STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495153	A. BUILDING _____ B. WING _____	C 09/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS HEALTHCARE CENTER	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
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated standard survey was conducted on 9/28/21 through 9/29/21. Two complaints were investigated during the survey. Complaint VA00053223 was substantiated with a deficiency cited at F607 and F608 for failure to report witnessed resident abuse in a timely manner and at F812 and F908 for failure to store and prepare food in sanitary manner. Complaint VA00052673 was substantiated with a deficiency cited at F880 for failure to follow COVID-19 protocols for screening employees prior to work. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The census in this 143 certified bed facility was 129 at the time of the survey. The survey sample consisted of four current resident reviews (Residents #1 through #4).	F 000	This plan of correction is prepared and executed because it is required by the provisions of state and federal law not because Cedars Healthcare Center admits or denies the validity of the allegations and citations listed on the pages of this Statement of Deficiencies. Communicare, Cedars Healthcare Center maitains that the alleged deficiencies dont jeopardize the health and safety of the residents, nor is it of such chacter as to limit our capacity to render adequate care. To remain in compliance with all federal and state regulations, the facility has taken or will take the actions set forth in the following plan of correction.	
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document	F 607	1. CNA #1 received education regarding facility abuse policy and reporting allegations of abuse immediately to the supervisor. 2. All residents have the potential to be affected. 3. DON/Designee will provide education to the current staff on reporting abuse immediately to the suprvisor when it occurs or is suspected. 4. DON/Designee will audit 10% of staff weekly x4 weeks to ensure all staff understand the abuse policy and know when to report abuse allegations and who to report the alligations to. Findings will be reported to QAPI committee monthly for 3 months to review compliance. 5. Date of Compliance: November 12th, 2021	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Paul E. Clements | TITLE: Executive Director | (X6) DATE: Oct 12, 2021

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 607	Continued From page 1	F 607		

review, clinical record review and complaint investigation, the facility staff failed to follow abuse prevention policies for reporting for one of four residents in the survey sample, Resident #4. A certified nurses' aide (CNA) failed report witnessed abuse of Resident #4 in a timely manner.

The findings include:

Resident #4 was admitted to the facility on 9/24/20 with diagnoses that included Huntington's disease, anxiety, gastroesophageal reflux disease, major depressive disorder, cognitive communication deficit and history of COVID-19. The minimum data set (MDS) dated 6/15/21 assessed Resident #4 with severely impaired cognitive skills as requiring the extensive assistance of one person for toileting and hygiene.

A facility reported incident form dated 9/13/21 documented CNA #1 observed CNA #2 "slapping" Resident #4 on the left side of his face and calling him a derogatory name.

The facility's investigation included the following written statements about the witnessed abuse.

A written statement by CNA #1 dated 9/13/21 documented, "...Date of Occurrence: 9/12/21...I witnessed another CNA [CNA #2] open handedly smack a patient [Resident #4] in the face because he called her names and was being difficult to change and combative. This happened around 10:15 pm when we were doing last rounds. I didn't report it at the time because I was in shock."

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F 607	Continued From page 2	F 607		

A statement dated 9/13/21 from the resident's roommate (other #1) documented, "[CNA #2 and CNA #1] came in last night. [CNA #2] always says don't start which gets [Resident #4] going. I heard thrashing around and words exchanged - he called her the 'N word' and [CNA#2] called him a 'Honkey Cracker'." (Sic)

A written statement by CNA #2 dated 9/13/21 documented, "...Date of Occurrence: 9/12/21...We went in to do him [Resident #4] for last rounds. He hit me in my chest - he scratched me and kicked me in my stomach - and hit me again...and it was a reaction and my hand didn't slap him but I did push back on his head and say don't do that and then I apologized because it was a reaction...but it was a reaction because he hit me...Didn't say anything to nurse because he did the same thing Saturday..." (Sic)

The assistant director of nursing (RN #1) documented an interview with CNA #1 about the incident with Resident #4. RN #1's interview with CNA #1 documented that CNA #1 heard CNA #2 call Resident #4 a "white honkey cracker." (Sic) CNA #1 documented the resident used racial slurs, called them names then kicked/punched CNA #2. RN #1 documented CNA #1 stated she attempted to intervene because Resident #4 was refusing care and when the resident hit CNA #2 again, CNA #2 stated, "Oh hell no" and smacked the resident on the left side of his face. RN #1 stated CNA #1 told CNA #2 that she was not supposed to do that and CNA #2 told her, "I don't care, he's not going to keep doing this to me." RN #1's interview documented CNA #1 stated she did not immediately report the witnessed verbal and physical abuse because she was "in shock."

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F 607	Continued From page 3	F 607		

The facility's investigation summary dated 9/17/21 documented, "The Facility conducted an internal investigation...Based on the findings from our investigation we confirmed the allegation of abuse and terminated the employee, who in the process of the investigation voluntarily resigned..." Notifications were made to the state agency, adult protective services and department of health professions.

On 9/28/21 at 3:20 p.m., the director of nursing (DON) was interviewed about CNA #1's delay in reporting verbal/physical abuse of Resident #4. The DON stated she was on vacation at the time of the incident so the assistant director of nursing (RN #1) interviewed the resident and staff involved. The DON stated the investigation revealed that on the evening of 9/12/21 CNA #1 witnessed CNA #2 hit Resident #4 after he was combative and resisted care. The DON stated CNA #1 did not immediately report what she had seen/heard and waited until the next morning to report the abuse. The DON stated during the investigation CNA #2 "admitted it" and resigned. The DON stated CNA #1 should have reported the witnessed abuse immediately.

On 9/28/21 at 3:30 p.m., the assistant director of nursing (RN #1) that investigated the incident was interviewed. RN #1 stated CNA #1 reported on the morning of 9/13/21 that the previous evening (9/12/21) she witnessed CNA #2 call Resident 4 a derogatory name and hit him in the face. RN #1 stated CNA #2 admitted that she called the resident a name and stated she pushed the resident's head back after the resident hit her. RN #1 stated CNA #1 did not report the witnessed abuse prior to leaving at the end of her

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F 607	Continued From page 4	F 607		

shift and waited until the next morning (9/13/21) to report the incident. RN #1 stated CNA #1 should have reported the incident immediately to her charge nurse or the supervisor on duty prior to leaving her shift.

Resident #4's plan of care (revised 7/2/21) documented the resident was resistive to care, cursed and hit at staff during personal care. Interventions to minimize behaviors included allowing resident choices about care, provide clear explanation of all care activities, negotiate a time for personal care with the resident and return at the agreed upon time.

The facility's policy titled Abuse, Neglect and Exploitation Policy (effective 5/1/17) documented, "It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of residents. It is the intent of this facility to prevent abuse, mistreatment, or neglect of residents...and to provide guidance to direct staff to manage any concerns or allegations of abuse, neglect or misappropriation of their property...The accurate and timely identification of any event which would place our residents at risk is a primary concern of the facility...All alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse..."

These findings were reviewed with the administrator and director of nursing on 9/29/21 at 10:30 a.m.

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F 607	Continued From page 5 This was a complaint deficiency.	F 607		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review and complaint investigation, the facility staff failed to report verbal/physical abuse in a timely manner for one	F 609	1. CNA #1 received education regarding facility abuse policy and reporting allegations immediately to the supervisor. 2. All residents have the potential to be affected. 3. DON/Designee will educate staff on reporting abuse immediately to the supervisor when it occurs or is suspected. 4. DON/Designee will audit 10% of staff weeky x4 weeks to ensur all staff understand the abuse policy and know when to report abuse allegation and who to report the alligation to. Findings will be reported to QAPI committee monthly for 3 months to reveiw compliance. 5. Date of Compliance: November 12th, 2021.	

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F 609	Continued From page 6	F 609		

of four residents in the survey sample. A certified nurses' aide (CNA) did not report witnessed verbal and physical abuse of Resident #4 by a staff member until the next day.

The findings include:

Resident #4 was admitted to the facility on 9/24/20 with diagnoses that included Huntington's disease, anxiety, gastroesophageal reflux disease, major depressive disorder, cognitive communication deficit and history of COVID-19. The minimum data set (MDS) dated 6/15/21 assessed Resident #4 with severely impaired cognitive skills as requiring the extensive assistance of one person for toileting and hygiene.

A facility reported incident form dated 9/13/21 documented CNA #1 observed CNA #2 "slapping" Resident #4 on the left side of his face and calling him a derogatory name.

The facility's investigation included the following written statements about the witnessed abuse.

A written statement by CNA #1 dated 9/13/21 documented, "...Date of Occurrence: 9/12/21...I witnessed another CNA [CNA #2] open handedly smack a patient [Resident #4] in the face because he called her names and was being difficult to change and combative. This happened around 10:15 pm when we were doing last rounds. I didn't report it at the time because I was in shock."

A statement dated 9/13/21 from the resident's roommate (other #1) documented, "[CNA #2 and CNA #1] came in last night. [CNA #2] always

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F 609	Continued From page 7	F 609		

says don't start which gets [Resident #4] going. I heard thrashing around and words exchanged - he called her the 'N word' and [CNA#2] called him a 'Honkey Cracker'." (Sic)

A written statement by CNA #2 dated 9/13/21 documented, "...Date of Occurrence: 9/12/21...We went in to do him [Resident #4] for last rounds. He hit me in my chest - he scratched me and kicked me in my stomach - and hit me again...and it was a reaction and my hand didn't slap him but I did push back on his head and say don't do that and then I apologized because it was a reaction...but it was a reaction because he hit me...Didn't say anything to nurse because he did the same thing Saturday..." (Sic)

The assistant director of nursing (RN #1) documented an interview with CNA #1 about the incident with Resident #4. RN #1's interview with CNA #1 documented that CNA #1 heard CNA #2 call Resident #4 a "white honkey cracker." (Sic) CNA #1 documented the resident used racial slurs, called them names then kicked/punched CNA #2. RN #1 documented CNA #1 stated she attempted to intervene because Resident #4 was refusing care and when the resident hit CNA #2 again, CNA #2 stated, "Oh hell no" and smacked the resident on the left side of his face. RN #1 stated CNA #1 told CNA #2 that she was not supposed to do that and CNA #2 told her, "I don't care, he's not going to keep doing this to me." RN #1's interview documented CNA #1 stated she did not immediately report the witnessed verbal and physical abuse because she was "in shock."

The facility's investigation summary dated 9/17/21 documented, "The Facility conducted an internal

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F 609	Continued From page 8	F 609		

investigation...Based on the findings from our investigation we confirmed the allegation of abuse and terminated the employee, who in the process of the investigation voluntarily resigned..." Notifications were made to the state agency, adult protective services and department of health professions.

On 9/28/21 at 3:20 p.m., the director of nursing (DON) was interviewed about CNA #1's delay in reporting verbal/physical abuse of Resident #4. The DON stated she was on vacation at the time of the incident so the assistant director of nursing (RN #1) interviewed the resident and staff involved. The DON stated the investigation revealed that on the evening of 9/12/21 CNA #1 witnessed CNA #2 hit Resident #4 after he was combative and resisted care. The DON stated CNA #1 did not immediately report what she had seen/heard and waited until the next morning to report the abuse. The DON stated during the investigation CNA #2 "admitted it" and resigned. The DON stated CNA #1 should have reported the witnessed abuse immediately.

On 9/28/21 at 3:30 p.m., the assistant director of nursing (RN #1) that investigated the incident was interviewed. RN #1 stated CNA #1 reported on the morning of 9/13/21 that the previous evening (9/12/21) she witnessed CNA #2 call Resident 4 a derogatory name and hit him in the face. RN #1 stated CNA #2 admitted that she called the resident a name and stated she pushed the resident's head back after the resident hit her. RN #1 stated CNA #1 did not report the witnessed abuse prior to leaving at the end of her shift and waited until the next morning (9/13/21) to report the incident. RN #1 stated CNA #1 should have reported the incident immediately to

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F 609	Continued From page 9 her charge nurse or the supervisor on duty prior to leaving her shift. Resident #4's plan of care (revised 7/2/21) documented the resident was resistive to care, cursed and hit at staff during personal care. Interventions to minimize behaviors included allowing resident choices about care, provide clear explanation of all care activities, negotiate a time for personal care with the resident and return at the agreed upon time. The facility's policy titled Abuse, Neglect and Exploitation Policy (effective 5/1/17) documented, "It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of residents. It is the intent of this facility to prevent abuse, mistreatment, or neglect of residents...and to provide guidance to direct staff to manage any concerns or allegations of abuse, neglect or misappropriation of their property...The accurate and timely identification of any event which would place our residents at risk is a primary concern of the facility...All alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse..." These findings were reviewed with the administrator and director of nursing on 9/29/21 at 10:30 a.m. This was a complaint deficiency.	F 609		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary	F 812	1a. Dish machine was being repaired at the time of the survey.	09/28/21

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F 812	Continued From page 10 CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, facility document review, staff interview and complaint investigation, the facility staff failed to store, prepare and serve food in a sanitary manner in the main kitchen, serving all residents in the facility. The findings include: On 9/28/21 at 10:15 a.m., accompanied by the dietary manager (other staff #2), the kitchen and food storage areas were inspected. The dishwasher, identified by the dietary manager as chemical/low temperature machine was running upon entrance to the kitchen. The dishwasher gauges for pre-wash temperature and wash temperature were not working. The grout on the	F 812	b. All areas of tile were cleaned and/or repaired. c. Dish machine cleaned. d. Storage bins in dry storage room were cleaned and items stored in the bins were closed e. Dry Storage room floor cleaned. f. All open items in the dry storage room as well as outdated items were discarded. g. Emergency food/supply room was organized. h. The light switch cover in the emergency food/supply area was replaced. i. All items in the paper supply room were covered, sealed and/or discarded. The room was cleaned and orgainized. j. All unsealed, undated, outdated and non-labeled items in the walk -in refrigerator and reach-in refigerator were discarded. k. All equipment and work areas (prep, cook and serve areas) were cleaned. Floor and walls were also cleaned. l. Juice dispenser and concentrate were discarded. m. Outlet covers were cleaned and/or replaced. n. The grates to the kitchen air conditioning unit were cleaned. o. Saniizer test strips obtaind for three-compartment sink. p. Staff educated on the proper method to thaw frozen meat. q. Dietary aide educated on appropriate hand hygine and infection protocol in the kitchen r. Staff educated on cleaning schedule expectations. 2. All residents have the potential to be affected by the deficient pratice. An audit	10/11/21 09/28/21 09/28/21 09/28/21 09/28/21 09/28/21 09/29/21 09/28/21 09/28/21 09/29/21 09/28/21 09/30/21 09/28/21 09/28/21 09/28/21 09/30/21 10/07/21

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F 812	Continued From page 11 tiled wall behind the dishwasher was black and stained. Crumbs, lint, dried debris were observed on top of the panel over the dishwasher gauges. On the wall near the dishwasher output was a missing tile with an opening. There were wires in the opening with tape over the wire ends. The open tile slot had an accumulation of brown debris under the exposed wires. The dietary manager stated at the time of this observation that he did not know why there was a wall opening with wires. The dietary manager stated he was aware the gauges were not working on the dishwasher and the rinse gauge at time was "sticking." When asked how he knew what the wash temperature was running, the dietary manager stated the water for the rinse cycle came from the same place as the wash water. The dietary manager used a hand held thermometer and measured the temperature of the water draining from the washer and it measured 100 degrees (F). The dietary manager stated the wash temperature was supposed to be between 120 and 140 degrees (F). On 9/28/21 at 10:35 a.m., the dry storage room was inspected. Three bulk storage sugar/flour bins were positioned in the end of the room. One bin contained two opened bags of white sugar. One bin had two opened bags of flour and the third bin had an opened bag of brown sugar. The sugars were stored in their original bags inside the storage bins. The tops and sides of all three bins were sticky when touched, with sugar and/or flour visible on the bin lids and in the floor around the bins. The flour bin top was covered with dried, white debris. The floor under the bins was black and the wall behind the bins was spattered with a black substance. The floor around the edge of the room near the wall was black. Brown	F 812	was completed of all areas of the kitchen related to the items identified in 1a-F. 3. Kitchen staff will be educated on appropriate cleaning practices and schedules, infection control practices, (ie-handwashing, use of gloves, hairnets, masks, etc), reporting of equipment needing repairs, dish washing temperature monitoring appropriate food storage and labeling, and the appropriate process for thawing frozen items. 4. Exective Director/Designee will audit the kitchen daily x2 weeks, weekly x2, then monthly x2 for compliance. 5. Date of Compliance-November 12, 2021	10/01/21 10/07/21 11/12/21

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sugar was observed at the base of several food storage pallets positioned near the bins. A 5-pound (lb.) bag of grits was stored on the food rack that was labeled as opened December 2019. Two packages of a powdered mix, identified by the dietary manager as cake mix, were stored on the food rack. The mixes were out of their original packaging and were not identified with the product name, a use-by or expiration date. The dietary manager stated food items were supposed to be labeled when opened and he was working on a cleaning schedule for the food storage areas.

The room identified by the dietary manager as the "emergency" food supply was in disarray. Empty boxes and cardboard were in the floor making it difficult to open the door. The light switch cover in this room was broken. Canned foods were stored on racks but it was difficult to identify products available due to impaired access to the food items (boxes and cardboard in the floor and on the storage racks).

Another storage room was inspected that contained paper products. This room had paper plates, cups and tops. This room also had employee lockers for storage of personal items while at work. There were three uncovered bins of disposable cup tops stored in this room. The tops had crumbs, lint and debris on the exposed surfaces. Eleven individual plastic tops were scattered on the floor in front of and under the storage rack. Two additional boxes of cup tops were stored that were uncovered and exposed. A box of foam plates/trays was stored uncovered.

The following food items were stored in the walk-in refrigerator and available for use: a 15 lb.

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box of bacon with no date opened; 1 gallon jar of mayonnaise with no date opened or use by date; opened bag of chopped lettuce that had brown edges with no date opened or discard date; 1 gallon jar of Caesar dressing with no date opened or use-by date; an opened 1 quart carton of liquid egg product with no date opened; an opened plastic tub of peeled hard boiled eggs with no date opened. There was reddish-yellow liquid pooled on top to the tub of hard-boiled eggs. There was no source determined for the reddish-yellow liquid pooled on the top of the egg tub. There were no leaking items, meats or thawing foods above the eggs at the time of the observation. Two 5-gallon buckets of pickles were stored on the bottom shelf. The tops on both pickle containers were dirty with crumbs, drips and stuck-on brown debris.

The following opened food items were stored in the reach-in refrigerator: an opened bag of whipped dairy topping with no date opened or use-by date; 1 gallon jar of mayonnaise with no date opened or expiration date; two 3-lb. boxes of cream cheese with use-by date of 9/7/21; a 2 lb. container of yogurt with use-by date of 9/27/21; six 2 lb. containers of yogurt with use-by date of 9/9/21; two 5 lb. containers of cottage cheese with use by date of 9/3/21; a 5 lb. container of cottage cheese with use-by date of 9/3/21.

On 9/28/21 at 11:05 a.m., the cook area of the kitchen was inspected. The control panel/knobs on the tilt skillet were dirty with dried, black/brown debris. The back splash behind the tilt grill was spattered with tan, white and brown drips/stains. Dried grease and brown drips were on the left side of the grill. The burners on the stovetop had an accumulation of black/rusty particles in the

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bottom of each burner. The control panel and knobs of the stovetop were dirty. The glass doors on the two convection ovens were dirty with brown stains/drips. The racks from the convection ovens were black and had black build-up on each of the rack rods. The dietary manager stated at the time of this observation that the stoves/grills were supposed to be cleaned once per week.

The prep table across from the convection ovens had an accumulation of black/brown build-up on the front panel and legs of the table. Stored under the table was an opened 3.5 lb. box of mashed potato flakes with no date opened or expiration date.

On 9/28/21 at 11:15 a.m., a juice dispenser machine and four bags of juice concentrate were observed stored under the coffee/tea cart. The juice machine was covered with an accumulation of black/brown/white drips/stains over the top, front and sides of the machine. The floor around the machine also had black/gray stains. The machine was not in use. Stored beside the machine were four bags of juice concentrate. The bags were stored in disarray, one partially in a stained cardboard box. The bags had been previously opened, were not labeled when opened and were sticky when touched. The dietary manager stated at the time of this observation that the juice dispenser had been broken "for about 5 months" and he was waiting to get it fixed.

The wall behind the coffee/tea machines had yellow/brown colored spatter. The coffee dispenser equipped with two dispensers, had only the right side working. The dietary manager

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stated the left dispenser was not working because it overflowed when used and it needed to be fixed.

The bracket for the bench can opener on the prep table near the toaster was dirty with an accumulation of black debris on the inside and outside of the bracket.

The outlet covers and conduit behind the blender and toaster were covered with crumbs and lint. The right outlet behind the toaster had a broken cover. The wall behind the toaster was rusty and spattered with brown debris.
The kitchen's air conditioning unit mounted near the ceiling beside the blender/toaster prep table had three air vents with louvered grates. All the grates were covered with a black substance. The wall beside the unit was spattered with black specks. The air from the unit was blowing directly over the prep table where the blender and toaster were located.

On 9/28/21 at 11:45 a.m., the three-compartment sink was observed in use. When the dietary manager was asked to check the sanitizer concentration, he stated he ran out of test strips yesterday and did not have any strips to test the concentration. The dietary manager obtained a pack of strips from a vendor working in the kitchen and tested the sanitizer with the solution meeting required levels.

On 9/28/21 at 11:50 a.m., frozen raw chicken was observed thawing in the prep sink. There were four plastic bags of chicken pieces in the bottom of the sink with cold water running onto the bag near the center. The chicken was not submerged in any level of water but was positioned with the

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bags directly on the sink bottom. When asked if the chicken was supposed to be submerged during thawing, the dietary manager stated, "It probably should be."

On 9/28/21 at 11:55 a.m., the steam table was inspected. The pans in the six steam wells were black on the inside. The water in the four of the steam pans was discolored (yellow, green) with food particles visible in the bottom of each pan. Two of the pans on the left side of the table were entirely black on the inside with no visibility to the bottom of the pans. Food particle were visible in the water. The handles of all six of the food pan covers were dirty with dried black, yellow, brown debris. All the flat surfaces of the steam table and tray conveyor had crumbs, dirt and debris. The support bars and edge along and under the rollers on the conveyor were dirty with debris. There was a piece of bacon hanging on one of the support bars. The cover to the outlet bar under the steam table was covered with crumbs and lint.

On 9/28/21 at 12:20 p.m., a dietary aide (other staff #3) was observed assisting the lunch service. The dietary aide had gloves on and discarded items into the trash can. The dietary aide then removed his gloves, pulled a towel from his back pocket, wiped his forehead then put on clean gloves and proceeded to handle plastic wrap. The dietary aide performed no hand hygiene after removing the gloves. The dietary aide cut his finger while opening a box of plastic wrap. The dietary aide left the kitchen and returned with a Band-Aid on his right ring finger with gloves in use. The dietary aide covered plated cake pieces with plastic wrap and placed them on a tray cart. The dietary aide again pulled

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the towel from his back pocket, wiped his face, removed his gloves and without hand hygiene put on new gloves. The dietary aide continued to wrap cake pieces with plastic wrap and positioned plate covers for the tray line. The dietary aide opened a box with individual packets of salad dressing. The dietary aide dropped five packet in the floor when opening the box. The dietary aide picked the packets from the floor and placed them back into the supply of dressings. The dietary aide removed gloves, put on new gloves and proceeded to handle plate covers, retrieve covered salads from the refrigerator and placed service items on the lunch trays. The dietary aide performed no hand hygiene between any of the observed glove changes.

The grout in the floor throughout the kitchen and dishwashing area was black. Dirty mop strings were observed on the floor and stuck around table and equipment legs throughout the kitchen. All horizontal surfaces along the walls such as conduit, outlet covers and panel covers were covered with crumbs and lint. Outlet and light switch covers were dirty with dried, brown substances on the surface.

On 9/28/21 at 1:00 p.m., the dietary manager was interviewed about the dirty kitchen items, improper food storage and unsanitary food service. The dietary manager stated there was a cleaning schedule for the kitchen but the cleaning "had lapsed." The dietary manager stated he was trying to get the items in disrepair fixed and had been trying to establish a new cleaning schedule. The dietary manager stated he had been unable to get some of the kitchen workers to perform cleaning as needed. The dietary manager stated the local health department inspected the kitchen

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on 9/16/21 and he was still working to correct items from that inspection.

On 9/28/21 at 1:20 p.m., the facility's registered dietitian (RD - other staff #4) was interviewed about the kitchen observations. The RD stated she completed sanitization audits once per month in the kitchen and she had previously identified issues in the kitchen with cleanliness and overall disorganization. The RD stated results of her audits were sent to the dietary manager and his supervisor. The RD stated she had seen no change in the kitchen and no response from her audits. The RD stated her role was mostly clinical as she was in the facility only two days per week. The RD presented kitchen audits dated 7/23/21, 8/20/21 and 9/17/21 that identified brown sugar bin with gnats, old date labels on bins, bags labeled inside bins, dirty tilt skillet and stove top, grease build up above stove/fryer, chicken thawing in sink without running water, missing dishwasher temperatures on log, dirty floors, broken switch plate in paper closet, staff drinks in reach-in refrigerator and freezer door not staying shut. The RD audit dated 9/17/21 documented, "...whole kitchen gives the vibe of disorder and messiness."

On 9/28/21 at 3:10 p.m., the facility's maintenance director (other staff #5) was interviewed about the exposed, taped electrical wires near the dishwasher and the air condition unit with dirty, black vents. The maintenance director stated he was not aware of the exposed wiring near the dishwasher until today. The maintenance director stated the shop was responsible for cleaning and maintaining the air conditioning unit in the kitchen. The maintenance director stated he got a "punch list" today that

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included cleaning of the unit.

The facility's policy titled Warewashing (revised 9/2017) documented, "All dishware, serviceware, and utensils will be cleaned and sanitized after each use...All dish machine water temperatures will be maintained in accordance with manufacturer recommendations for high temperature or low temperature machines..." The dish machine log listed the required wash temperature for a chemical washer as 120 to 140 degrees (F) and documented, "If temperature or chemical concentration does not meet parameters, stop washing and alert a manager..."

The facility's policy titled Food Storage: Dry Goods (revised 9/2017) documented, "All dry goods will be appropriately stored...in accordance the FDA Food Code...All packaged and canned food items will be kept clean, dry, and properly sealed...Storage areas will be neat, arranged for easy identification, and date marked as appropriate..."

The facility's policy titled Food Storage: Cold Foods (revised 4/2018) documented, "All Time/Temperature Control for Safety (TCS) foods, frozen and refrigerated, will be appropriately stored in accordance with guidelines of the FDA Food Code...All foods will be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination..."

The facility's policy titled Environment (revised 9/2017) documented, "All food preparation areas, food service areas, and dining areas will be maintained in a clean and sanitary condition...The Dining Services Director [dietary manager] will

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ensure that the kitchen is maintained in a clean and sanitary manner, including floors, walls, ceilings, lighting, and ventilation...The Dining Services Director will ensure that all employees are knowledgeable in the proper procedures for cleaning and sanitizing of all food service equipment...All food contact surfaces will be cleaned and sanitized after each use...The Dining Service Director will ensure that a routine cleaning schedule is in place for all cooking equipment, food storage areas, and surfaces..."

The facility's policy titled Food: Preparation (revised 9/2017) documented, "All foods are prepared in accordance with the FDA Food Code...All staff will practice proper hand washing techniques and glove use...The Cook (s) thaws frozen items that requires defrosting prior to preparation using one of the following methods...Completely submerging the item under cold water (at a temperature of 70 [degrees] F or below) that is running fast enough to agitate and float off loose ice particles...All TCS foods that are to be held for more than 24 hours at a temperature of 41 [degrees] F or less, will be labeled and dated with a 'prepared date' (Day 1) and a 'use by date' (Day 7)..."

The facility's checklist for proper hand hygiene for dining service employees (dated 2020) documented, "While alcohol-based hand sanitizers...are the preferred method for cleaning our hands in most clinical situations, handwashing is the standard set by the 2017 Food Code, Section 2-301 for kitchen settings...Handwashing with soap and water is required in a dining services setting in the following situations...In between glove changes...After removing gloves...After handling

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F 812	Continued From page 21 dirty dishes or trash...After blowing your nose, coughing, sneezing or touching your hair, face, or clothes...When you take one step away from your work station...Between tasks..." These findings were reviewed with the administrator and director of nursing on 9/28/21 at 3:45 p.m. The administrator stated at this time that the dietary manager (dining services director) was employed by a contracted food service. The administrator stated he had not been made aware of monthly kitchen audits performed by the RD. This was a complaint deficiency.	F 812		
F 880 SS=E	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 arrangement based upon the facility assessment conducted according to §483.70(e) and following	F 880	1. Other staff #6 and Other staff #7 were counseled on entering through the front door and completing Covid-19 screening per policy. 2. All staff and residents have the potential to be affected by this deficient practice. Audit tool implemented immediately to identify compliance with staff screening process. 3. IP/Designee will educate staff on Covid19 screening process for staff. 4. IP/Designee will audit staff sign-in screening logs daily x2 weeks, then weekly x2 and then monthly x2 for compliance. Findings will be reported to QAPI committee monthly for 3 months to review compliance. 5. Date of Compliance November 12, 2021	

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F 880	Continued From page 22 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 transport linens so as to prevent the spread of infection.	F 880		

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§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 staff interview, facility document review and complaint investigation, the facility staff failed to follow COVID-19 protocols for employee screening for two of ten laundry/housekeeping employees. Two laundry employees reported to work for at least a month without completion of pre-shift temperature checks and screening questions as required in the infection control protocols for COVID-19 prevention.

The findings included:

On 9/29/21 at 7:05 a.m., the registered nurse responsible for infection prevention (RN #1) was interviewed about COVID-19 screenings for staff reporting to work. RN #1 stated staff were only allowed to enter the building at the front door of the facility. RN #1 stated all staff members were required to have a temperature check and to answer questions and sign an attestation about any symptoms or possible exposure to COVID-19. RN #1 stated the temperature check and screening questions were required for each staff member prior to entering the building and reporting to work.

On 9/29/21 at 9:00 a.m., the director of nursing (DON) provided copies of the COVID-19 employee screening logs for September 2021. The COVID-19 screening logs dated 9/1/21 through 9/27/21 documented no entries for two of ten employees that worked in the laundry and housekeeping departments.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495153	A. BUILDING _____ B. WING _____	C 09/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS HEALTHCARE CENTER	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
F 880	Continued From page 24	F 880		

On 9/29/21 at 8:45 a.m., the laundry employee (other staff #6) not found on the log sheet was interviewed. The laundry employee stated she entered work through the back door and had not been completing the temperature check and screening questions. The laundry aide stated her ride brought her to the back of the building because it was near the laundry area so she entered the building at the back door.

On 9/29/21 at 8:47 a.m., another laundry employee (other staff #7) was interviewed about entrance to the building. This laundry employee stated, "I come through the back door." This laundry employee stated she was vaccinated and she did not complete the temperature checks and screening questions each day.

On 9/29/21 at 8:50 a.m., the laundry/housekeeping supervisor (other staff #8) was interviewed about the two laundry employees entering through the back door and not participating in daily COVID-19 screening. The supervisor stated it was "the basics" for employees to enter at the front and go through the screening each day. The supervisor stated, "That's something we need to do a better job of."

The facility's COVID-19 Plan (revised 6/20/21) documented under steps for COVID-19 prevention, "...Have only one entrance and exit site at the facility...All visitors, vendors and staff will have their temperatures checked once they enter the facility. If a fever is identified (>100...), that person will be asked to return home and staff are tested for Covid-19 utilizing POC Antigen or PCR testing method...All visitors, vendors and staff will be asked if they have any signs and

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F 880	Continued From page 25 symptoms that are associated with COVID-19 such as fever/chills, shortness of breath, body aches, cough, diarrhea, nausea/vomiting, congestion, headache, loss of appetite, fatigue and sore throat..." This finding was reviewed with the administrator and director of nursing on 9/29/21 at 10:30 a.m. This was a complaint deficiency.	F 880		
F 908 SS=D	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, facility document review, staff interview and complaint investigation, the facility staff failed to ensure a properly functioning dishwasher in the main kitchen. The pre-wash temperature gauge and the wash temperature gauge on the dishwasher were not functioning. The findings include: On 9/28/21 at 10:15 a.m., accompanied by the dietary manager (other staff #2), the kitchen and food storage areas were inspected. The dishwasher, identified by the dietary manager as chemical/low temperature machine was running upon entrance to the kitchen. The gauges for pre-wash temperature and wash temperature on the dishwasher were not working. The dietary manager stated he was aware the gauges were not working on the dishwasher and the rinse gauge at times was "sticking." When asked how	F 908	1. The dish machine was repaired and is in good woking condition. 2. Audit kitchen equipment was conducted to ensure it in good condition. 3. Exectutive Director/Designee will educate dietary staff on entering repair needs in the facility TELS system. 4. Maintenance Director/Designee will audit dietary equipment to ensure it is in good working condition wekly x4 and monthly x2. Findings will be reported tthe QAPI committee monthly for 3 months to review compliance. 5. Date of compliance-November 12, 2021	

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F 908	Continued From page 26	F 908		

he knew the wash temperature, the dietary manager stated the water for the rinse cycle came from the same place as the water for the wash. The dietary manager used a hand held thermometer and measured the temperature of the water draining from the washer and it measured 100 degrees (F). The dietary manager stated the wash temperature was supposed to be between 120 and 140 degrees (F).

On 9/28/21 at 1:00 p.m., the dietary manager was interviewed again about the dishwasher gauges not working. The dietary manager stated he had been trying to get the equipment repaired and the dysfunctional gauges were noted when the local health department inspected the kitchen on 9/16/21.

On 9/28/21 at 3:10 p.m., the maintenance director (other staff #5) was interviewed about the dysfunctional dishwasher gauges. The maintenance director stated an outside vendor provided service and repair for the dishwasher.

The facility's policy titled Warewashing (revised 9/2017) documented, "...All dish machine water temperatures will be maintained in accordance with manufacturer recommendations for high temperature or low temperature machines..." The dish machine log listed the required wash temperature for a chemical washer as 120 to 140 degrees (F) and documented, "If temperature or chemical concentration does not meet parameters, stop washing and alert a manager..."

This finding was reviewed with the administrator and director of nursing on 9/28/21 at 3:45 p.m.

This was a complaint deficiency.

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