

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115436	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/14/2025
NAME OF PROVIDER OR SUPPLIER Cedar Valley Nsg & Rehab Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 225 Philpot Street Cedartown, GA 30125	
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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and review of the facility policy titled Care Plans, Comprehensive Care Plans, the facility failed to revise the comprehensive care plan to include the use of an anticoagulant (blood thinner) for one of 25 sampled residents (Resident (R)2) reviewed for care planning. This had the potential for the resident not to be monitored for potential bleeding and have unmet care needs. Findings include: Review of the facility's policy titled Care Plans, Comprehensive Care Plans, indicated A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident. Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' conditions change. Review of R2's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/17/2025 and located in the electronic medical record (EMR) under the MDS tab, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated the resident was cognitively intact. The MDS revealed the resident was admitted on [DATE] with diagnoses to include long-term use of anticoagulants, personal history of pulmonary embolism, personal history of other venous thrombosis and embolism; the resident receives an anticoagulant. Review of R2's physician Orders located in the EMR under the Orders tab revealed an order from 4/3/2025 for apixaban oral tablet 5 milligrams (mg) [an oral anticoagulant] to be taken twice a day. Review of R2's EMR located under the Care Plan tab, a comprehensive care plan with an initiated date of 3/12/2025, did not display the use of an anticoagulant for R2. During an interview on 8/13/2025 at 11:00 am, Licensed Practical Nurse (LPN)1 stated yes, an anticoagulant should be on the care plan to help communicate the care needed for that resident. During an interview on 08/13/2025 at 12:40 pm, the MDS Coordinator (MDSC) stated that an anticoagulant should be on the care plan so that staff know the needs of the R2. It looks like someone resolved it; so, it doesn't show on the care plan. During an interview on 8/14/2025 at 1:15 pm, the Director of Nursing (DON) stated that an anticoagulant should have been on R2's care plan to let the staff know that the anticoagulant was being used and how to monitor for it. The DON stated the care plan lets all nursing staff know how to properly take care of a resident.		

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.

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