STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495380		R-C 11/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHASE CITY HEALTH AND REHAB CENTER	5539 HIGHWAY FORTY SEVEN CHASE CITY, VA 23924

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{F 000}	INITIAL COMMENTS An unannounced Medicare/Medicaid revisit to the abbreviated survey conducted 10/3/17 through 10/4/17, was conducted 11/13/17 through 11/14/17. No complaints were investigated on this survey. Uncorrected deficiencies are identified within this report. Corrected deficiencies are identified on the CMS 2567-B report. The facility was not in compliance with 42 CFR Part 483, the Federal Long Term Care requirements for 1 of 1 of the original deficiencies. The census in this 120 certified bed facility was 109 at the time of the survey. The survey sample consisted of 13 current Resident reviews (Residents #101 through # 113).	{F 000}		
{F 314} SS=D	TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES CFR(s): 483.25(b)(1) (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.	{F 314}		12/6/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/22/2017

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 314}	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review and facility document review, the facility staff failed to accurately assess a pressure ulcer for one of 13 residents, Resident #103. Resident #103 was observed with a dark, hardened area on his right great toe. The area was inaccurately assessed as a Stage 2 pressure ulcer by the facility wound nurse. Findings were: Resident #103 was originally admitted to the facility on 10/06/2017 with the following diagnoses, including but not limited to: Cancer of the larynx, tongue, and prostrate, diabetes mellitus, and hypertension. The admission MDS (minimum data set) with an ARD (assessment reference date) of 10/13/2017, assessed Resident #103 as having a cognitive summary score of "13", indicating he was cognitively intact. Upon entry to the facility they survey team requested a list of all residents with current pressure ulcers requiring treatment. Resident #103 was on the list provided and added to the survey sample accordingly. The clinical record was reviewed on 11/13/2017. The admission MDS was reviewed. Resident #103 was admitted to the facility with one Stage 1 pressure ulcer and one suspected deep tissue injury. The physician order section contained the	{F 314}	1. Resident #103 right great toe wound has been assessed by Certified Wound Care Nurse for verification of accuracy. 2. Current residents with pressure ulcers have been assessed by Certified Wound Care Nurse and Center Wound Care Nurse to ensure accuracy of wound assessment. 3. Center Wound Care Nurse will received individual education from Certified Wound Care Nurse on wound and pressure ulcer assessment and classification. 4. Weekly pressure ulcer rounds with Wound Care Nurse and member of clinical leadership team for 12 weeks to verify accuracy of assessment. Wound and ulcer weekly tracking report will be reviewed by DON/ADON or designee weekly to identify any changes in wound assessment and follow up as indicated x 12 weeks. DON/ADON or designee will report findings to QAPI for further recommendations. 5. Date of compliance December 6, 2017.	

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{F 314}	Continued From page 2	{F 314}		

following order: Bacitracin ointment to right great toe every day shift for Stage 2- clean with normal saline, cover with gauze, and tape to close.

Review of Resident #103's pressure ulcer reports included the following: "11/07/2017 Site: Right toe Stage 2 noted 0.3 cm X 0.3 cm X 0 cm; Describe exudate type/odor/amount per site: No drainage area dry, no odor, no s/s (signs/symptoms) of infection; Description of healing: Improved; Treatment Recommended: Continue; Physician notified of status."

A progress note dated 11/08/2017 was reviewed and contained the following: "MD in facility, wound rounds performed, new orders received to cleanse right great toe with ns (normal saline), apply Bacitracin, gauze and tape to cover qd (every day) and prn (as needed) r/t area scabbing over and slow healing noted..." The note was written by the wound nurse.

Resident #103 was not in the facility on 11/13/2017 as he was out for a procedure. On 11/14/2017 this surveyor observed a dressing change with the wound nurse for Resident #103. Resident #103 was observed in his bed, head elevated to approximately 90 degrees. The dressing had already been removed from Resident #103's right great toe. The right great toe was observed with a darkened area on the end. The wound nurse was asked what the staging of the wound was. She stated, "This is a stage 2...see how it is lifting on the edges, that's why we are calling it a 2." The wound nurse was asked if the area was hardened. She stated, "Yes, that's why we are using the Bacitracin on it, to try to soften it up...this started out as a deep tissue injury...we were using skin prep on it but

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{F 314}	Continued From page 3 once it opened up last week we changed it." This surveyor did not discuss the wound any further at the resident's bedside as Resident #103 was alert and oriented. After the dressing change the clinical record was again reviewed. A physician note date 11/08/2017 contained the following information: "Pt seen with wound nurse to look at right great toe...right great toe with scabbing over rt toe wound slow healing...cleanse with NS Bacitracin..." During a meeting with the administrator and the DON (director of nursing) on 11/04/2017 at approximately 10:15 a.m., a copy of the facility policy on staging of pressure ulcers was requested. The above information was discussed and concerns were voiced regarding the assessment and staging of the pressure area on Resident #103's great toe. A policy "Pressure Ulcer Prevention And Care Program" was received and reviewed. Under the section "Classifications", the following information was observed "Stage 2: Partial thickness skin loss involving epidermis dermis, or both; superficial and presents clinically as an abrasion, blister, or shallow crater." An unstageable pressure area was described as: "Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green, or brown) and/or eschar (tan/brown or black) in the wound bed; Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore stage, cannot be determined." An additional meeting was held with the DON,	{F 314}		

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{F 314}	Continued From page 4 administrator, and the wound nurse. The description of a stage 2 pressure area per the facility guidelines was discussed. She stated, "I just talked to the doctor and told him what the toe looks like and he agreed that the area is unstageable." The wound nurse was asked if she had contacted the doctor after the meeting the survey team had with the administrator and the DON earlier that day. She nodded her head up and down [yes]. The wound nurse was asked why during the dressing change she had stated that the pressure area was a Stage 2. She stated, "I kept it at a Stage 2 last week because I thought that dried area was going to come on off of there...." The wound nurse was asked if pressure areas were assessed and staged based on what she thought was going to happen to the wound in the future or based on the observation and assessment done at the time. The wound nurse reviewed her notes, those of the physician and the orders. She stated, "I should have staged it as Unstageable last week" She continued, "It wasn't as dark last week...it was worse yesterday when he got back from the hospital...it was much darker and dry then and the dressing was off." The wound nurse was asked if she had documented the appearance of the wound and her assessment when the resident returned from the hospital. She stated, "No." (Resident #103 left the facility at 6:20 a.m. for a procedure and returned at 4:32 p.m.) The wound nurse was asked to walk this surveyor through the progression of the area on Resident #103's toe. While reviewing the record she provided the following: Upon admission Resident #103 had a suspected deep tissue injury of his right great toe. It opened on 10/25/2017 and was identified as a Stage 2 and was treated with a	{F 314}		

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{F 314}	Continued From page 5 foam dressing twice a week. On 10/31/2017 there was no change in the wound or the treatment. On 11/07/2017 the area was assessed as having no drainage, and was dry, follow up with the physician occurred on 11/08/2017. On 11/08/2017 the treatment was changed, the area was drying and not as pink as it had previously been. The doctor looked at it and changed the treatment. The wound nurse stated, "I should have assessed that as an unstageable then." No further information was obtained prior to the exit conference on 11/14/2017.	{F 314}		