 29 residents, Resident #56. Findings were: Resident #56 was admitted to the facility on 05/08/2018 with the following diagnoses, included, but not limited to: Major depressive disorder, elevated blood pressure, absolute glaucoma, legal blindness, hypokalemia and diabetes mellitus. The most recent MDS (minimum data set) was a	F 677	1. Resident #56 nails have been cleaned and trimmed. 2. All residents have the potential to be affected by this practice. An audit of current resident's nails was conducted and residents needing nail care were identified and care provided accordingly. 3. DON/Designee will educate clinical staff on providing nail care per care plan based on resident's preference. 4. DON/Designee will assess 10 residents 2x weekly x 4 weeks, weekly x 1 month then monthly x 1 month for clean /trimmed nails per resident preference. The findings will be reported to the QAPI committee for review and further recommendations. 5. Date Compliance: Sept 10th, 2019	

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F 677	Continued From page 11 quarterly assessment with an ARD (assessment reference date) of 06/17/2019 assessed Resident #56 as cognitively intact with a summary score of "15". On 07/31/2019 at approximately 8:30 a.m., Resident #56 was observed sitting on the side of her bed eating breakfast. The thumb nail on her right hand and the pinky nail of her left hand were observed as long, dark in color and curved. All of her other nails were cut short. She was asked why those two nails were long. She stated, "Nobody has cut them." She was asked why the others were short. She stated, "I chew those off, I can't get those two." She was asked if the long nails bothered her. She stated, "Yes, they hurt...I hit them and it pulls the skin...they came and worked on my feet but they didn't do my hands." At approximately 10:00 a.m., Resident #56 was sitting in her room. LPN (licensed practical nurse) # 2 was in the room speaking with her. She stated that LPN #3 would be coming to cut her nails for her. LPN #3 came to the room and cut and filed both of the long nails. The facility policy for nail care was requested and received. The policy, "Nail and Hair Hygiene Services" contained the following information: "...Nail Hygiene Services: refers to the routine trimming, cleaning, filling but not polishing of undamaged nails, and on an individual basis, care for ingrown or damaged nails....Routine Nail Hygiene: Residents will have routine nail hygiene...as part of the bath or shower. Nails should be trimmed immediately after bathing or alternatively, soaking nails in warm soapy water prior to trimming or filing to reduce tearing and provide ease of trimming and filing..."	F 677	See Page 11 of 38	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495153		08/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 677	Continued From page 12 The administrator and the DON (director of nursing) were informed of the above information during an end of the day meeting on 07/31/2019. No further information was obtained prior to the exit conference on 08/01/2019.	F 677	See Page 11 of 38	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to physician orders for three of 29 residents in the survey sample. Facilty staff failed to obtain vital signs every 4 hours after a medication error for Resident #105; failed to follow orders for medication administration for Resident #123, and failed to implement a bowel management program for Resident #76. The findings include: 1. Resident #105 was originally admitted to the facility on 04/01/19 and readmitted on 05/13/19 with diagnoses that included dysphasia, hypertension, depression, hemiplegia/hemiparesis, muscle weakness,	F 684	1. Resident #105 was given medication in error. MD/RP was notified immediately. No negative outcomes were observed. Resident #123 has had no adverse effects of administration of inhaler, receives inhaled medication daily and has been educated on swishing and spitting following inhaler administration. The nurse received medication administration education and med pass observations. MD was notified of complaint of constipation and PRN bowel regimen was ordered for resident #76. Resident is currently having regular bowel movements and monitored for constipation. 2. All residents have the potential to be affected by current practices. An audit of all residents with steroid inhalers was conducted to ensure physicians orders and manufacture recommendations are being followed. An audit of all residents was conducted to ensure all resident are having a bowel movement at least weekly and bowel regimens are in place as needed.	

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	495153		08/01/2019

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F 684	Continued From page 13 anemia, and complex regional pain syndrome. The minimum data set (MDS) dated 07/03/19 coded the resident as being moderate cognitively impaired for daily decision making with a score of 8 out of fifteen. Resident #105's clinical record was reviewed on 07/31/19 at 9:30 a.m. Resident #105's clinical record documented a nursing note dated 07/04/19 at 11:57 a.m. as followed: "This am (morning) res. (resident) received medication in error, MD notified and will monitor for drowsiness and monitor vs (vitals) q4 24H (every 4 hours for 24 hours). Res (resident) at this time has no ill effects from the medication and is participating with therapy this am (morning), she is alert and pleasant. Res (resident) is aware, attempt to notify daughter no answer to number listed and voice mailbox is full. VS (vitals) at time of incident....." The facility's investigation of Resident #105's medication error dated 07/04/19 documented, "This resident was coming down the hall with therapy and nurse mistaken her for another resident with similar appearance and administered wrong medication. Res (resident) made comment (I don't take my medications crushed). Error caught and MD's notified. Therapist commented to staff that this is [Name of Resident #105].... Med Error Cause... Did not id resident...mistaken for another resident..." Recommendation: nursing staff to properly identify all residents prior to medication administration." The "Medication Error Report" documented the incident was reported on 07/04/19 at 10:00 a.m. and the MD was notified at 10:30 a.m.	F 684	3. DON/Designee will educate licensed nurses on the facilities medication incident policy to include monitoring, obtaining vital signs as ordered and observing resident for negative outcomes. Educate licensed nurses on following physician orders and manufacture guidelines for inhaled medications. Educate licensed nurses on monitoring frequency of bowel movements and obtaining bowel regimen orders when needed. 4. DON/Designee will audit all medication incident reports to ensure vital signs are obtained per order x 3 months. DON/Designee will observe 2 nurses weekly x 4 weeks and 5 nurses monthly x2 to ensure nurses are following manufacture guidelines on all inhaled medications. DON/Designee will monitor the no bowel movement report daily 5x weekly in clinical meeting and ensure bowel regiment is available as needed x 4 weeks then will review 10 residents monthly x 2 months. The findings will be reported to the QAPI committee monthly for review and further recommendations. 5. Date of compliance: Sept 10th,2019	

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	495153		08/01/2019

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F 684	Continued From page 14 The facility's medication investigation report documented the following: "Immediate Action Taken: "Treatment ordered per MD, monitor vs q4H x24 H and observe for drowsiness." Resident #105's clinical record documented vitals taken at the following times: 1. 07/04/19 at 11:57 a.m. 2. 07/04/19 at 12:22 p.m. 3. 07/04/19 at 21:43 (9:43 p.m.) 4. 07/04/19 at 21:45 (9:45 p.m.) 5. 07/05/19 at 00:50 (12:50 a.m.) 6. 07/05/19 at 09:24 a.m. A review of the nurses notes revealed only three nurses notes during the 24 hour period after the medication error incident on 07/04/19. There we no notes that Resident #105 refused to have her vitals taken during that period. A review of the facility's policy titled "Medication Administration" revised on 12/14/17, documents the following: "I. General Procedures.... f. Observe the "five rights" in giving medication: i. the right resident....j. Full attention should be given during preparation of medications. "II. Preparation..... d. Identify the resident by picture and state name. e. Provide privacy and dignity....." A review of the facility's policy titled "Medication Incident", documented the following: "II. Adverse Events: a. Access the resident for	F 684	See Page 13 of 38	

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	495153		08/01/2019

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F 684	Continued From page 15 adverse events when medication errors or discrepancies are identified. Include full vitals. Signs and symptoms the resident may be experience that are new or different....." "IV. Document in the medical record..... d. Resident conditions including follow up assessments, if indicated." These findings were reviewed with the administrator, director of nursing (DON) and corporate consultant during a meeting on 07/31/19 at 4:00 p.m. 2. On 07/31/19 at 8:00 AM, during a medication pass and pour observation, LPN #4 prepared medications for Resident #123. A medication included for Resident #123 was Symbicort 80/4.5 mcg (micrograms) inhaler. LPN #4 administered the prepared medications to the resident and then handed the resident the Symbicort inhaler. The resident self administered herself two inhalations, one right after another. LPN #4 did not provide the resident with instruction prior to, during or after for the self administration of Symbicort. Resident #123 completed the self administration and then took a drink of water and swallowed it. LPN #4 was asked if Resident #123 was supposed to swish and spit after the Symbicort inhalations. LPN #4 stated that the resident didn't have an order to swish and spit and "maybe the resident took the medication this way at home (without rinsing her mouth after)." LPN #4 was made aware that this is usually a manufacturer's recommendation. LPN #4 pulled the Symbicort box out of the medication cart and looked at it and stated, "See it doesn't say that." The medication package insert was attached to the box and removed and reviewed. The package	F 684	See page 13 of 38	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	495153		08/01/2019

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F 684	Continued From page 16 insert documented, "...Dosage and Administration...After inhalation, the patient should rinse the mouth with water without swallowing." At approximately 8:30 AM, a medication reconciliation was completed for Resident #123. The resident's current physician's orders dated 07/31/19 documented, "...Symbicort Aerosol 80-4.5 MCG...2 puff inhale orally two times a day...gargle after administration..." The resident's July 2019 MARs (medication administration records) were reviewed and documented the same as the above physician's order for the Symbicort. On 07/31/19 at 8:40 AM, a policy on medication administration was requested from the DON (director of nursing). The policy documented, "...Administer medication only as prescribed by the provider...always follow manufacturer's guidelines for specific medication use...a minimum period of one minute is suggested between puffs of same inhalers...rinse mouth after steroid inhalers..." 07/31/19 09:41 AM, an interview with LPN #4 was conducted regarding the above findings. The LPN stated, "Ok, we can get that changed." No further information and/or documentation was presented prior to the exit conference on 8/1/19. 3. Resident #76 was admitted to the facility on originally on 2/8/19, with the most current readmission on 4/13/19. Diagnoses for this resident included, but were not limited to: history	F 684	See page 13 of 38	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495153		08/01/2019

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F 684	Continued From page 17 of a stroke, urinary retention with catheter placement, history of pressure ulcer, muscle weakness, diabetes mellitus, high blood pressure, hyponatremia, and protein calorie malnutrition. The resident's most current MDS was a quarterly assessment dated 5/6/19. This MDS assessed the resident with a cognitive score of 14, indicating the resident was cognitively intact for daily decision making skills. The resident was also assessed as requiring extensive assistance from staff for most all ADL's, including toileting with assistance of at least one staff person. The resident was also assessed as "frequently incontinent" of bowel on this MDS. An interview was conducted with Resident #76 on 07/30/19 at 11:34 AM. Resident #76 was asked if he had any problems with his bowels. Resident #76 stated, "I've been constipated since I've been here." Resident #76 was asked if the facility gave him anything to help with his bowels. He stated he thought the staff gave him stuff but stated that it didn't help much and he wasn't sure what they gave him. He also stated that he wore an incontinent pad for protection and that staff help him get cleaned up. Resident #76 stated that he calls staff when he needs to be changed. He stated that he used to have a peg tube, but not longer has that and is eating a regular diet now. The resident's current physician's orders were reviewed. The resident did not have any medications ordered to promote bowel movements and/or bowel regularity. The resident's MARs were reviewed and did not evidence the resident had received any medications to promote bowel movements and/or	F 684	See Page 13 & 18	

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	495153		08/01/2019

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F 684	Continued From page 18 bowel regularity. The resident's CCP (comprehensive care plan) was reviewed and documented, "....has dehydration or potential fluid deficit related to...administer medications as ordered...monitor/document bowel sounds and frequency of BM [bowel movement]: provide medication per order..." The resident's bowel records were reviewed and documented that the resident did not have a documented bowel movement from July 1st through July 5th; five days without a bowel movement. The bowel records also documented the resident did not have a bowel movement from July 10th through July 13th; four days without a bowel movement. On 07/31/19 at 2:29 PM, the Director of Nursing (DON) was asked if the facility uses standing orders that would include a bowel protocol. The DON stated that the facility does not use standing orders and if a resident doesn't have anything ordered for bowels the nurse will call and get an order for it. The DON was asked if there was a facility bowel protocol. The DON stated that the facility did have a bowel protocol. The DON also stated that there is a notification/reminder that pops up for the nurse to let them know if a resident hasn't had a bowel movement after a couple of days and the nurse is to address this. The DON was asked if there was a written policy or protocol. A policy titled, "Policies and Standard Procedures" documented, "...Report immediately (unless values are consistently at this level and	F 684	See Page 13 of 18	

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	495153		08/01/2019

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F 684	Continued From page 19 the physician is aware)...Non-immediate (Report next office day)...Constipation Severe abdominal pain, rigid, abdomen, absent bowel sound [this was under the report immediately column]...less than 1 BM (bowel movement) in a week [this was under the non-immediate column/report the next office day]..." No notification was found regarding this resident for bowels. The DON was made aware of the above concerns regarding Resident #76. The DON stated that the resident has never complained and that his bowel sounds are being assessed. The DON was made aware of the resident's interview and made aware of the resident's bowel records, in addition to the resident's CCP. No further information and/or documentation was presented prior to the exit conference on 8/1/19 to evidence that a bowel management program had been implemented for Resident # 76 or that the resident had a BM during the time above.	F 684	See page 13 & 18	
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent	F 686	1. Resident #121 heels were immediately floated with pillows to prevent skin breakdown. 2. All residents with physician orders to float heels have to potential to be affected. All residents with physician order to float heels were audited to ensure care cards were updated to reflect order and heels are being floated.	

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	495153		08/01/2019

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F 686	Continued From page 20 new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility staff failed to follow physician's orders to float heels while in bed, for one of 29 residents in the survey sample, Resident #121. The Findings Include: Resident #121 was admitted to the facility on 4/26/19. Diagnoses for Resident #121 included; Diabetes, dementia, Alzheimer's disease, and dysphagia. The most current MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 7/10/19. Resident #121 was assessed with a score of 4 indicating severe cognitive impairment. On 7/30/19 Resident # 121's medical record was reviewed. An active physician's order dated 10/4/16 documented "float heels when in bed to decrease pressure on heels." On 7/31/19 at 9:50 AM, Resident #121 was observed laying in bed. Resident #121's certified nursing assistant (CNA #3) was standing just outside Resident #121's door and was asked to observe Resident #121's heels while in bed. Resident #121's heels were observed laying against the mattress and were not floated. CNA #3 was then interviewed and stated that she was unaware that Resident #121 had a physician's order to float heels when in bed. On 07/31/19 at 4:00 PM, the above information was presented to the director of nursing (DON)	F 686	3. DON/Designee educate clinical staff on facility policy on pressure ulcer prevention and ensuring care cards are updated to include floating heels. 4. The DON/designee will observe residents with orders to float heels 3x weekly x 4 weeks weekly x 1 month and monthly x1 to ensure care card is updated and heels are floated while in bed. The findings will be reported to the QAPI committee for review and further recommendations. 5. Date of Compliance: Sept 10th, 2019 RECEIVED AUG 26 2019 VDH/OLC	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	495153		08/01/2019

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F 686	Continued From page 21 administrator and nurse consultant. No other information was presented prior to exit conference on 8/1/19.	F 686		
F 688 SS=E	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview and clinical record review, the facility staff failed to ensure physican's orders were in place for a hand splint for Resident # 1. Findings include: Resident # 1 was admitted to the facility 4/4/19 with a readmission date of 5/28/19. Diagnoses for Resident # 1 included, but not limited to: chronic congestive heart failure, cortical	F 688	1. Resident #1 was evaluated by Occupational Therapy for splint management. Physician orders obtained for splint management and entered into the EMR. 2. All residents with splints have the potential to be affected by current practice. All resident with splints were audited to ensure physician orders were in place. 3. DON/Designee will educate licensed nurses on obtaining therapy referrals and physician orders for residents with splints. 4. DON/Designee will audit all new admissions for splints and ensure physician orders and therapy referrals are in place. DON/Designee will audit all therapy referrals for splints and ensure splint management orders are obtained and entered in the EMR 5x weekly x 4 weeks, 2x weekly x 1 month, and weekly x 1 month. The findings will be reported to the QAPI committee for review and further recommendations. 5. Date of compliance: Sept 10th, 2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495153		08/01/2019

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F 688	Continued From page 22 blindness, spina bifida, diabetes, history of stroke, and hemiplegia/hemiparesis of left side following stroke. The most recent MDS (minimum data set) was a quarterly review dated 7/19/19. Resident # 1 was assessed as being cognitively intact with a total summary score of 13 out of 15. During the initial tour of the facility 7/30/19 beginning at 10:15 a.m., Resident # 1 was observed with a splint on his left hand. When asked about the splint, Resident # 1 stated "I had a stroke and a heart attack on the operating table; I wear this now because my hand is contracted. I think it's to help straighten out my fingers." Resident # 1 was then asked how many hours per day the splint was worn. Resident # 1 stated "Well, pretty much I wear it all the time..." A review of the clinical record was conducted 7/30/19 at 2:00 p.m. The current POS (physican order summary) did not include any orders for the use of the splint, and there were no therapy orders for management of the splint. A review of the care plan revealed the hand splint was not care planned. On 7/31/19 at 8:00 a.m. after observation of Resident # 1's dressing change, CNA (certified nursing assistant) # 2 came in to apply the hand splint. The covering was observed stained and dirty. CNA # 2 was asked about the application of the splint. Neither CNA # 2 nor the resident were sure about the frequency of application, or how to wash it. CNA # 2 stated "I will check with therapy how to wash the foam insert. As far as when he is to wear it, we just put it on whenever he wants."	F 688	See Page 22 of 38 RECEIVED AUG 26 2019 VDH/OLC	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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CEDARS HEALTHCARE CENTER	1242 CEDARS CT CHARLOTTESVILLE, VA 22903

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F 688	Continued From page 23 On 7/31/19 at 8:30 a.m. the therapy director, identified as Other Staff (OS) # 5 was asked about the hand splint, and if therapy was working with Resident # 1 with the management of the splint. OS # 5 stated "We are looking about that order now; we're not sure not sure where it (splint) came from, so we will see about getting the doctor to put the order in...." OS # 5 was then asked how long Resident # 1 had been using the splint. She stated "I honestly don't know; let me do some digging and I will get back to you." On 7/31/19 at 1:15 p.m. LPN (licensed practical nurse) # 4, who was the charge nurse, and RN (registered nurse) # 1, who was the unit manager, were interviewed about the hand splint. They each stated the resident had the hand splint on admission; it was assumed the doctor at the hospital had applied it prior to admission, and was not noted upon admission by facility staff. LPN # 4 stated "I think it was just for his comfort...." RN # 1 stated "It was just missed..." On 7/31/19 at 1:45 p.m. OS # 5 stated, "We now have orders for the hand splint. I went down and assessed him, and put a different hand splint on that is better suited to his hand contracture as that one will separate his fingers and straighten out his hand...it's also more comfortable than what he had. As far as how long he's been using it, he's been using it since admission. Even though we had him in therapy, the hand was not the focus of treatment, and wasn't dealt with...we now have him on caseload for contracture management." On 7/31/19 during an end of the day meeting with facility staff beginning at 4:05 p.m. the DON	F 688	See page 22 of 38 RECEIVED AUG 26 2019 VDH/OLC	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	495153		08/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS HEALTHCARE CENTER	1242 CEDARS CT CHARLOTTESVILLE, VA 22903

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F 688	Continued From page 24 (director of nursing) stated, "Well, he did come from the hospital to us with the hand splint, but there were no orders for it, so it didn't get put in the system here. That's also why it wasn't on the care plan." The DON was asked when Resident # 1 was admitted, even without orders for the hand splint, what was the expectation for staff admitting residents? The DON stated "The splint should have been noted on admission, and since there were no orders should alert the physician here so referrals could be done to therapy." No further information was provided prior to the exit conference.	F 688	See page 22 of 38	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic	F 758	1. Resident #71 has order for PRN IM Ativan for seizure management. The physician documented necessity in the resident record to include appropriateness of medication and duration of use. 2. All residents with PRN psychotropic have the potential to be affected. An audit was completed for all PRN psychotropic medications to ensure necessity of use and to ensure that the duration is indicated in the order. 3. DON/Designee will educate medical director, pharmacy consultant and licensed nurses on PRN psychotropic use guidelines to include obtaining a stop date for all PRN psychotropic.	

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	495153		08/01/2019

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F 758	Continued From page 25 drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to ensure one of 29 residents in the survey sample was free of unnecessary medications. Resident # 71 in the survey sample had a PRN (as needed) order for Ativan for longer than 14 days without a stop date. The findings were: Resident # 71 was admitted to the facility on 7/15/03, and readmitted on 10/9/17 with	F 758	4. DON/Designee will audit all new PRN psychotropic orders 5x weekly x 4 weeks, 2x weekly x 1 month, and weekly x 1 month to ensure stop dates are included in physician order. Findings will be reported to QAPI committee for review and recommendations. 5. Date of compliance: September 10th, 2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495153		08/01/2019

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F 758	Continued From page 26 diagnoses that included hyperlipidemia, Cerebral Palsy, Non-Alzheimer's dementia, seizure disorder, anxiety disorder, depression, psychotic disorder, dysphagia, cognitive communication deficit, moderate intellectual disabilities, generalized muscle weakness, tracheostomy status, and gastroesophageal reflux disease. According to the most recent Minimum Data Set, a Quarterly review with an Assessment Reference Date of 6/6/19, the resident was assessed under Section C (Cognitive Patterns) as being severely cognitively impaired, with a Summary Score of 02 out of 15. Resident 71 had the following order, dated 10/9/17, for "Ativan solution 2 mg/ml (milligrams per milliliter) (Lorazepam). Inject 1 mg intramuscularly every 15 minutes as needed for seizures." The Ativan, in the same dosage, was reordered on 10/4/18. Neither order had a stop date. (NOTE: Ativan [Lorazepam] is a short acting benzodiazepine used to treat anxiety and irritability with psychiatric or organic disorders. Given orally, it has an onset of one hour with a peak of two hours. Ref. Mosby's 2017 Nursing Drug Reference, 30th Edition, page 722.) According to a review of the Electronic Medication Administration Records in the resident's Electronic Health Record, the PRN Ativan was not administered in April, May, and June of 2019, and not in July as of 7/30/10, the date of record review. At approximately 10:00 a.m. on 7/31/19, the Director of Nursing (DON) was interviewed regarding the PRN Ativan order for Resident # 71.	F 758	See Page 25 of 38 RECEIVED AUG 26 2019 VDH/OLC	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	495153		08/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 758	Continued From page 27 The DON indicated there was an exception to the 14 day PRN limitation when Ativan was used for someone with seizures. Review of Resident # 71's hard copy clinical record revealed a Consultant Pharmacist Recommendation to Physician dated 7/30/18. The consultant pharmacist made the following recommendation, "Recommend discontinue PRN use of Ativan, or reorder for a specific number of days up to 60 per the following federal guidelines...." There were two options for the physician's response to the pharmacist's recommendation: "Discontinue PRN order," and "Continue PRN use of Ativan for _____ days (specify duration) as the benefit outweighs the risks." Resident # 71's physician accepted the pharmacist's recommendation of "Continue PRN use of Ativan for _____ days (specify duration) as the benefit outweighs the risks." The duration for PRN Ativan use was not specified by the physician. The recommendation was signed by the physician on 8/7/18. The findings were discussed during a meeting at 4:00 p.m. on 7/31/19 that included the Administrator, Director of Nursing, Corporate Nurse Consultant, and the survey team.	F 758	See Page 25 of 38	
F 761 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	F 761	1. The unit manager notified the pharmacy of the label error on resident #42 synthroid. The synthroid with the incorrect labeling was removed from medication cart, returned to the pharmacy and a new medication card was obtained with a correct label.	

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	495153		08/01/2019

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F 761	Continued From page 28 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 observation, staff interview and clinical record review, the facility staff failed to label a medication accurately for one of 29 residents in the survey sample. Resident #42's medication Synthroid was labeled by the pharmacy with inaccurate dosage instructions. The findings include: Resident #42 was admitted to the facility on 1/27/15 with a re-admission on 11/18/16. Diagnoses for Resident #42 included cerebral infarction, lymphedema, diabetes, hypothyroidism, atrial fibrillation, obesity and high blood pressure. The minimum data set (MDS) dated 4/26/19 assessed Resident #42 as	F 761	Resident #42 received the correct dose of medication and there were no negative outcomes. 2. All residents have the potential to be affected by this practice. An audit of medication labels and physician orders for synthroid was completed to ensure no other medications were labeled incorrectly. 3. DON/designee will educate licensed nurses on the monitoring/matching of labeling in accordance to physician orders and in accordance to professional principles and include the appropriate additional instructions. 4. DON/Designee will audit physician orders of all residents on synthroid daily 5 x a week for 4 weeks then monthly x2 to ensure labeling and instructions match the physician order. The findings will be reported to the QAPI committee monthly for review and further recommendations. 5. Date of compliance: Sept 12th, 2019 RECEIVED AUG 26 2019 VDH/OLC	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	495153		08/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 761	Continued From page 29 cognitively intact. A medication pass observation was conducted on 7/31/19 at 7:40 a.m., with licensed practical nurse (LPN #1) administering medication to Resident #42. Among the medications administered to Resident #42 was Synthroid 50 mcg. Resident #42's clinical record documented a physician's order dated 1/7/18 for Synthroid 50 mcg each morning with instructions to give the 50 mcg tablet along with a 12.5 mcg tablet for a total dose of 62.5 mcg. The Synthroid medication label from the pharmacy had the same order/instructions for a 62.5 mcg daily dose. On 7/31/19 at 8:50 a.m., LPN #1 was interviewed about Resident #42's Synthroid dosage. LPN #1 reviewed the resident's Synthroid medication supply card that included instructions to give the 50 mcg tablet along with a 12.5 mcg tablet for a total dose of 62.5 mcg. LPN #1 stated the order was confusing and she thought the resident was ordered only the 50 mcg daily dose. On 7/31/19 at 9:15 a.m., the director of nursing (DON) was interviewed about Resident #42's Synthroid. After researching, the DON stated at one time the resident was prescribed 62.5 mcg but that dosage was discontinued and changed to 50 mcg each day. The DON stated when the order was discontinued, the instructions to give with 12.5 mcg for a total dose of 62.5 mcg were not removed from the clinical record, MAR or the pharmacy label. A copy of the order to discontinue the 62.5 mcg dose was requested. On 7/31/19 at 10:50 a.m., the DON presented a copy of the physician's order dated 1/7/18 to	F 761	See Page 28 of 38	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495153		08/01/2019

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F 761	Continued From page 30 discontinue the 12.5 mcg dose of Synthroid for Resident #42 and give 50 mcg each day. On 7/31/19 at 1:13 p.m., the DON stated the resident had been administered the 50 mcg dose of Synthroid since it was ordered on 1/7/18. The DON stated she checked with the pharmacy and the 12.5 mcg Synthroid dose had not been filled and/or sent from the pharmacy since January 2018. The DON stated the pharmacy reported the label instructions were not updated when the 12.5 mcg dose was discontinued. The DON stated the pharmacy "had missed" the inaccurate label for the Synthroid. This finding was reviewed with the administrator and director of nursing during a meeting on 7/31/19 at 4:15 p.m.	F 761	See page 28 of 38	
F 773 SS=D	Lab Srvcs Physician Order/Notify of Results CFR(s): 483.50(a)(2)(i)(ii) §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure laboratory results were promptly reported to the physician	F 773	1. Resident #77 labs were reported on day 2 following abnormal lab values. Resident has had no negative outcomes occur. 2. All residents with abnormal lab results have the potential to be affected. An audit of all abnormal lab results from the past 30 days were reviewed to ensure timely MD notification had occurred. 3. DON/Designee will educate licensed nurses on facility laboratory results reporting policy to include timely physician notification of all abnormal laboratory results.	

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	495153		08/01/2019

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CEDARS HEALTHCARE CENTER	1242 CEDARS CT CHARLOTTESVILLE, VA 22903

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F 773	Continued From page 31 for one of 29 residents (Resident #77). Findings include: Resident #77 was admitted to the facility on 1/10/10, with the most current readmission 4/17/19. Diagnoses for Resident #77 included, but were not limited to: history of a stroke, diabetes mellitus, obesity, hyponatremia, neuropathy, high blood pressure, peripheral vascular disease, above the knee amputation of the left leg and seizure disorder. The most current MDS (minimum data set) was a quarterly assessment dated 6/18/19. This MDS assessed the resident with a cognitive score of 12, indicating the resident had moderate impairment in daily decision making skills During clinical record review, the resident's nursing notes documented that on 6/10/19 (Monday) the resident had new onset of "involuntary extremity jerking on the right side" and the resident was administered lorazepam 0.5 mg (milligrams) as a one time dose. The NP (nurse practitioner) wrote the following on 6/10/19 2:35 PM, "[Name of Resident #77] was seen today for eval of new onset of right sided involuntary jerking of his leg, arm, abdomen and face. Pt (patient) reports he feels cold when he is jerking but otherwise says he feels fine. He had some reported "seizure like activity" during one of his previous hospital stays, and was kept on his keppra for this reason..." On 6/12/2019 at 2:16 PM, Nurse Practitioner/PA Progress Note documented, "CHIEF COMPLAINT: f/u on jerking movements...seen	F 773	4. DON/Designee will audit abnormal labs 5 x weekly x 4 weeks, 3 x week for 1 month, then 10 residents x 1 month during clinical meeting to ensure timely physician notification has occurred. Findings will be reported to the QAPI committee for review and further recommendations. 5. Date of compliance: Sept 10th, 2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495153		08/01/2019

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CEDARS HEALTHCARE CENTER	1242 CEDARS CT CHARLOTTESVILLE, VA 22903

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F 773	Continued From page 32 today for f/u on jerking movements. His repeat labs were essentially unchanged and nurse is still working on getting the head CT ordered. He has still had some jerking today but not as severe as Monday. Nurse also notes that the 1x dose of ativan did not seem to have any impact. He notes he feels more depressed today and that he is just not getting any better...jerking- labs stable, awaiting CT of head. Has a history of seizures and is currently on Keppra. will check a keppra level and cont to monitor. He does not appear to be bothered by the jerking and is in NAD so will just cont to closely monitor..." 6/12/2019 (Wednesday) at 3:28 PM, Nurses Note Note documented, "...Resident alert and verbal...Resident continues with lethargy and twitching...NP in today and New Orders: 1. Check Keppra level today..." 6/16/2019 (Sunday)12:01 PM, Nurses Note documented, "Keppra level elevated per lab result and [Name of physician] notified and new order to change Keppra to 750 mg in am and 500 mg in pm..." The resident's current physician's orders were reviewed and documented, that the resident was ordered and receiving 750 mg (milligrams) of keppra twice daily everyday from 4/17/19 to 6/16/19. The resident's CCP (comprehensive care plan) documented, "...seizure disorder related to stroke...give medications as ordered, monitor/document for effectiveness and side effects...obtain and monitor lab/diagnostic work as ordered. Report results to MD (medical doctor) and follow up as indicated...location of seizure	F 773	See Page 31 of 38	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495153		08/01/2019

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CEDARS HEALTHCARE CENTER	1242 CEDARS CT CHARLOTTESVILLE, VA 22903

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F 773	Continued From page 33 activity, type of seizure activity [jerks, convulsive movements, trembling], duration, level of consciousness...sleeping or dazed..." The resident's laboratory section was reviewed. A keppra level was ordered on 6/12/19 and results were completed on 6/14/19. The resident's keppra level result value was 63.2 and was indicated that the result was H (High). The reference range for keppra is 6.0 - 46.0. The DON (director of nursing) was made aware of concerns with the delay in notification to the physician of the abnormally high keppra level for Resident #77. The DON stated that the resident was having symptoms of a sub-therapeutic level by exhibiting seizure like symptoms and that they (the facility) did not feel like the resident's keppra level being high was the concern. The DON stated that the NP then ordered for the keppra level to be drawn on 6/12/19. The DON stated, "It takes a while to get those [keppra levels] back." The DON was made aware that the level was ordered on 6/12/19 and was completed on 6/14/19 and that the physician was not notified until 6/16/19 of the high level. The DON stated, "It was high, not critical." The DON was asked for a policy on the expectation for prompt notification of lab testing. A policy was presented. The policy documented, "....delays may adversely affect a resident's diagnosis, treatment, assessment, and interventions...nurses will have a sense of urgency for reporting critical lab...findings...the facility assumes responsibility for the timeliness and quality of the laboratory...services...the facility will review the results in a timely manner and notify the ordering physician/provider of the	F 773	See Page 31 of 38 RECEIVED AUG 26 2019 VDH/OLC	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495153		08/01/2019

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CEDARS HEALTHCARE CENTER	1242 CEDARS CT CHARLOTTESVILLE, VA 22903

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F 773	Continued From page 34 results and document reporting and follow up care in the progress notes...labs and/or other diagnostic results will reviewed by a nurse before placing on /in the medical chart to determine if additional follow up is needed...A sense of urgency is required...lab values that reflect a dangerous level (high or low) such as bleeding time or drug levels..." The DON and NP were made aware of the concerns with the delay in reporting the lab results to the physician for a high level that was well beyond the therapeutic range. No further information and/or documentation was presented prior to the exit conference on 8/1/19.	F 773	See Page 31 of 38	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual	F 880	1. Provided education immediately to the LPN #4 regarding infection control practices during medication administration. 2. All residents who receive medications have the potential to be affected. All facility licensed nurses will be audited with med pass observation for medication administration infection control practices. 3. DON/Designee Educate licensed nurses on facility infection control policy and procedure for medication administration. 4. DON/Designee will conduct random audit of nurse's on each shift medication administration to monitor infection control practices monthly x 3 then	

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(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
F 880	Continued From page 35 arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and	F 880	See page 35 of 38 RECEIVED AUG 26 2019 VDH/OLC	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	495153		08/01/2019

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F 880	Continued From page 36 transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on a medication pass and pour observation, staff interview and facility document review, the facility staff failed to ensure infection control practices were followed for medication administration. Finding include: On 07/31/19 at 7:45 AM during a medication pass and pour observation, LPN (Licensed Practical Nurse) #4 applied gloves and began preparing medications for Resident #74. LPN #4 prepared ordered medications, which included two baclofen tablets. LPN #4 took the medications to the resident with gloved hands. Resident#74 took the cup of pills and dropped one onto the bed, which then fell to the floor. The medication tablet was picked up by LPN #4 with her gloved hand. The medication was identified as baclofen. LPN #4 took the pill and the resident's water cup and threw it into the trash can. LPN #4 told the resident that she would replace the dropped medication with a new pill. LPN #4 went to the medication cart, pushed a new baclofen tablet pill out of a blister card package, touching the pill with her gloved hand and put the tablet into the medication cup and took the medication to the resident. LPN #4 administered the medication to the resident, exited the room, removed the gloves and cleansed her hands with sanitizer.	F 880	See page 35 & 38 RECEIVED AUG 26 2019 VDH/OLC	

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F 880	Continued From page 37 LPN #4 was asked if she was aware of what had just happened regarding her gloves. LPN #4 stated, "Yes, that was just nerves." A policy on infection control practices during medication administration and gloves was requested. The policies were presented and reviewed. The policy titled, "Personal Protective Equipment Gloves" documented, "... and documented, "...worn when delivering medication or working with materials that may be absorbed via the skin...applying or removing patches...understand the concept...inside the glove is clean...outside the glove is contaminated...remove gloves at resident door way, before leaving the room...perform hand hygiene before and after the use of non-sterile gloves...limit surfaces and items touched with gloved hands..." The policy titled, documented, "...Do not touch the medication, either when opening a liquid or a dose pack... dropped medications will be discarded...safety and avoiding adverse effects is considered a high priority for medication administration..." The DON (director of nursing) and the administrator were made aware of the above concerns in a meeting with the survey team on 7/31/19 at approximately 4:00 PM. No further information and/or documentation was presented prior to the exit conference on 8/1/19.	F 880	See Page 35 of 38 RECEIVED AUG 26 2019 VDH/OLC	