STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495153	A. BUILDING _____ B. WING _____	**08/26/2020**

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0550 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and facility document review, the facility staff failed to treat one of 3 residents in the survey sample with dignity and respect. A certified nursing assistant (CNA) spoke rudely to Resident #2 when the resident asked for assistance getting out of bed. The findings include: Resident #3 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The most recent minimum data set (MDS) which was the discharge assessment, assessed Resident #3 as cognitively intact for daily decision making with a score of 14 out of 15. Section G: Functional Status of the MDS assessed Resident #3 requiring extensive assistance with one person physical assistance for transfers, bed mobility, dressing, hygiene, bed mobility, toileting and locomotion; total dependence with one person physical assistance for bathing; and having lower and upper range of motion limits on one side. Resident #3 was assessed as independent with set-up assistance only for eating. Section H: Bladder and Bowel of the MDS assessed Resident #3 as frequently incontinent for bowel and always incontinent for bladder. The admission assessment dated [DATE] the Functional Status section documented Resident #3 required limited assistance, with one person physical assistance for bed mobility, transfer, and toilet use. Resident #3 was documented as independent, requiring set-up only for eating. Observed on the care plans was the following: 03/03/2020 (Resident #3) has an ADL (activities of daily living) Self Care Performance Deficit. Goals: (Resident #3) will improved current level of function in Bed Mobility, Transfers, Eating, Dressing, Toilet Use and Personal Hygiene through the review date. Interventions: Encourage (Resident #3) to use call bell to call for assistance. Encourage (Resident #3) to participate to the fullest extent possible with each interaction. Monitor/document/report to MD PRN any changes, any potential improvement, reasons for self-care deficit, expected course, declines in function. 03/03/2020 (Resident #3) has bladder incontinence - requires ext (extensive) asst (assistance) with toileting at times. Goals: (Resident #3) will remain free from skin breakdown due to incontinence and brief use through the review date. Interventions: (Resident #3) has unobstructed path to the bathroom. INCONTINENT: Check as required for incontinence . A review of the facility's investigation documented the initial FRI was sent to the state agency on 03/03/2020 and the follow-up investigation on 03/10/2020. The investigation documented two witness statements, one from the CNA and one from the charge nurse on duty the day of the incident. The charge nurse was no longer employed by the facility and was not available for interview. The documentation revealed the CNA was suspended on 03/04/2020 during the investigation. On 03/11/2020, the identified CNA was terminated for performance/policy violation including a substantiated allegation of verbal abuse and poor customer services. Staff education on the abuse, neglect and exploitation was provided on 03/07/2020. Per the charge nurse's witness statement, the CNA came to her because Resident #3 was upset and cursed at her because she wanted to go out for a smoke break. The charge nurse and another staff member went to Resident #3's room to ask what happened. Resident #3 stated the aide told me I had to wait until trays were up . that they weren't going out for smoke break.The charge nurse said to Resident #3 that she shouldn't curse at staff and if something was wrong to talk with the nurse and then proceeded to take Resident #3 upstairs to smoke. Per the CNA's witness statement, .I went into her room and said hello and good morning .provided her care and got her up. In the afternoon, she (Resident #3) rang her light and I went and said I'll be with you in a second and left the light on. When I went into her room she was crying and yelling, I want to get the F up. I've been telling you that I want to get up. I said, I understand but I was with another resident and there are other residents that want to get up and down. She was still yelling and crying and I said you don't need to cry because I'm going to get you up. I left and went to get the nurse because she was crying and throwing a fit. The nurse went back there. We did not have an exchange of words and when I made the statement of getting up and down, I was referring to other residents that want to get up and down. The patient was cursing at me and I did not yell or curse at her. I got my nurse immediately when she was yelling. The patient was upset at the response time to get her up. The nurse went into the room and explained that unit 4 does smoke break and it would be ok. The nurse then got the resident up for break. I still provided care for her the rest of the day until I went to the other unit. On 08/25/2020, the facility social worker (OS #1) was interviewed regarding the allegation. OS #1 stated she personally did not talk with Resident #3 regarding the incident and the facility Administrator and unit manager conducted the investigation. On 08/25/2020 at 2:30 p.m., the unit manager (LPN #3) where Resident #3 resided was interviewed. LPN #1 stated the incident took place on a weekend and was investigated as soon as it was brought to her and the administrator's attention. LPN #3 stated Resident #3 gave a physical description of staff and based on the description and schedule they were able to identify the specific certified nursing assistant (CNA). LPN #3 stated Resident #3 told her that the CNA came into her room and was very rude about getting her up for the day and for the smoke break. LPN #3 stated Resident #3 could not remember verbatim the words used by the CNA, but it was something about up and down. LPN #3 stated Resident #3 stated the CNA was mad because she had rung her call bell requesting to get out of bed. LPN #3 stated the CNA did not routinely work on the unit, however that did not excuse her response. LPN #3 stated based on the investigation the CNA was suspended and then later terminated for providing poor customer service. On 08/25/2020 at 2:57 p.m., the administrator was interviewed regarding the allegation. The administrator stated based on his interview with Resident #3 and the CNA's previous customer service concerns the facility substantiated the allegation and terminated the CNA. The administrator stated the facility completed abuse and neglect training with staff on 03/07/2020 and completed inpatient room rounds with residents to address any concerns. The administrator stated since the pandemic, management staff continues with ongoing room rounds to address any concerns that would have normally been discussed in resident council meetings. The administrator stated staff receives continued education on the abuse/abuse reporting policy annually in March, which includes customer service training. A review of the facility's investigation documented the initial FRI was sent to the state agency on 03/03/2020 and the follow-up investigation on 03/10/2020. The investigation documented on 03/03/2020, Resident #3 reported that on Sunday, 03/01/2020 she had an interaction with a CNA who entered the room and stated, I guess you're going to want to get up today . up and down, up and down. The documentation revealed the CNA was suspended on 03/04/2020 during the investigation. On 03/11/2020, the identified CNA was terminated for performance/policy violation including a substantiated allegation of verbal abuse and poor customer service. Staff education on the abuse, neglect and exploitation was provided on 03/07/2020. Included in the documentation was a timeline documenting the following to support past non-compliance effective 03/12/2020. 3/4/3030 - initial report filed with resident interview and accused employee suspension noted. Resident and staff interviews begin. 3/7/2020 - Education completed on abuse/abuse reporting policy. 3/11/2020 - Accused employee (name of employee) terminated due to customer service/substantiated verbal abuse allegation related to . 04/1/2020 - Further education of staff regarding abuse/abuse reporting policy. Standard/IP (inpatient) room rounds allow for substantial, routine interaction between resident population and management staff and provides an avenue for voicing any concerns, etc. Ongoing education for new orientees and annual abuse/abuse reporting

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495153	A. BUILDING _____ B. WING _____	**08/26/2020**

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0550 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) training via Relias occurs throughout the year including March. These findings were reviewed with the administrator and assistant director of nursing during a meeting on 08/26/2020 at 8:45 a.m. No further information was received by the survey team prior to the exit conference on 08/26/2020 at 9:15 a.m. This is a complaint deficiency.