STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495380	A. Building B. Wing	03/15/2024

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

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 - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 41449 Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to ensure residents receive treatment and care in accordance with professional standards of nursing practice for one resident (Resident #2- R2), in a survey sample of 5 residents. The findings included: For R2, the facility staff failed to administer medications in accordance with physician orders and failed to notify the ordering provider when medications were not administered. On 3/14/24-3/15/24, a closed record review was conducted of R2's chart which included physician orders, medication administration records (MAR), hospital records and progress notes. This review revealed that on 3/11/24, R2 was not administered two medications that were ordered to be administered at 6:30 a.m. The medications included Glimepiride and Protonix. The reason documented was coded as a 7, which according to the chart codes noted 7=sleeping. Review of the progress notes revealed an entry dated 3/11/24 at 6:38 a. m., that read, Resident has been resting quietly in bed this shift. Resident appears to be comfortable. Resident will talk to staff when you talk to him. He denied pain. Resident noted holding solids in his mouth. Resident requesting cold water and he tolerated water with no issues. There was another note on the same day that indicated the nursing staff requested an order to crush medications for R2. Review of the hospital discharge summary dated 2/22/24, revealed the following statement which read in part, Speech saw patient due to concern for aspiration and recommended . crush medications in applesauce/pudding/yogurt. This order had not been carried out when R2 was readmitted to the facility. According to the MAR, on 3/9/24, R2 did not receive the Bactrim antibiotic as ordered at 4:30 p.m. The code on the MAR was noted as 9, which according to the chart code indicated other/see nurse notes. According to the nurse note dated 3/9/24, it read, medication not given, with no further explanation. (continued on next page)

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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(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 - Few	On 3/14/24, in the afternoon, an interview was conducted with LPN #1. When asked about the documentation of medications administered, LPN #1 stated that medications are documented on the MAR. When asked what a blank means, LPN #1 said, it has not been given. When asked what the protocol is when a medication is not given, LPN #1 said, if not given contact the provider and notify the family. When asked to explain why the provider (doctor or nurse practitioner) is notified, LPN #1 said, to keep up with continuity of care and so they can monitor for side effects and/or give an alternate order. On 3/14/24 at 4 p.m., during an end of day meeting, the facility Administrator, Director of Nursing and Regional Director of Clinical Services were made aware of the above concerns. On 3/15/24 at 1:10 p.m., an interview was conducted with LPN #2. LPN #2 was asked about medication administration and the documentation of medications being administered. LPN #2 said, medications are documented as being administered as soon as they are given. When asked what a blank on the MAR indicates, she stated, they weren't given. When asked if she must notify anyone when medications are refused or not administered, LPN #2 stated, I put a note in and let the nurse practitioner know, because medications are important. On 3/15/24, during an interview, the director of nursing (DON) was presented with the above findings. The DON confirmed that documentation doesn't support that the doctor was made aware of R2 not being administered the associated medications. The DON went on to say that with regards to the Bactrim, the nurse noted that R2 was receiving intravenous antibiotics and attempted to call the nurse practitioner to question the order for the Bactrim and was not able to reach the provider, so the nurse decided to hold the medication. Review of the facility policy titled; Medication Administration was conducted. This policy read in part, medications will be administered by legally authorized and trained persons in accordance with applicable State, Local and Federal laws and consistent with accepted standards of practice . The Lippincott Manual of Nursing Practice, eighth edition, was reviewed. On page 18, in box 2-3, Common Legal Claims for Departure from Standards of Care were noted to include, but not limited to: . Failure to implement a physician/NP/PA order properly or in a timely fashion, failure to administer medications properly and in a timely fashion, or to report and administer omitted doses appropriately On 3/15/24 at 1:45 p.m., during an end of day meeting, the survey team shared the above concerns. No additional information was provided.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 41449 Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to maintain a complete and accurate clinical record for one resident (Resident #2- R2), in a survey sample of 5 residents. The findings included: For R2, the facility staff failed to maintain an accurate and complete clinical record with regards to medication administration, physician notification, skin condition, and change in bowel consistency. On 3/14/24 and 3/15/24, a closed record review was conducted of R2's chart. R2 was not a resident of the facility at the time of survey and therefore was not able to be interviewed. 1a. According to the March 2023 MAR (medication administration record), R2 was scheduled to receive Glimepiride, Protonix, and Bactrim on 3/9/24 at 6:30 a.m. All three entries for the administration of these medications were blank. There was no progress note entries on 3/9/24, with regards to medications not being administered, or that documented the physician had been notified. On the afternoon of 3/14/24, an interview was conducted with LPN #1. When asked about the documentation of administered medications, LPN #1 stated that medications are documented on the MAR. When asked what a blank means, LPN #1 said, it has not been given. When asked what the protocol is when a medication is not given, LPN #1 said, if not given, contact the provider and notify the family. When asked to explain why the provider (doctor or nurse practitioner) is notified, LPN #1 said, to keep up with continuity of care and so they can monitor for side effects and/or give an alternate order. On 3/14/24 at 4 p.m., during an end of day meeting, the facility Administrator, Director of Nursing and Regional Director of Clinical Services were made aware of the above concerns. On 3/15/24 at approximately 9:20 a.m., the DON (director of nursing) notified the survey team that she had spoken with RN #2, who was the assigned nurse to R2 on 3/9/24. The DON reported that RN #2 reported that she had given R2 the medications but failed to document. The DON had RN #2 come to the facility and correct the documentation and presented the survey team with a copy of the MAR that had each of the medications signed off as being administered on 3/9/24. During the above interview, the DON also confirmed that documentation of medications administered is to be done immediately following the administration and as a result she had provided RN #2 with a disciplinary action. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/15/24 at 1:10 p.m., an interview was conducted with LPN #2. LPN #2 was asked about medication administration and the documentation of medications being administered. LPN #2 said, medications are documented as being administered as soon as they are given. When asked what a blank on the MAR indicates, she stated, they weren't given. When asked if she must notify anyone when medications are refused or not administered, LPN #2 stated, I put a note in and let the nurse practitioner know, because medications are important. 1b. According to the nursing progress note dated 3/11/24, R2 had open area noted to scrotum, Calazinbc [sic] applied, NP [nurse practitioner] made aware. There was no clinical assessment or description of the area documented. The notification to the NP was noted in the communication book at the nursing station and gave no additional details. Therefore there was no documentation of the size or depth of the site, if there were any signs or symptoms of infection, if pain was present, or anything that might indicate etiology or treatment indicators. On the morning of 3/15/24, during an interview with the DON, the DON confirmed that the documentation was lacking and was not complete. The DON provided the survey team with evidence that a physician order for Calazinc cream to bilateral buttocks/scrotum/groin q [every] shift for redness was obtained on 2/29/24. 1c. According to a nursing progress note entered in R2's record on 3/11/24 at 10:18 a.m., resident noted to have a watery discharge from his buttock. There were no additional details of this to indicate if the discharge was coming from a wound, pustule, or any other assessment detail. This same detail was noted in a physician communication book to the provider serving as notification on their next visit to the facility. On 3/14/24, during an end of day meeting, the surveyor questioned the director of nursing regarding this entry and asked for any additional information to be provided. On 3/15/24 at approximately 9:20 a.m., the DON reported to the survey team that she had spoken with LPN #2 who made the entry and reported that it had been a jelly/watery discharge from R2's rectum. The DON further confirmed that the documentation was not complete and didn't accurately provide the needed information, noting that the buttock and rectum are two anatomically different parts of the body. The DON also clarified that the medical provider's communication book is used for .non-urgent needs that can be addressed on their next visit. Anything immediate needs to be called to the provider. The facility policy titled, Documentation in medical record was reviewed. This policy read in part, 1. Licensed staff and interdisciplinary team members shall document all assessments, observations, and services provided in the resident's medical record in accordance with state law and facility policy. 2. Documentation should be completed at the time of service but should be no later than the shift in which the assessment, observation, or care service occurred unless authorized . 3b. Documentation shall be accurate, relevant, and complete, containing sufficient details about the resident's care and/or responses to care . During an end of day meeting held with the facility administrator, DON and regional clinical director, the above concerns were shared. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	No additional information was provided.