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 _____	**03/04/2020**

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 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, clinical record review, and during the course of a complaint investigation, the facility staff failed to ensure medication was administered per the physician's orders [REDACTED].#1. On admission to the facility, Resident #1 was not administered [MEDICATION NAME] 300 mg (milligrams) ER (extended release) as ordered by the physician, but instead given [MEDICATION NAME] 300 mg (immediate release). Resident #1 received the incorrect medication release form for 13 days before it was discovered and changed to the correct form. Findings include: Resident #1 was admitted to the facility on [DATE] and was discharged from the facility on 06/27/19. [DIAGNOSES REDACTED]. The resident's most current full MDS (minimum data set) was a 14 day admission assessment. This MDS assessed the resident with a cognitive score of 10, indicating there resident had moderate impairment in daily decision making skills. During clinical record review the following progress notes were observed: A progress note dated, 6/3/2019 and timed 3:49 PM documented, .Per son's concern resident should be on the extended release [MEDICATION NAME] for both doses. Resident not ordered ER (extended release) at bedtime. This nurse contacted (name of) NP (nurse practitioner) with request. It was verified that resident did take ER before. Verbal order given to change the 300 mg dose at HS (hour of sleep) to [MEDICATION NAME] 300 mg ER. Son and husband made aware . A late entry progress note by the NP created on 06/06/19 and timed 11:11 AM and made effective for 06/04/19 documented, .skilled rounds, recent admit for .osteo[DIAGNOSES REDACTED] .denies acute concerns, but is poor historian dt (due to) [MEDICAL CONDITION]. Nursing reports up last night [MEDICATION NAME] Son noted she takes ER [MEDICATION NAME], not IR (immediate release) 300 mg. Dose changed. Have changed [MEDICATION NAME] to 300 mg ER. Will check [MEDICATION NAME] level . Resident #1's admission orders [REDACTED].[MEDICATION NAME] 300 mg (milligrams) CR (controlled release) .nightly .[MEDICATION NAME] 450 mg CR .every morning . On 03/03/20 at approximately 5:40 PM, the DON (director of nursing) and administrator were made aware of concerns with Resident #1 not getting the ER/CR medications as ordered. According to the hospital discharge summaries, Resident #1 had been on this medication at home, and during the hospital stay prior to admission to the long term care facility. The DON stated that she wasn't sure what happened, but thought that it may have been an error in transcription upon admission. No further information and/or documentation was presented prior to the exit conference on 03/04/20. This is complaint deficiency.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, clinical record review and facility document review, the facility staff failed to ensure infection control practices were followed for one of two resident in the survey sample, Resident #2. Resident #2's nebulizer mask was observed on the floor. Findings include: Resident #2 was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. The resident most current MDS (minimum data set) was an admission assessment dated [DATE]. This MDS assessed the resident with a cognitive score of 15, indicating the resident was cognitively intact for daily decision making skills. The resident was assessed as requiring extensive assistance from one staff person for transfers, dressing toileting and hygiene. The resident was assessed as receiving IV medications at the facility. On 03/03/20 at 11:25 AM, Resident #2 was interviewed in her room. The resident was sitting in her wheelchair on the right side of the bed. On the left side of the bed was a bedside table with a nebulizer machine sitting on top. A nebulizer mask with tubing was attached to the machine, and the mask was laying in the floor. The nebulizer mask was not protected in anyway. There was no labeling on the tubing or nebulizer mask to indicate when it was changed. On 03/03/20 at 12:50 PM, Resident #2 was interviewed again. Resident #2 stated that the housekeeper came in and cleaned. The area on the other side of the bed (documented above) was again observed, and the resident's nebulizer mask was still on the floor. On 03/03/20 at 2:45 PM, Resident #2's nurse, RN (registered nurse) #3 and CNA (certified nursing assistant) #1 were in the room with Resident #2. RN #3 was starting the resident's IV antibiotics. RN #3 had a pair of gloves on while hanging the IV bag. RN #3 then removed his gloves and went to wash his hands. The nebulizer mask was still on the floor at that time. At 2:50 PM, RN #3 returned to Resident #2's room to administer a nebulizer treatment. Resident #2's mask was now laying on top of the resident's beside table. The nebulizer mask or tubing was not labeled with a date and was not in any type of protective cover. RN #3 picked up the nebulizer and was going to put medication into the nebulizer. RN #3 was stopped prior to the medication being added to the nebulizer and was asked who picked the nebulizer mask off of the floor. RN #3 stated that he had picked it up and that the mask wasn't on the floor that it was just hanging from the bedside table and wasn't actually touching the floor. RN #3 was made aware of the above observations of the nebulizer laying on the floor. RN #3 stated that he would go get a new nebulizer and tubing set for Resident #2. Resident #2's physician's orders [REDACTED].record findings .pre assessment .record findings .[MEDICATION NAME]-[MEDICATION NAME] solution 0.5-2.5 .vial inhale orally every 6 hours as needed . The resident's care plan was reviewed and documented, .altered respiratory status .pneumonia, [MEDICAL CONDITION] exacerbation .administer medication/puffers as ordered .provide oxygen as ordered . On 03/03/20 at 3:30 PM, the administrator and DON (director of nursing) were made aware of the above observations. The DON stated that the expectation would be if something is dropped on the floor, then it should be discarded and staff are expected to get a new one. The administrator and DON were asked for a policy on infection control practices for nebulizer equipment/dropping equipment on the floor. At 4:50 PM the administrator and DON returned with policies. The documented, .aerosol therapy .a physician's orders [REDACTED].include the mode of administration .mask .equipment and maintenance .masks are to be changed once a week and PRN (as needed) .tubing .are to be changed once a week and prn .when soiled .remove mask from bag, apply the current date on mask bands in the back, using a marker/pen, date tubing using a label - do not write directly on tubing or masks .will be changed when contaminated .falls on floor .left unused . On 03/04/20 at 8:45 AM Resident #2's room was observed. Resident #2's nebulizer mask was on top of the resident's bedside table, the mask was in a bag that was dated but the mask and tubing were not dated. At 9:00 AM, the DON was made aware that the nebulizer and tubing were observed again. The DON stated that the oxygen tubing should be dated with tape and that she didn't see where it said that in the policy, but she would label it and change the tubing weekly. Resident #2's TARs (treatment administration records) were reviewed for February and (NAME)2020 and revealed that the resident had a place to document when oxygen tubing was changed, but not specifically for any nebulizer masks or tubing equipment to be changed. No further information and/or documentation was presented prior to the exit conference on 03/04/20 to evidence that the facility staff maintained proper infection control practices to prevent infection for nebulizer mask and tubing equipment for Resident #2.
F 0921 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.**

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.

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F 0921 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview and staff interview, the facility staff failed to ensure a sanitary environment in a resident room for one of two residents in the survey sample, Resident #2. Resident #2's IV (intravenous) pole and IV machine were visibly soiled. Findings include: Resident #2 was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. The resident most current MDS (minimum data set) was an admission assessment dated [DATE]. This MDS assessed the resident with a cognitive score of 15, indicating the resident was cognitively intact for daily decision making skills. The resident was assessed as receiving IV medications at the facility. On 03/03/20 at 11:25 AM, Resident #2 was interviewed in her room. Resident #2 was sitting in her wheelchair on the right side of the bed. An IV pole with an empty bag of antibiotic medication was right beside the bedside table. Resident #2 stated that she gets the IV medication three times a day and that the next dose was due at 2 PM. The IV pole had an IV machine attached to it. The IV machine had unknown dried spots and stains on the face of the machine and on the sides. The IV pole was visibly soiled with unknown dried stains, that extended down the pole to the bottom of the IV pole. The floor where the IV pole was standing had two dried white stains and two blue IV port tubing tabs laying in the floor. On 03/03/20 at 12:50 PM, Resident #2 was interviewed again. Resident #2 stated that the housekeeper came in and cleaned. Resident #2 stated that the room wasn't too bad right now but stated, They could do better. Resident #2 was unable to see on the other side of the bed. The area on the other side of the bed (documented above) was again observed. The white stained areas near the IV pole on the floor were now gone, the two blue tabs were still on the floor, the IV pole and machine were both in the same manner. On 03/03/20 at 4:50 PM the administrator stated that the above mentioned items would be cleaned. The administrator stated that these things should be cleaned on a routine basis and should also have daily cleaning. The administrator stated that deep cleaning occurs between residents and that they (the facility) do routine deep cleanings on these items. The administrator did not present a policy and/or any cleaning schedules. No further information and/or documentation was presented prior to the exit conference on 03/04/20 to evidence that the facility maintained a sanitary conditions and comfortable environment for Resident #2 in her room.