

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  495153	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/27/2025
NAME OF PROVIDER OR SUPPLIER  Cedars Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>41449</p> <p>Based on observation, resident and staff interviews, clinical record review, and facility documentation review, the facility staff failed to follow professional standards of practice with regards to medication administration for three residents (Resident #2- R2, Resident #4-R4, and Resident #5 -R5), in a survey sample of six residents.</p> <p>The findings included:</p> <p>1. For Resident #2, the facility staff failed to administer medications timely.</p> <p>On 2/26/25 at 11:25 a.m., an interview was conducted with R2 in her room. R2 reported, I haven't gotten my morning medications yet. When asked what time they are scheduled, R2 reported, 8 a.m. When asked how often this happens, R2 said, A lot. When asked if she knows why, R2 said, No, I don't know why. The resident stated that she has told the head nurse and nurses, but it doesn't get any better.</p> <p>On 2/26/25, a clinical record review was conducted. According to R2's physician orders and medication administration record, four medications, including propranolol for hypertension and carbidopa-levodopa for Parkinson's, were scheduled at 7 a.m., gabapentin for nerve pain was scheduled 8 a.m., and 10-12 other medications were scheduled for 9 a.m. administration.</p> <p>According to the Medication Audit Report, R2 received her scheduled 8 a.m., dose of gabapentin on 2/26/25 at 11:39 a.m., with five other 9 a.m. scheduled medications. This same report noted that on 2/19/25, R2 had propranolol and carbidopa-levodopa scheduled for 7 a.m. and gabapentin scheduled for 8 a.m. that were not administered until 10:11 a.m., along with 12 other 9 a.m. medications. On 2/21/25, this report documented that the 7 a.m. doses of propranolol and carbidopa-levodopa were not administered until 9:22 a.m. On 2/22/25, R2's medications scheduled for 7 a.m., including the carbidopa-levodopa were given at 10:43 a.m., while the propranolol HCL tablet, which was also scheduled for 7a.m., was not administered until 5 p.m. It was also documented that the 12 noon dose of oxycodone for pain was not given to R2 until 2:59 p.m., along with 3 other meds also scheduled for noon. On 2/23/25, the report showed that the 6 p.m. dose of oxycodone for pain was not given to R2 until 11:28 p.m., along with the 5 p.m. dose of propranolol and 8 other medications scheduled between 7 p.m. and 9 p.m. On 2/24/25, the 6 a.m. doses of oxycodone for pain, levothyroxine for hypothyroidism, and alprazolam for anxiety were all documented as being given to R2 at 8:44 a.m.</p> <p>2. For Resident #4 (R4), the facility staff failed to administer medications timely.</p> <p>(continued on next page)</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 495153
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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 2/26/25, a closed record review was conducted. According to R4's physician orders, she was ordered to receive albuterol nebulizers three times a day for COPD. R4 also had physician orders for Bevespi inhaler, and two puffs were to be administered twice daily for COPD.</p> <p>According to the Medication Admin Audit Report R4 had multiple instances where medications were not administered within an hour of the scheduled time. On numerous occasions, 12/28/24, 12/29/24, 12/30/24, 12/31/24 and 1/1/25, R4's medications scheduled for administration at 7 a.m., were not administered until after 10 a.m.</p> <p>On 1/2/25, medications scheduled to be administered at 5 p.m. were documented as having been administered at 9:30 p.m. On 1/3/25, medications ordered to be administered at 1 p.m., were documented as having been administered at 5:04 p.m.</p> <p>According to the Medication Admin Audit Report on 1/3/25, R4 was not given the scheduled 7 a.m. albuterol nebulizer treatment until 6:37 p.m. As a result, a prn as needed dose/administration of a nebulizer treatment had to be administered at 9:40 a.m. The administration was not documented until 6:40 p.m.</p> <p>3. For Resident #5 (R5) the facility failed to follow professional standards of nurse practice with regards to the timely administration of Breo Ellipta Inhaler.</p> <p>On 2/26/25 at approximately 1:30 p.m., R5 stopped the surveyor and asked the surveyor to step into his room. R5 said, I have not had my inhaler for several days and I really need it. R5 opened the top drawer of his bedside table and removed the silver packaging that the Breo comes in and showed the surveyor, again saying that he needed it to breathe. R5 was observed to be on continuous oxygen per nasal cannula.</p> <p>On 2/26/25, a clinical record review was conducted of R5's chart. This review revealed that R5 had a diagnosis to include chronic obstructive pulmonary disease (COPD). According to the physician orders, R5's orders included, but were not limited to, Breo Ellipta Inhalation Aerosol Powder breath activated 200-25 MCG/ACT.</p> <p>On 2/27/25 at approximately 11:00 a.m., R5 reported he still had not received his Breo and said, This place ain't worth a damn! According to R5's medication administration record, R5 was to receive the Breo in the morning at 7:00 am, but as of 11:20 a.m., the Breo was still not documented as having been administered. Further review revealed that the Breo was documented as not being administered on 2/18/25, 2/20/25, 2/22/25, 2/23/25, 2/24/25, 2/25/25, and 2/26/25. R5's clinical record did not indicate that the physician had been notified of these omitted doses of this medication used to improve breathing.</p> <p>On 2/26/25 at 2:22 p.m., an interview was conducted with a registered nurse (RN #1). When asked about the discrepancies with administering medications, RN #1 stated that medications are to be given within an hour of the scheduled time. When asked why, RN #1 stated . to maintain therapeutic levels in the resident.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 2/27/25 at approximately 9:30 a.m., an interview was conducted with the medical director, who is the attending physician of many of the residents. When asked about medication administration and timing of medications, the medical director said, They are on a liberalized med pass here. When asked what he meant by that, the medical director said, Plus or minus an hour of the scheduled time. When asked why is this important, he indicated to maintain therapeutic levels of certain medications.</p> <p>On 2/27/25 at 10:50 a.m., an interview was conducted with licensed practical nurse #2 (LPN #2). LPN #2 was asked about the timing of medication administration. LPN #2 stated, We can give an hour before or after. When asked why that is, LPN #2 said, To give you grace since we have 30 patients, and to give you some time to get to them.</p> <p>On 2/27/25 at 1 p.m., during an end of day/pre-exit meeting with the facility administrator, director of nursing, and regional director of operations, the facility director of nursing stated that medications are given when ordered, 1 hour before or after the ordered time. They were made aware of the above findings.</p> <p>According to the facility's policy titled, Medication Administration, it read in part, . The purpose of this policy is to provide guidance for the process for providing monitoring that all medications are received and administered in a timely manner .II. Safety Precautions: a. Observe the 'five rights' for administration. i. the right resident, ii. the right time, iii. the right medicine, iv. the right dose, v. the right method of administration .</p> <p>According to Lippincott's Manual of Nursing Practice, Eighth Edition, on page 18 it read in part, Common Legal Claims for Departures from Standards of Care . Failure to administer medications properly and in a timely fashion, or to report and administer omitted doses appropriately .</p> <p>No additional information was provided.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>41449</p> <p>Based on resident interview, staff interview, and clinical record review, the facility staff failed to follow physician orders for one resident (Resident #2- R2) in the survey sample of six residents.</p> <p>The findings include:</p> <p>For R2, the facility staff failed to accurately transcribe a physician order, resulting in multiple occurrences of medications being administered at the wrong dose.</p> <p>On 2/26/25 at 11:25 a.m., R2 was visited in her room. When asked about medications, R2 reported she had difficulty getting her medications timely.</p> <p>On 2/26/25 and 2/27/25, a clinical record review was conducted of R2's chart. According to a progress note dated 2/10/25, from a neurologist that R2 saw that day, the note read in part, . Assessment/Plan: . Her exam is most notable for mild symmetric bradykinesia, minimal rigidity, and a prominent postural/action tremor that attenuates at rest . I am inclined to agree that this is likely drug-induced tremor; unfortunately, she is unable to reduce/stop VPA [valproic acid]. Since the postural/action component is most bothersome, we will restart propranolol at a very low dose . Drug-induced tremor/parkinsonism, restart propranolol: 5 mg daily for 2 weeks, then 5 mg bid [twice a day] for 2 weeks, then 5mg tid [three times a day], can continue to up-titrate from there . Medication changes as of 2/10/2025, added: propranolol (Inderal) 10 mg tablet, take 0.5 tablets by mouth three times daily, follow titration schedule .</p> <p>According to the physician orders and medication administration record, the propranolol was transcribed at the facility on 2/10/25 as Propranolol HCL oral tablet 10 mg, give 0.5 tablet by mouth three times a day for HTN [hypertension]. The MAR indicated that R2 received three doses daily on 2/12/25 - 2/21/25, then again on 2/24/25 - 2/25/25, until the supply was depleted.</p> <p>On 2/27/25 at 11 a.m., the surveyor approached the nurse working the medication cart where R2 resides. The nurse identified themselves as the unit manager. When asked to see R2's propranolol medication, the nurse was unable to find it in the medication cart.</p> <p>On 2/27/25 at 11:10 a.m., review of R2's medication administration record revealed that the propranolol was signed as having been administered that morning. The surveyor then went back to the nurse/unit manager to inquire about the medication being documented as having been administered, when the medication was not available in the medication cart. The nurse reported that he had given the last dose that morning. When asked to see the empty medication card, the nurse was unable to provide evidence to the surveyor.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 2/27/25 at 12:02 p.m., a telephone call was placed to the pharmacy and an interview was conducted with the pharmacist. The pharmacist confirmed that on 2/10/25, R2's propranolol was sent to the facility. The pharmacist also confirmed that 45 tablets were dispensed for a 30-day supply. When asked to confirm the order, the pharmacist stated it was to be given three times daily. When asked to explain how 45 tablets could be a 30-day supply if three tablets are being given daily, the pharmacist then stated that she needed to talk to the pharmacy manager. Upon returning to the call, the pharmacist stated that the pharmacy had provided the full 10 mg tablets, instead of the half tablets as ordered, which was an error on our part. We are to cut the tablets and send. The pharmacist then confirmed that the resident likely received the full tablet of 10 mg three times daily, which was twice the ordered amount, as the facility was reporting that they had no supply left. The pharmacist also stated that they would need to talk to the physician about this before they can fill it again.</p> <p>On 2/27/25 at 1 p.m., during an end of day/pre-exit meeting with the facility administrator, director of nursing and regional director of operations, the facility's director of nursing was shown the above documentation, agreed that the order had been entered incorrectly, and stated that R2's dose should have been titrated up. The discrepancy with regards to the pharmacy sending full tablets versus 1/2 tabs was also discussed, adding that the pharmacist stated that they would have to talk with the doctor before the pharmacy could fill that medication again.</p> <p>On 2/27/25 at approximately 2 p.m., the facility's director of nursing let the surveyor know they had found a card of the propranolol for R1.</p> <p>No additional information was provided.</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>41449</p> <p>Based on observation, resident and staff interviews, clinical record review, and facility documentation review, the facility staff failed to ensure medications were available for administration for four residents (Resident #4-R4, Resident #5-R5, Resident #1-R1, and Resident #20-R20) in a survey sample of 6 residents.</p> <p>The findings included:</p> <p>1. For R1, the facility staff failed to have Gabapentin available for administration in accordance with physician orders.</p> <p>On 2/26/25 at 11:15 a.m., an interview was conducted with R1. During the interview, R1 said, This is my 3rd day without gabapentin. I think it has to do with agency nurses. They are just lazy and don't do like they should.</p> <p>According to the physician orders, it was noted that R1 had an order for Gabapentin Capsule 400 mg, give 2 capsules by mouth every 8 hours for neuropathy. On 2/25/25, it was documented that the order was put on hold.</p> <p>According to the medication administration record, R1 did not receive two doses of the scheduled Gabapentin on 2/24/25 and did not receive any of the three doses on 2/25/25. The medication order was then placed on hold until the second scheduled dose on 2/26/25.</p> <p>On 2/27/25 at 9:30 a.m., an interview was conducted with the medical director and attending physician of R1. The physician was asked about medications and reported that the pharmacy delivers twice daily, and medications are given plus or minus within an hour of when scheduled. When asked about medications not being available, the physician said, It happens frequently. When asked about hold orders, the doctor stated that hold orders are happening if medications are not available to be given, particularly narcotics when the pharmacy says they are waiting on a prescription. The doctor explained that he would send prescriptions electronically but frequently the pharmacy would say they don't receive it. The doctor also stated that the pharmacy would not fill for the entire quantity written on the prescription, which required more frequent reordering of the medication by facility staff, and added, We use a lot of agency staff that are unfamiliar with the residents.</p> <p>On 2/27/25 at 10:50 a.m., the surveyor asked the licensed practical nurse (LPN #2) to allow the surveyor to see R1's Gabapentin supply. The card of medication had a prescription label that noted it was filled 2/25/25 and received on 2/26/25, in a quantity of 30 capsules. The facility also had two additional cards with 30 capsules each, which, when totaled, would be about a 15-day supply.</p> <p>2. For R2, the facility did not have the blood pressure medication propranolol available to administer as ordered by the physician.</p> <p>On 2/26/25 at 11:25 a.m., R2 was visited in her room. When asked about medications, R2 reported she had difficulty getting her medications timely.</p> <p>(continued on next page)</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 2/26/25 and 2/27/25, a clinical record review was conducted of R2's chart. According to the physician orders R2 had an order dated 2/10/25, that read, Propranolol HCL oral tablet 10 mg, give 0.5 tablet by mouth three times a day for HTN [hypertension].</p> <p>According to the medication administration record for February 2025, R2 did not receive the Propranolol on the following occasions: two missed doses on 2/11/25, three missed doses on 2/22/25, and one missed dose each on 2/23/25 and 2/26/25. According to the nursing progress note entries, on 2/11/25, it was documented not available. On 2/16/25, the nurse documented, The resident's medication is out of stock at this time, reordered from pharmacy 2/16 will monitor for s/s [signs and symptoms] hypertension. On 2/22/25, it was documented, Awaiting meds from pharmacy. On 2/23/25, the nursing note read, on order. On 2/26/24, the documentation read, being delivered.</p> <p>On 2/27/25 at 11 a.m., the surveyor approached the nurse working the medication cart where R2 resides. The nurse identified themselves as the unit manager. When asked to see R2's propranolol medication, the nurse was unable to find it in the medication cart.</p> <p>On 2/27/25 at 12:02 p.m., a telephone call was placed to the pharmacy and an interview was conducted with the pharmacist. The pharmacist confirmed that on 2/10/25, R2's propranolol was sent to the facility. The pharmacist confirmed that 45 tablets were dispensed for a 30-day supply. When asked to confirm the order, the pharmacist stated it was to be given three times daily. When asked to explain how 45 tablets could be a 30-day supply if three tablets are being given daily, the pharmacist paused, then stated that she needed to talk to the pharmacy manager. Upon returning to the call, the pharmacist stated that the pharmacy had provided the full 10 mg tablets, instead of the half tablets as ordered, . which was an error on our part. We are to cut the tablets and send. The pharmacist then confirmed that the resident likely received the full tablet of 10 mg three times daily, which was twice the ordered amount, as the facility was reporting that they had no supply left. The pharmacist also stated that they would need to talk to the physician about this before they can fill it again.</p> <p>3. For Resident #4 (R4), the facility did not have the respiratory medication Bevespi available to administer as ordered by the physician.</p> <p>On 2/26/25, a closed record review was conducted. According to the physician orders, R4 was ordered Bevespi inhaler, and two puffs were to be administered twice daily for COPD.</p> <p>According to the medication administration record (MAR), R4 did not receive the Bevespi from 12/27/24 through 12/31/24. According to the nursing progress note dated 12/30/24, it read, Awaiting medicine from pharmacy. Will contact pharmacy to follow-up.</p> <p>On 2/27/25 at 12:02 p.m., the surveyor contacted the facility's contracted pharmacy via telephone. An interview was conducted with a pharmacist, who reported that R4's Bevespi order was received by the pharmacy on 12/27/24 but was not dispensed until 1/1/25. The pharmacy manager confirmed that deliveries are made to the facility daily by the pharmacy. When questioned about the delay in R4's Bevespi being delivered, the pharmacist stated, it was not covered by insurance, so they were probably waiting to hear back from the facility about how to proceed.</p> <p>4. For Resident #5 (R5), the facility did not have the respiratory medication Breo Ellipta available to administer as ordered by the physician.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 2/26/25 at approximately 1:30 p.m., R5 stopped the surveyor and asked the surveyor to step into his room. R5 stated he has not had his inhaler for several days and really needs it. R5 opened the top drawer of his bedside table and removed the silver packaging that the Breo comes in and showed the surveyor, again saying he needed it to breathe. R5 was observed to be receiving continuous oxygen per nasal cannula.</p> <p>On 2/26/25, a clinical record review was conducted of R5's chart. This review revealed that R5 had a diagnosis to include chronic obstructive pulmonary disease (COPD). According to the physician orders, R5's orders included, but were not limited to, O2 at 2 LPM [liters per minute] via NC [nasal cannula] continuously for COPD and Breo Ellipta Inhalation Aerosol Powder breath activated 200-25 MCG/ACT.</p> <p>According to the medication administration record (MAR), R5 was noted as not receiving the daily Breo inhaler on 2/18/25, 2/20/25, 2/22/25, 2/23/25, 2/24/25, 2/25/25, and 2/26/25. According to R5's nursing progress notes, an entry dated 2/18/25 read, On order, RP [responsible party] notified. R5's nursing note dated 2/20/25 read, in route from pharmacy. R5's nursing note entry dated 2/22/25 read, on hold. On 2/23/25, the nurse documented, too soon to order on hold.</p> <p>On 2/26/25 at approximately 4:30 p.m., the surveyor approached the nurse and asked about R5's Breo and requested to see if it was in the medication cart. The nurse, RN #1 stated it was not available, that she had notified the unit manager, and called the pharmacy, who had reported it would be out on the next run.</p> <p>On 2/26/25 at 4:35 p.m., the surveyor conducted an interview with the assistant director of nursing/unit manager (Administrative Staff #2- AS#2). When asked about R5's Breo, AS#2 said, He needs a new one, the pharmacy said it was too soon, so I told them to fill it anyway.</p> <p>On 2/27/25 at 9:30 a.m., an interview was conducted with the medical director, the attending physician for R5. When asked about medications, the physician reported that the pharmacy delivers twice daily, and that medications are given plus or minus an hour of when scheduled. When asked about medications not being available for administration, the physician said, It happens frequently. The physician went on to state that R5 . really needs it [referring to the Breo] because he has COPD and is on oxygen.</p> <p>On 2/27/25 at 12:02 p.m., a phone conversation was held with the pharmacist at the facility's contracted pharmacy. The pharmacist reported that R5's Breo Ellipta was most recently filled on 1/30/25, which included 30 inhalations. The pharmacist further reported that it was delivered on 2/26/25 at 9:25 p.m., to the facility.</p> <p>On 2/27/25 at approximately 12:15 p.m., R5 reported that he still had not received his Breo and said, This place ain't worth a damn!</p> <p>On 2/26/25 at 2:22 p.m., an interview was conducted with a registered nurse (RN #1). When asked what the process is when a medication is not available, RN #1 said, We call the pharmacy to see if they have it in the Omnicell [emergency supply of medications]. If not available, we can ask the pharmacy to send it STAT [urgently]. We have to write a note that it is not available.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 2/26/25 at 4:29 p.m., an interview was conducted with the Assistant Director of Nursing (ADON). The ADON was asked to explain the process staff are to take when a medication is not available for administration. The ADON stated that staff can see if the medication is in the Omnicell, get an order from the doctor to hold the medication, contact the pharmacy to see when it is coming, identify what the issue is that they haven't received it, and let the responsible party know.</p> <p>On 2/27/25 at approximately 9:30 a.m., an interview was conducted with the medical director, who is also the attending physician for many of the residents. When asked about his expectations with regards to medication orders, the physician stated that he expects residents to receive their medications as ordered. The medical director went on to report that the pharmacy delivers to the facility twice daily. When notified of the above findings of residents not receiving medications as ordered, the physician said, It happens frequently We use a lot of agency staff who are unfamiliar with the residents.</p> <p>According to the facility policy titled, Medication Administration was reviewed. The policy read in part, . The purpose of this policy is to provide guidance for the process for providing monitoring that all medications are received and administered in a timely manner .</p> <p>The facility policy titled, Missed Medication/Medication Error was received and reviewed. The policy read in part, Medication error/incident: any physician/provider prescribed medication that is not administered to the resident as prescribed regardless of the category or the reason for not providing the medication . II. For any medication(s) not available during a routine medication pass: 1. The charge nurse will check the E-kit to attempt to offer medication in a timely manner. 2. If medication is taken from the E-kit, the pharmacy will be notified so the E-kit can be exchanged . 3. In the event the medication is not available from the E-kit or the Emergency Pharmacy, the charge nurse will notify the physician immediately and receive guidance on how to proceed .</p> <p>On 2/27/25 at 1 p.m., during an end of day/pre-exit meeting, the facility administrator, director of nursing and regional director of operations, was made aware of the above findings.</p> <p>No additional information was provided.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  495153	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/27/2025
NAME OF PROVIDER OR SUPPLIER  Cedars Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>41449</p> <p>Based on observation, staff interview, and facility documentation review, the facility staff failed to store, prepare and serve food in a sanitary manner in the main kitchen, having the potential to affect multiple residents on 4 of 4 nursing units.</p> <p>The findings included:</p> <p>1. The facility staff failed to let dishes air dry and were stacking dishes wet or wet nesting, which can cause bacteria growth.</p> <p>On 11/19/24, during the lunch meal, observations were conducted in the dining room of the meal service. The dietary aide (Other Employee #17) was at the tray line plating food without wearing a beard guard, although facial hair was visible.</p> <p>On 11/20/24 at 1:40 p.m., during a follow-up visit to the kitchen, the cook (Other Employee #14) was observed in the area by the stove, preparing food without wearing a hair net. The dietary aide (Other Employee #15) was observed preparing beverages and her hair net was only covering the ends of her hair in the back. When asked about hair nets, Other Employee #15 stated that they don't have any large enough to cover her hair and that she usually has to wear two. The food services district manager, who was also present, stated that Other Employee #15 could put two on as she normally does, and that he would have some larger ones sent to the facility.</p> <p>On 11/20/24 at approximately 1:45 p.m., following the surveyor's conversation with Other Employee #15 about the hair net, the cook exited the kitchen and upon return, while walking through the kitchen, was donning a hair net. When asked why the hair net was not worn prior to the surveyor entering the kitchen, the cook gave no response</p> <p>On 11/20/24 at approximately 1:48 p.m., the dietary district manager confirmed that all kitchen staff should wear hair nets and beard guards as appropriate when in the kitchen.</p> <p>On 11/20/24, during an end of day meeting, the facility administrator was made aware of the above concerns.</p> <p>On 11/21/24, at approximately 12:30 p.m., an observation was made in the dining room. The kitchen employee that was working the steam table was distributing food to plates, had visible facial hair but had no beard guard on.</p> <p>On 11/21/24 at 2:24 p.m., as the surveyor was walking past the kitchen, the door was open, and the surveyor observed the facility's social services director standing by the stove without a hair net on.</p> <p>On 11/21/24, in the afternoon, an interview was conducted with the social services director. When the surveyor discussed that the employee had been observed in the kitchen, the social services director stated she was dropping off some food that had been brought in.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Cedars Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1242 Cedars CT Charlottesville, VA 22903	
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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>According to the facility policy titled, Staff Attire, it read in part, 1. All staff members will have their hair off the shoulders, confined in a hair net or cap, and facial hair properly restrained .</p> <p>On 11/21/24, during the end of day meeting, the facility administrator was made aware of the additional observations of facility staff in food preparation areas without proper hair restraints.</p> <p>No further information was provided.</p> <p>2. The facility staff failed to wash dishes in a manner to properly clean and sanitize the items.</p> <p>On 11/20/24 at approximately 1:45 p.m., a dietary aide was observed manually washing dishes in the three-compartment sink. The employee was only using 2 of the 3 sinks. He was washing the dishes in the wash sink and then immediately removing them and taking them to the sanitizer, then took the dishes and placed them on a drying rack. No rinse was provided for the dishes as the middle sink was empty. The surveyor attempted to interview the staff member, but he didn't speak English.</p> <p>The dietary services district manager was present and confirmed the above observations. The district manager was giving gestures to instruct the dietary aide to fill the middle sink and to rinse dishes before dipping into the sanitizer.</p> <p>The facility policy titled, Manual Warewashing was reviewed. The policy didn't address dishes being rinsed.</p> <p>On 11/20/24, in the afternoon, during a follow-up visit to the kitchen it was observed that following dishes being washed in the dish washer, they were being stacked wet, causing wet nesting. An interview was conducted with the dietary aide (Other Employee #15), who confirmed the observation and stated that not allowing dishes to air dry could cause bacteria growth.</p> <p>According to the facility policy titled, Warewashing, it read in part, .4. All dishware will be air dried and properly stored.</p> <p>On 11/20/24, during an end of day meeting, the facility administrator was made aware of the above findings.</p> <p>No additional information was provided.</p>		