

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

PRINTED: 02/16/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495153	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/02/2021
NAME OF PROVIDER OR SUPPLIER CEDARS HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1242 CEDARS CT CHARLOTTESVILLE, VA 22903		
(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	
E 000	Initial Comments	E 000			
F 000	<p>INITIAL COMMENTS</p> <p>An unannounced Medicare/Medicaid abbreviated standard survey and Focused Inspection Control survey were conducted on 02/02/2021. Two complaints were investigated during the survey. VA00050397 and VA00050545, were unsubstantiated. The facility was in compliance with 42 CFR Part 483.80 infection control regulations, and the CMS and Centers for Disease Control (CDC) recommended practices for COVID -19.</p> <p>The census in this 143 certified bed facility was 111 at the time of the survey. The survey sample consisted of four current record reviews, and one closed record review.</p> <p>There were six COVID positive residents in the facility. There were no COVID positive staff members. The facility conducted the first round of COVID vaccines on 01/05/2021 with 103 residents and 33 staff receiving the vaccine. The second round was completed on 01/26/2021 with 99 residents and 38 staff receiving the vaccine.</p>	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.