Cedars
HEALTHCARE CENTER
Serving with Pride.

Vallie Anderson, LTC Supervisor

Office of Licensure and Certification

Division of Long Term Care Services

9960 Mayland Dr, Suite 401

Richmond, VA 23233

12/22/2022

RE: Cedars Healthcare Center

Dear Ms. Anderson,

Please find enclosed the Plan of Correction put forth in response to the CMS-2567 dated December 20, 2022 in relation to the survey conducted December 6, 2022 through December 7, 2022. If you have any questions, please contact me at 434-296-5611.

Sincerely,

, NHA

Jo Peterson, NHA

Interim Executive Director

Enclosures

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 _____	R-C 12/07/2022

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 000}	INITIAL COMMENTS An unannounced Medicare/Medicaid follow-up survey to an abbreviated survey of 10/11/2022 through 10/13/2022 was conducted 12/06/2022 through 12/07/2022. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. New findings are identified on the 2567. The census in this 143 certified bed facility was 113 at the time of the survey. The survey sample consisted of six (6) current Resident reviews (Residents #101 through #106).	{F 000}	The Cedars Center provides this plan of correction without admitting or denying the validity or existence of the alleged deficiencies. The plan of correction is executed solely because it is required by state and federal law.	
F 567 SS=D	Protection/Management of Personal Funds CFR(s): 483.10(f)(10(i)(ii) §483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds. (i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled	F 567	**F567** **1.** Resident #106 is still a resident of the facility. Resident #106 received her requested money on 12/7/22. **2.** All residents who possess a RFMS account at the facility have the potential to be affected. On 12/7/22 the Executive Director(ED) and the Business Office Manager (BOM) reconciled the petty cash to ensure there was sufficient money for resident requests. **3.** The BOM and facility staff who handle cash were reeducated on 12/07/22 by the ED regarding the need for the facility to provide access to the residents' money upon request as soon as possible. Newly hired staff who handle cash will be educated during orientation by the ED/Designee.	

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

NHA — Interim Executive Director — 12/22/22

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 567	Continued From page 1 accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund. (B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund. This REQUIREMENT is not met as evidenced by: Based on resident interview and staff interview, the facility failed to ensure personal funds was available for one of six residents, Resident #106. The findings include: Resident #106 did not have access to money upon request. Diagnoses for Resident #106 included; Guillain-Barre syndrome, reflux, gout, and bipolar. The most current MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 9/26/2022. Resident #106's cognitive score was 15 indicating cognitively intact for daily decision making. On 12/6/22 at 4:10 PM Resident #106 (Resident Council President) was interviewed. During the interview Resident #106 verbalized that she has requested $40.00 the last 2 days and the	F 567	Starting 12/22/22 the facility ED and BOM will reconcile/audit the petty cash to ensure there are sufficient funds 3 times a week for 4weeks and then monthly for 3 months. Starting 12/22/22 the ED will audit Ambassador rounds Monday-Friday to assure resident funds are available weekly for 4 weeks and then monthly for 3 months. 4. Results of the audits will be reported by the BOM/designee monthly to the QAPI committee for any additional follow up and/or in servicing until the issues is resolved and randomly thereafter as determined by the QAPI committee. 5. Date of Compliance 01/05/23	

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F 567	Continued From page 2	F 567		

receptionist said they (the facility) did not have the money available. Resident #106 said that money not being available goes on frequently, adding that if you're not one of the first resident's to ask for it, then the facility runs out of money.

On 12/6/22 at 4:25 PM an interview was conducted with the receptionist (Other Staff, OS #2).
OS #2 explained that the facility usually receives $150.00 to $200.00 a day, but if the money runs out, the receipts for the distributed funds are sent to corporate, and then another check is supposed to be sent to the facility. OS #2 stated that once that check gets cashed by the bank, then the resident's can get money. OS #2 went on to say that resident's are allowed to have up to $40.00 per day.

OS #2 was asked if Resident #106 received any money today or the prior day (12/5/22). OS #2 verbalized, Resident #106 did not get any money on 12/5/22 as the facility only received $150.00 and the money ran out and did not get any money today because no money was available to distribute. OS #2 verbalized the business office manager (person that requests money from corporate) is off work today.

OS #2 was asked how much money was supposed to be on hand to accommodate all residents requesting money of $40.00 or less. OS #2 verbalized that there should be $700.00 a day to accommodate resident's request for money, but the money varies from day to day.

On 12/6/22 at 4:30 PM the above findings was presented to the director of nursing (DON) and administrator. The administrator verbalized that

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F 567	Continued From page 3 she and the DON had only been at the facility for a few weeks and was unaware this was happening. On 12/7/22 at 10:40 a.m., the administrator verbalized the facility will be providing education on money availability according to the policy to ensure resident's are receiving money upon request. No other information was presented prior to exit conference on 12/7/22.	F 567		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility failed to ensure a complete and accurate MDS (minimum data set) for one of six residents, Resident #105. The Findings Include: Section's "C' (Cognitive Patterns), "D" (Mood), and "J" (Pain) were not assessed on Resident #105 and Resident #103's current MDS. Diagnoses for Resident #105 included; Dysphagia, cirrhosis of liver, liver failure, and depression. The most current MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 11/17/2022. Resident #105's cognitive status was not assessed on the MDS.	F 641	**F641** 1. Resident #105 is still a resident of the facility. Resident #105 had a BIMS, PHQ-9 and Pain interview completed and locked on 11/29/22. 2. All residents of the facility have the potential to be affected. On 12/7/2022 the Regional Resident Care Coordinator (R2C2) audited the most recently submitted MDS for all current residents of the facility to determine who had sections C, D and J0300 – J0600 dashed to ensure that an interview had been completed with a response documented in PCC UDA's. 3. The Resident Assessment Coordinators (RAC) and the Mobile Resident Assessment Coordinators (MRAC) were provided reeducation by the R2C2 regarding the RAI process for the completion of section C, D and J0300 – J0600 of the MDS on 12/7/22.	

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F 641	Continued From page 4 On 12/6/22 Resident #105's medical record was reviewed. The current MDS dated 11/17/22 (quarterly assessment). Section "C" documented an interview for mental status should not be done (C0100) and instructed to complete part C0700 through C1000 (staff assessment for mental status). C0700 through C1000 was then reviewed and did not indicate this section had been completed (using dash marks in the boxes). Section "D" (Mood) was then reviewed and documented that a mood interview should be conducted. Review of the "Resident Mood Interview, D0200 through D0600" was not been completed and dash marks were entered in all boxes. Section "J" (Health Conditions) documented a pain assessment interview should be conducted. Review of the "Pain Assessment Interview" (J0300 through J0600) documented dashes in all boxes. On 12/7/22 at 7:50 AM the facilities regional MDS coordinator (registered nurse, RN #1) was interviewed. RN #1 reviewed the concerns for Resident #105's MDS and verbalized that the MDS coordinator responsible for inputting the data was a mobile/remote coordinator and was no longer at the facility. RN #1 said that she could not speak for the MDS coordinator as to why the sections of the MDS were not complete, but said that it could be due to not doing the assessments timely. On 12/7/22 at 10:40 AM the information was presented to the director of nursing and administrator.	F 641	Newly hired RAC's and MRAC's will be educated by the Regional Resident Care Coordinator (R2C2) during orientation regarding the RAI process for the completion of section C, D and J0300 – J0600. Starting on 12/21/22 the R2C2 will be auditing section C, D and J0300 – J0600 of all MDS prior to submission weekly for 4 weeks and monthly for 3 months and randomly thereafter. 4. Results of the audits will be presented monthly by the R2C2 to the QAPI committee for any additional follow up and/or in servicing until the issues is resolved and randomly thereafter as determined by the QAPI committee. 5. Date of Compliance 01/05/23	

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F 641	Continued From page 5 No other information was presented prior to exit conference on 12/7/22. {F 689} Free of Accident Hazards/Supervision/Devices SS=D CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility staff failed to ensure fall mats were in place for one of six residents, Resident #103. Findings were: During the facility entrance conference on 12/06/2022 at approximately 11:00 a.m., a list of residents requiring total assistance and a list of residents with falls/accidents/incidents since the AOC (Allegations of Compliance) date of 11/09/2022 were requested. Resident #103 was on both lists as needing total assistance and having a fall on 11/21/2022. Resident #103 was admitted to the facility with the following diagnoses, including but not limited to: Cerebral infarct, hemiplegia, asthma, atrial fibrillation, delusional disorder, anxiety, and dementia.	F 641	**F689** 1. Resident #103 is still a resident of the facility. Resident #103 had fall mats placed on 12/7/22 by the Director of Nursing/designee. 2. 100% audit conducted on all current residents of the facility with fall mats that have the potential to be affected by this practice.	

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{F 689}	Continued From page 6 The most recent MDS (Minimum data set - cms assessment tool) was an annual assessment with an ARD (assessment reference date) of 09/14/2022. The cognitive assessment was not completed on the MDS. However, a quarterly MDS with an ARD of 06/05/2022 assessed Resident #103 as severely impaired with a cognitive summary score of "06". On 12/06/2022 at approximately 11:30 a.m., Resident #103 was observed sitting in her bed. The head of the bed was at approximately ninety degrees. Bilateral half side rails were in the upright position, there were no fall mats observed at her bedside. Resident #103's medical record was reviewed at approximately 2:30 p.m.. The progress note section contained the following entry: "11/25/2022 22:26 (10:26 p.m.) This writer entered residents (sic) room and resident was lying on floor at the foot of the bed. Resident was bleeding fro nose and appears to have bruised right eye. This writer and nurses aide got resident back into bed, per resident she placed herself into the floor because she did not want the aide to help her anymore and was seeking alternate assistance. This writer explained that if she is to require assistance she needs to use her call bell and staff will help with her needs, explained that purposefully going into the floor is dangerous and to please not do so. No c/o [complaints of] pain, bruises or skin issues noted besides right eye/eyelid." The comprehensive care plan was reviewed and contained the following focus area: "[Name] is at risk for falls r/t [related to] Gait/balance problems, she has a fall history."	{F 689}	3. Director of Nursing in-serviced all Licensed Nurses and GNAs on the following policies and procedures related to resident falls: Fall Prevention Program and steps to take after a fall has occurred. Ensure fall/safety interventions are in place for residents. Appropriate fall interventions after a fall to reduce risk of injury. Documentation of all required details of fall update care plan and kardex. GNAs check kardex for resident fall/safety interventions. Ambassadors within non-nursing departments will conduct regular checks of their assigned High Fall Risk. Residents to ensure all respective interventions are in place, and immediately notify a member of Nursing Management regarding any items not in place so it can be corrected in a timely manner. Director of Nursing/Designee in-serviced all non-nursing staff on related procedures and expectations with regards to: Monitoring the environment for fall-risk hazards, to ensure a safe environment for all staff and residents	

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{F 689}	Continued From page 7 Interventions included but were not limited to: "Assess risk for falls-complete fall assessment per policy and procedure; Educate resident on the risk of her climbing into floor; Place fall mat at bedside (Date initiated 02/02/2022). An additional care focus area: "[Name] has a behavior problem...placing pillows in the floor from bed and then using siderails to slide into the floor" was also observed. A Fall Risk Observation Tool dated 11/28/2022 contained the following information, including, but not limited to: "Diminished safety awareness.... non-ambulatory..., total mechanical lift for all transfers:,,,unable to bear weight, unable or unwilling to cooperate, limited in movement, heavy or obese..., fall within the last 30 days..." Resident #103 was identified as a potential risk for falls at the conclusion of the assessment. On 12/06/2022 at approximately 3:50 p.m., Resident #103 was again observed sitting in bed, the head of the bed at approximately 45 degrees, bilateral 1/2 side rails in the up position. No fall mats were observed on either side of her bed. CNA (Certified nursing assistant) #1 was in the room assisting Resident #103 with a drink. She was asked if the resident had fall mats to go beside her bed. She stated, "I don't see any." After leaving the room, CNA #1 was interviewed. When asked if Resident #103 was supposed to have fall mats, CNA #1 stated, "I've never seen her with one...she will come out of the bed though and put herself right on the floor." When asked if she had reviewed Resident #103's Kardex care plan prior to working with her, CNA #1 responded, "No, the nurses tell us what we need to do."	{F 689}	4. Director of Nursing/Designee will conduct daily audits Monday-Friday x 8weeks of all current residents fall interventions, as well as all new admissions, to ensure fall interventions are in place and present on kardex and care plan. Results of these audits will be presented at both the weekly Risk Management Meeting and monthly QAPI Committee Meetings x3 months for their review and recommendations. 5. Date of compliance 1/5/23	

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{F 689}	Continued From page 8 LPN (licensed practical nurse) #1 was coming down the hallway and overheard the conversation. She stated, "She [Resident #103] got moved to that room about a month ago...the fall mats may not have come with her. If they are on her care plan we should be using them." LPN #1 went to the room Resident #103 had previously been assigned and stated, "I don't see them...I'll check the care plan." An end of the day meeting was held with the DON (director of nursing) and the administrator on 12/06/2022 at approximately 4:30 p.m. The above findings were discussed. The DON was asked if interventions, such as fall mats, were on the care plan should they be implemented and in place. She stated, "Yes." On 12/07/2022 at approximately 8:00 a.m., Resident #103 was observed in bed. The head of the bed was at approximately ninety degrees, bilateral side rails were in the upright position, and fall mats were observed on both sides of her bed. On 12/07/2022 at approximately 10:30 a.m., a meeting was held with the DON and the administrator. The DON stated that fall mats had been placed beside Resident #103's bed. She was asked the purpose of the fall mats. She stated to break a fall and prevent injury. No further information was obtained prior to the exit conference on 12/07/2022.	{F 689}		