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 10/13/2022

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 survey was conducted 10/11/2022 through 10/13/2022. Two complaints were investigated during the survey. Complaint VA00056391 was substantiated with deficient practice. Complaint VA00056503 was substantiated with deficient practice. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The census in this 143 certified bed facility was 116 at the time of the survey. The survey sample consisted of one current resident review and two closed record reviews.	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices 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 staff interview, clinical record review, facility document review and complaint investigation, the facility staff failed, for one of three residents in the survey sample (Resident #2), to provide a safe transfer with a mechanical lift resulting in a leg fracture and failed to prevent a fall during provision of personal care resulting in a femur fracture and scalp laceration. The findings include:	F 689		

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

Interim Executive Director 11/3/22

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 689	Continued From page 1 Resident #2 was admitted to the facility with diagnoses that included multiple sclerosis, quadriplegia, neurogenic bladder, cauda equina syndrome, muscle atrophy, post traumatic seizures, anemia, anxiety and depression. The minimum data set (MDS - cms assessment tool) dated 8/24/22 assessed Resident #2 as cognitively intact for decision making skills and as requiring total dependence of one person for bed mobility and bathing, with the extensive assistance of two people for transfers. a) Safe Positioning of Resident #2's legs was not maintained during a transfer with a mechanical lift. The resident's right leg hit against the lift frame during the transfer, resulting in a fracture of the right lower leg (harm). Resident #2's clinical record documented a nursing note dated 4/22/22 stating, "...resident with c/o [complaint of] pain to RLE [right lower extremity]. this nurse assessed and noted a hematoma below right knee. pt [patient] stated that her leg hit the bar of the lift during transfer...this nurse observed swelling to right ankle...new orders for xray." (sic) A nurse practitioner (NP) documented on 4/23/22, "Patient bumped R [right] leg in transferring out of lift and developed small hematoma behind R knee. Ice applied already with recommendation for light compression." A NP note dated 4/24/22 documented, "...Patient now c/o pain in the RLE post crush injury. Xray unavailable to be performed until tomorrow and patient is requesting transfer to ED [emergency department] for imaging and evaluation..."	F 689	**F689** 1.Resident #2 no longer resides at facility. All residents that transfer by mechanical lift have the potential to be affected. All residents who receives a bed bath have the potential to be affected. 2.Nurse Managers will review all residents' progress notes for the previous 30 days to identify incidence of fall or injury related to mechanical lift transfers. Nurse Managers will audit all residents to identify who requires mechanical lift transfers. Perform audit care plans of all residents that require mechanical lift for transfers to ensure appropriate care plan is completed and assuring lift/transfer status is documented on the Kardexes. Nurse Managers will audit all residents' progress notes for the previous 30 days to identify incidence of fall during the provision of personal care. Nurse Managers will audit resident's care plan and Kardexes to ensure mobility assistance documentation.	

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F 689	Continued From page 2 A nursing note dated 4/24/22 documented, "Patient was sent to ER [emergency room] on 4/24/22...An incident occurred on 4/22/22 at bedtime, during a transfer via hoyer lift. The patients leg hit the bar on the hoyer maachine [machine], causing the patient to be in pain. Through out the night the leg started to slightly swell and was warm to the touch...no one available to do X-ray until Monday morning. The patient tried to hold off, but is very sure the leg is broken so she requested this nurse send her to the emergency room..." (sic) The clinical record documented Resident #2 was transported to the emergency room on 4/24/22 at 11:40 a.m. The emergency department report dated 4/24/22 documented, "Patient presents with an injury to the right lower extremity. Blunt trauma that occurred 2 days ago. She is functionally quadriplegic. Tenderness along the proximal tibia and fibula without obvious deformity. Mild soft tissue swelling present...Patient's x-rays show evidence of a nondisplaced fracture of the tibia and fibula..." The resident returned to the nursing facility with the right leg immobilized in a splint and orders for orthopedic follow-up. Staff witness statements and the facility's investigation of the 4/22/22 incident documented staff failed to maintain positioning of the resident's legs/feet during the mechanical lift transfer resulting in the right leg trauma/fracture. The facility's incident report dated 4/22/22 documented certified nurses' aide (CNA) #3 and #6 were transferring Resident #2 from her wheelchair to bed using the Hoyer lift when the injury occurred. A written statement from CNA #6 dated 4/22/22	F 689	3.Nurse Managers will educate nursing staff regarding appropriate mechanical lift residents transfer. Nursing staff to perform return demonstration of transfer training provided. Nurse Managers will educate nursing staff on resident safety during provision of personal care. Education will include nursing staff reviewing residents' Kardexes before rendering care to ensure compliance to plan of care. 4.Director of Nursing will complete random audits of at least 5 residents transferred by mechanical lifts to ensure safety. Audits will be completed weekly x 4 then monthly x 3. Audits will be reviewed in QAPI meetings monthly x 3 to evaluate need for further monitoring. Director of Nursing will complete 5 random bed mobility audits weekly x 4 then monthly x 3. Audits to be reviewed in QAPI meetings monthly x 3 months to evaluate need for further monitoring. 5.Date of Compliance 11/9/22	11/9/22

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F 689	Continued From page 3 documented, "...[CNA #3] and I were transfering [Resident #2] to bed with a howler [Hoyer] lift that her legs swung accidentally and hit the bar resulting to some injuries on her right leg." (sic) A statement obtained from CNA #3 on 4/25/22 documented, "Went in room to help [CNA #6] get [Resident #2] to bed. We had to put hoyer pad under her. We got pad under her [CNA #6] was controlling lift. She started lifting her up but I noticed her foot was caught under her footrest on the wc [wheelchair]. I told [CNA #6] to move forward but she started backing up. I told her to stop. I was then able to get her foot from under the footrest and we put her to bed..." (sic) The incident report documented a statement from Resident #2 dated 4/26/22 as, "...stated she [Resident #2] was being transferred from chair to bed by mechanical lift. The aides were putting her into bed when she started leaning forward in the sling. The Aide [CNA #3] was trying to adjust her in the sling when she hit her leg on the metal part of the lift. She [Resident #2] stated she started having pain and swelling in the area." The incident form documented an interview/statement from CNA #6 dated 4/26/22 stating, "I was transferring [Resident #2] back to bed with [CNA #3]. I was operating the lift and [CNA #3] was assisting in turning the resident in the sling. The resident was leaning forward, [CNA #3] was holding her shoulders to prevent her from leaning. I was lifting her up, I starting backing up away from the chair the resident said 'my leg' and I stopped operating the lift. The resident said she hit her leg on the support beam of the mechanical lift. We moved her legs to the side and continued to transfer her into the bed.	F 689		

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F 689	Continued From page 4 Once in the bed she said her R leg was painful. I told the nurse..." (sic) The incident form documented an interview/statement from licensed practical nurse (LPN) #6 dated 4/28/22. LPN #6's statement documented, "I was the nurse working on Friday 4/22/22 with the resident. I was working with the resident and she complain in R ankle, I noted some swelling below her knee. I asked the CNA about the incident, the CNA stated that the resident was leaning forward in the lift and her leg hit the lift during the transfer...The resident complained of pain and was medicated..." (sic) On 10/11/22 at 7:30 p.m., CNA #3 was interviewed by telephone about Resident #2's incident on 4/22/22. CNA #3 stated she and CNA #6 were transferring the resident from her wheelchair to bed with the Hoyer lift. CNA #3 stated CNA #6 operated the lift remote and when raised from the chair, Resident #2 started leaning forward in the sling. CNA #3 stated she pulled back on the resident's shoulders to keep her from falling when the resident's leg hit against a metal bar on the lift. CNA #3 stated when Resident #2 starting going forward in the sling, they were unable to guide the resident's legs. CNA #3 stated while she was holding on the shoulders, CNA #6 tried to get to the legs to guide them but she did not get to them in time. CNA #3 stated Resident #2 was "total care" and was unable to independently move her arms and legs. Concerning the resident's positioning during the transfer, CNA #3 stated, "I was concentrating on keeping her from falling in the floor and did not see her feet." CNA #6 was not available for interview as she no	F 689		

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F 689	Continued From page 5	F 689		

longer worked at the facility.

Resident #2's plan of care for activities of daily living (revised 2/4/22) documented the resident had self-care impairments due to quadriplegia and was "dependent on staff for all aspects of care..." Interventions to maintain physical functioning included use of a Hoyer lift for transfers with two person assistance, total assistance for bed mobility and "may leave hoyer pad in place under resident when sitting..."

On 10/12/22 at 8:40 a.m., the administrator, director of nursing (DON) and mobile DON (administration staff #3) were interviewed about Resident #2's transfer with fracture of 4/22/22. The administrator, DON and mobile DON stated they were not employed at the facility in April 2022. The mobile DON stated the information about the incident was documented on the incident/investigation form and in statements and interviews with staff. The DON stated the resident required two-person assistance for transfers with a mechanical lift and was totally dependent on staff for care needs. The mobile DON stated from review of the incident form, Resident #2's leg hit against a bar on the lift during a transfer when the resident leaned in the sling.

The mechanical lift manufacturer's instruction manual (part no. 1078987) documented on page 9 under safety warnings, "...Adjustments for safety and comfort should be made before moving the patient..." Page 27 of this manual documented when the patient is lifted, the patient is raised to a sitting position with the patient's head supported by the sling and/or an assistant. Page 28 of this manual illustrated transfer of the

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F 689	Continued From page 6 patient with one person operating the lift and the other person guiding the resident's feet/legs while the head is supported by the sling. The facility's training checklist titled Mechanical Lift Application and Use (referenced/adapted from FDA patient lift safety guide (2018), safe patient handling Perry & Potter 9th edition) included in steps to ensure safety during a transfer to lift the person two inches off the surface and then check that the person was secure and comfortable. b) Resident #2 fell from bed during the provision of a bed bath. The resident was hospitalized and diagnosed with a displaced fracture of the right femur and a scalp laceration as a result of the fall (harm). Review of Resident #2's clinical record documented a nursing note dated 4/17/22 stating, "...called to residents room by staff member stating she had fallen off of bed while she was providing care to the resident...observed resident lying on floor on her back. resident stated she had pain in left scapula bilateral legs and head. residents head was noted to be bleeding from left side. writer attempted to assess the area to head but resident stated it was to [too] much pain for her to tolerate...able to apply pressure dressing to head to attempt to stop the bleeding...transported to...hospital to be evaluated." (sic) The emergency room history and physical dated 9/17/22 documented, "...bed-bound...presenting to ED [emergency department] for evaluation of leg pain after being dropped from bed during efforts to have her back washed...In the ED a	F 689		

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F 689	Continued From page 7 right proximal femur fracture was identified with imaging..." The resident was also diagnosed with a 4 centimeter scalp laceration that was closed with staples. The resident was admitted to the hospital and had surgery for repair of the displaced femur. The hospital discharge summary dated 9/21/22 documented that Resident #2 had acute blood loss during the surgery with post-operative anemia. On 9/21/22 the resident was transitioned to comfort care and transferred to a hospice care unit. The facility's investigation of Resident #2's fall documented a statement from CNA #2 who was caring for Resident #2 at the time of the fall. CNA #2's statement dated 9/19/22 documented, "I was washing her to give her a full bed bath. I turned her on her right side to wash her back. I turned to get a wash cloth + towel and I heard 'I'm falling. I'm about to fall.' I tried to catch her but it was too late. She landed on her back with her right knee pulled up. She asked me to put a pillow under her head and leg, which I did. I then covered her up and went to go get the nurse..." A statement from licensed practical nurse (LPN) #3 who was working when Resident #2 fell dated 9/23/22 documented, "...[CNA #2] called me and said that [Resident #2] fell. When I entered the room [Resident #2] was on her back, her head was bleeding...I asked her how did she fall and she said she was over too far..." The facility reported incident investigation sent to the state agency dated 9/23/22 documented, "On 9/17/22, certified nurses' aide [CNA #2] was providing ADL [activities of daily living] to [Resident #2]. In the course of providing care, aide rolled resident onto her side, away from her.	F 689		

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F 689	Continued From page 8 CNA [#2] proceeded to run around to gather additional items to perform care. While [CNA #2's] back was turned, resident fell off of the bed...As a result of the fall, resident fractured femur...CNA's statement reflects that she turned her back to the resident during patient care and that there were not two staff members providing care to resident...CNA has been terminated due to providing improper care." Resident #2's plan of care (revised 7/11/22) documented the resident was at risk of falls due inability to support/control movement due to paralysis/quadriplegia and was dependent on staff "for all aspects of care." Interventions to maintain activities of daily living included "...total asst [assistance] bed mobility..." On 10/11/22 at 11:40 a.m., LPN #1 that routinely cared for Resident #2 was interviewed. LPN #2 stated the resident required "total care" and was unable to use her arms and legs due to paralysis. LPN #2 stated two people were required to provide ADL care because the resident was totally dependent. On 10/11/22 at 11:55 a.m., CNA #1 that routinely cared for Resident #2 was interviewed. CNA #1 stated the resident was able to only move her head and it was always best to have two people when bathing the resident. On 10/11/22 at 12:00 p.m., the unit manager (LPN #2) was interviewed about Resident #2's fall from bed. LPN #2 stated Resident #2 fell from bed after CNA #2 turned her in bed during a bath. LPN #2 stated one CNA was providing care during the bath when the resident rolled from the bed into the floor. LPN #2 stated two people	F 689		

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F 689	Continued From page 9 were recommended to provide ADL care and bed mobility for Resident #2 due to her paralysis. On 10/11/22 at 12:26 p.m., LPN #3 caring for Resident #2 on 9/17/22 was interviewed. LPN #3 stated on the evening of 9/17/22 that CNA #2 called her and reported Resident #2 fell from the bed. LPN #3 stated she found the resident in the floor on her back with bleeding noted from her head. LPN #3 stated Resident #2 said she was over too far in the bed when she fell. LPN #3 stated she applied a dressing to the resident's head to control bleeding and the resident stated her arm and legs hurt. LPN #3 stated CNA #2 was giving the resident a bed bath when the resident rolled off the bed. LPN #3 stated at times one CNA provided ADL care for Resident #2 but many times two staff people assisted with Resident #2. LPN #3 stated the resident had been turned away from the CNA and with the CNA at the resident's back was unable to stop or break the fall. On 10/11/22 at 4:20 p.m., CNA #2 who was caring for Resident #2 at the time of the fall was interviewed. CNA #2 stated she had cared for Resident #2 "for years" and was familiar with the resident's routine. CNA #2 stated she usually performed Resident #2's bed bath without assistance of another staff person. CNA #2 stated she turned the resident on her side and then turned away from the resident to get a wash cloth. CNA #2 stated Resident #2 then said, "I'm too close. I'm falling." CNA #2 stated as the resident rolled, she was unable to grab or hold the resident in bed. CNA #2 stated the resident was alert after falling but was bleeding from the head and expressed pain. CNA #2 stated she notified the nurse immediately of the fall. CNA #2	F 689		

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F 689	Continued From page 10 stated she had never been told that Resident #2 required two-person assistance for a bed bath. On 10/12/22 at 8:40 a.m., the administrator, director of nursing (DON) and mobile DON were interviewed about Resident #2's fall/fracture of 9/17/22. The administrator and DON were not working in the facility at the time of the incident. The mobile DON stated CNA #2 turned her back on Resident #2 during a bed bath to get supplies and the resident fell to the floor with the bed in high position. The mobile DON stated CNA #2 was unable to stop or hold the resident. The mobile DON stated Resident #2 required total care and dependence on staff for all ADL needs. When asked about the expectation for turning residents, the DON stated CNA #2 should have turned the resident toward her instead of away from her since she was providing assistance with one person. The mobile DON stated their investigation concluded that CNA #2 did not follow proper procedure for the bed bath. The mobile DON stated the improper procedures that contributed to the fall included positioning the resident too close to the edge of the bed, not having two-person assistance and turning away from the resident to get supplies with the resident unsecured. The facility's training checklist titled Positioning in Bed Assistance (referenced/adapted from Lippincott Manual of Nursing Practice (2019), Lippincott nursing procedures (2018), Perry & Potter 9th edition) included in steps for lateral positioning of a resident in bed, "...roll the person onto their side towards you...Place a pillow under the neck and head and behind the neck..." These findings were reviewed with the	F 689		

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F 689	Continued From page 11 administrator, DON and mobile DON on 10/11/22 at 6:00 p.m. and on 10/12/22 at 8:40 a.m. No additional information was provided. This was a complaint deficiency.	F 689		
F 921 SS=D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, facility document review, and in the course of a complaint investigation, the facility staff failed to ensure two of fourteen doors in the facility were locked with functioning door alarms. Findings included: Resident #1 eloped from the facility on 09/24/2022 through two malfunctioning doors at the service entry to the building. A facility reported incident was sent to the state office and erroneously contained information that Resident #1 had fractured his femur. Resident #1 was recently admitted to the facility, no MDS (minimum data set) information was available. The admission nursing assessment completed on 09/21/2022 did not include any information regarding the resident's cognitive status/ability. Review of the clinical record on 10/11/2022 included the progress note section with the	F 921	Past noncompliance: no plan of correction required.	

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 10/13/2022

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 921	Continued From page 12 following entry dated 09/24/2022 at 15:43 (3:43 p.m.) "Resident Eloped Home". On 10/11/2022 at approximately 12:00 p.m., The DON (director of nursing) and the Mobile DON were asked for information regarding the elopement and Resident #1's disposition post elopement. Per the DON, Resident #1 left the facility and was found at home by the local police department without injury. Presented at approximately 12:15 p.m., the facility investigation of this reported incident contained the following: "Summary of investigation: On 9/24/2022, Resident [#1] was last seen by aides on the unit while rounding around 10:45/11:00 AM. Resident had not previously exhibited exit seeking behaviors. Staff searched the facility, grounds, and immediate locations without locating resident. Checked to ensure resident did not sign himself out. Attempted to contact resident on his cell phone and his wife. Local law enforcement contacted and provided resident picture and contact number. The investigation was completed on 9/30/2022. Resident was located on 9/24/2022 at 1345 (1:45 p.m.) by law enforcement. Resident was taken to local hospital. Interview was unable to be performed by resident due to being in hospital. Elopement drill on all three shifts have been scheduled. All resident [s] will have elopement re-assessment performed. Staff education on elopement process and who to inform during elopement. All doors have been inspected and repaired on day of elopement." Witness statements from the facility investigation were reviewed at approximately 12:30 p.m. Staff who had observed Resident #1 on the day of elopement were interviewed. CNA (certified	F 921		

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F 921	Continued From page 13 nursing assistant) #5 was interviewed at approximately 12:40 p.m. on 10/11/2022. She was asked if she remembered the resident and the day he eloped from the facility. She stated, "Yes, I remember...he was always talking about going home. I told them when he went missing to look up his address, I bet that's where he was...the police were there waiting on him when he got there." She was asked how she thought he left the building. She stated, "It had to be a door down here, the elevator is broken." CNA #4 was interviewed at 1:20 p.m. She stated that she had seen the resident that morning. He was dressed and was walking up and down the hallway. She was asked if she was aware that the service area doors were not functioning properly on the day Resident #1 eloped. She stated, "Yes, I knew they didn't lock." She was asked how long the doors had been like that and had she reported it. She stated, "I don't know how long...I'm agency, I didn't report it." The maintenance director was interviewed at 3:30 p.m. about the doors that had malfunctioned. He stated, "I don't know what happened. I had disconnected the door for the elevator people before that and had reconnected everything and tested it. The company that came out to fix it said that both doors had screws that were not placed right and they fixed them...I was out with COVID the day this happened. My assistant was here and he called me about it." The above information was discussed during an end of the day meeting with the DON and the administrator on 10/11/2022 at approximately 6:00 p.m.	F 921		

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F 921	Continued From page 14 The maintenance assistant and the maintenance director were interviewed on 10/13/2022 at approximately 8:55 a.m. The assistant stated that he had been in the facility the day of the elopement. He stated, "I was going out the door and I put the code in as I was walking out I noticed the light was red but the door didn't alarm...everything happened so fast, almost at the same time I was told a resident had gotten out...it was chaos." The maintenance director and his assistant were asked how often the doors were checked for functionality. The director stated, "Everyday but the weekends...we aren't here on the weekends to do it." They were asked if anyone had told them the doors were not working properly prior to that day (09/24/2022). Both stated, "No." A facility "Abatement plan for Elopement" as well as a PIP (performance improvement plan) was presented and reviewed on 10/13/2022. The abatement plan included the following: "1. Resident was able to leave facility without notifying staff through the back door that was not working properly. All residents have the potential to be affected. 2. The placement, function, and expiration date of residents with wander guard will be audited. The service door will be fixed by outside vendor. 3. Elopement drill performed on all three shifts. Staff education on the elopement process, and to notify management immediately when doors are not working properly. 4. Nursing will audit admission for potential elopement during admission 5 X (times) week X 12 weeks. Audits to be reviewed in QAPI (quality assurance performance improvement) monthly X 3 months to evaluate need for further evaluation and for auditing.	F 921		

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F 921	Continued From page 15 5. Date of Compliance 10/7/22." Education of staff regarding the above mentioned education was reviewed by the survey team and found to be in order. Per consultation with the state office it was determined that the abatement plan would be accepted and the citation recommended at past noncompliance. The above information was discussed with the administrator and the DON on 10/13/2022 at approximately 11:30 a.m. No further information was obtained prior to the exit conference on 10/13/2022. This is a complaint deficiency and cited at past noncompliance.	F 921		