STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING ______ B. WING ______	C 09/08/2017

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CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 9/6/17 through 9/8/17. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. One complaint was investigated during the survey. The census in this 180 certified bed facility was 160 at the time of the survey. The survey sample consisted of 22 current Resident reviews (Residents #1 through #21 and #26) and 4 closed record reviews (Residents #22 through #25).	F 000		
F 176 SS=D	RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE CFR(s): 483.10(c)(7) (c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility documentation review, clinical record review, and the facility staff failed to assess one of 26 Residents in the survey sample (Resident #15) ability to self administer Voltaren Gel. The findings included: Resident #15 was admitted to the facility on 11/19/17. Diagnoses for Resident #15 included but are not limited to Chronic Pain. Resident #15's Quarterly Minimum Data Set (MDS-an assessment protocol) with an Assessment	F 176	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center□s allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated.	10/18/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 09/19/2017

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 176	Continued From page 1 Reference Date of 5/28/17, coded Resident #15 with a BIMS (Brief Interview for Mental Status) of 15 of 15 indicating no cognitive impairment. In addition, the Quarterly MDS coded Resident #15 as being independent in Dressing, Eating, Toilet use and Hygiene. Resident #15 was coded as not being observed ambulating and having a wheel chair and walker as mobility devices. On 9/6/17 at approximately 9:45 a.m., an observation was made of Resident #15 sitting on her bed with a tube of Voltaren* Gel lying on the bed beside her. On 9/7/17 at approximately 1:00 p.m., an observation was made of Resident #15's room. Resident #15 was out of the room. No observation was made of Voltaren Gel within sight in Resident #15's room. On 9/7/17 at approximately 9:40 a.m., Resident #15 was asked about her pain control. Resident #15 stated, "I get pain pills and they help me very much." Resident #15 was asked if she uses any topical medications. Resident #15 stated, "Yes, I use...I can't think of the name of it. Let me show you." Resident #15 then obtained a tube of Voltaren Gel from her unlocked belongings. Resident #15 was asked to tell me about Voltaren Gel. Resident #15 stated, "About all I can tell you is I use it for pain of my knees." On 9/17/17 at approximately 9:40 a.m., The Unit 1 LPN #1-UM (Licensed Practical Nurse - Unit Manager) was asked to show a copy of a Medication Self Administer Assessment for Resident #15 to have Voltaren Gel at bedside. The Unit 1, Unit Manager LPN #1, provided a	F 176	1. Resident #15 has been assessed and found to be safe to administer and store the Voltaren Gel at her bedside. 2. All residents who have a physician□s order for a medication that may be kept at bedside for self- administration will be assessed for safety of administration and storage of the medication. 3. Licensed Nurses will be educated on completion of the Self-Administration Evaluation to assess the resident for proper administration, documentation, and storage of self-administered medication. 4. New orders for self-administration of medication will be reviewed weekly. At the quarterly care plan meeting, identified residents will be re-assessed by a Licensed Nurse, for continued ability to self-administer medication. Issues noted will be referred to the Quality Assurance Committee for review and recommendation. 5. Completion date: 10/18/2017	

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F 176	Continued From page 2 copy of the Physician order to have Voltaren Gel at bedside. The Unit Manager was asked to provide a copy of the Resident #15's ability to safely administer Voltaren Gel. The Unit Manager LPN #1, stated, "I do not see an assessment for that." Resident #15's 4/10/17 Physician Order documented the following: "Voltaren Gel 1% Apply 1 application unsupervised transdermally (on skin) every day and evening shift for pain apply to bilateral knees." Resident #15's 9/8/17 Physician Order documented the following: "May Keep Voltaren 1# Gel at bedside. Staff to educate patient on BID (twice daily) application to knees." Resident #15's 8/26/17 Current Care Plan documented a Focus Area for Potential for pain. Interventions included but were not limited to: "Administer medications per Medical Doctor order." Medline Plus documented potential side effects of Voltaren Gel 1% are as follows: "severe or do not go away: dryness, redness, itching, swelling, pain, hardness, irritation, swelling, scaling, or numbness at application site acne stomach pain constipation gas dizziness numbness, burning, or tingling in the hands,	F 176		

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arms, feet, or legs

Some side effects can be serious. If you experience any of these symptoms or those listed in the IMPORTANT WARNING section, call your doctor immediately:

hives
itching
difficulty swallowing
swelling of the face, throat, arms, or hands
unexplained weight gain
shortness of breath or difficulty breathing
swelling in the abdomen, ankles, feet, or legs
wheezing
worsening of asthma
yellowing of the skin or eyes
nausea
extreme tiredness
unusual bleeding or bruising
lack of energy
loss of appetite
pain in the upper right part of the stomach
flu-like symptoms
dark-colored urine
rash
blisters on skin
fever
pale skin
fast heartbeat
excessive tiredness

Diclofenac gel (Voltaren) or liquid (Pennsaid) may cause other side effects. Call your doctor if you have any unusual problems while using this medication."

The Facility Policy and Procedure titled, "Self-Administration of Medication at Bedside"

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F 176	Continued From page 4 with an effective date of 2/1/15 documented the following: "The patient may request to keep medications at bedside for self-administration in a lock box. Verify physician's order in the patient's chart for self-administration of specific medications under consideration. Complete Self-Medication Request/Evaluation form. A licensed nurse will monitor and chart self-administered drugs, and will monitor for proper storage on each med pass." The facility administration was informed of the findings during a briefing on 9/8/17 at approximately 12:00 noon The facility did not present any further information about the findings. DEFINITIONS Voltaren Gel 1%: Medline Plus documented the following: Diclofenac topical gel (Voltaren) is used to relieve pain from osteoarthritis (arthritis caused by a breakdown of the lining of the joints) in certain joints such as those of the knees, ankles, feet, elbows, wrists, and hands. Diclofenac topical liquid (Pennsaid) is used to relieve osteoarthritis pain in the knees. Diclofenac is in a class of medications called nonsteroidal anti-inflammatory drugs (NSAIDs). It works by stopping the body's production of a substance that causes pain.	F 176		
F 278 SS=D	ASSESSMENT ACCURACY/COORDINATION/CERTIFIED CFR(s): 483.20(g)-(j)	F 278		10/18/17

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(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.

(h) Coordination
A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.

(i) Certification
(1) A registered nurse must sign and certify that the assessment is completed.

(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

(j) Penalty for Falsification
(1) Under Medicare and Medicaid, an individual who willfully and knowingly-

(i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or

(ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment.

(2) Clinical disagreement does not constitute a material and false statement.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interviews, clinical record review, and review of the facility's policy the facility staff failed to accurately code the Minimum Data Set (MDS) assessment for one of

Provider's plan of correction:

1.The MDS for Resident #17 has been modified to reflect the correct information at section A1500.
2. Residents with a diagnosis of

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26 residents (Resident #17), in the survey sample.

The facility staff failed to code Resident #17's MDS assessment correctly at section "A1500" through "A1550".

The findings included:

Resident #17 was originally admitted to the facility 10/15/1998 and readmitted 9/25/2000 after an acute illness resulting in hospitalization. The current diagnoses included; a developmental disorder, cerebral palsy, an autistic disorder and "mental retardation" (MR).

The quarterly MDS assessment with an assessment reference date (ARD) of 7/14/17 coded the resident as not having the ability to complete the Brief Interview for Mental Status (BIMS). The staff interview was coded for long and short term memory problems as well as severely impaired daily decision making abilities. The resident was also coded as having no speech, rarely to never understands what's said to him and rarely to never can make himself understood. Resident #17 was coded as having no mood or behavior problems and requiring total care of 1-2 people with all activities of daily living.

A Physician's progress note dated 7/13/17, listed past medical history as follows; infantile cerebral palsy, mental retardation, severe autism, and cerebral anoxia at birth.

Review of Resident #17's clinical record revealed

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developmental disorder, cerebral palsy, autistic disorder, or mental retardation were reviewed to ensure that section A1500 was coded correctly on their MDS.
3. Discharge planners were educated on the coding of developmental disorder, cerebral palsy, autistic disorder, or mental retardation in section A1500 of the MDS.
4. New admissions will be reviewed for coding of A1500 on a random weekly basis. At the quarterly care plan meeting, residents will be reviewed for a diagnosis of developmental disorder, cerebral palsy, autistic disorder, or mental retardation to ensure that section A1500 was coded correctly. Issues noted will be referred to the Quality Assurance Committee for review and recommendation.
5. Completion date: 10/18/17

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a document titled "Screening for Mental Illness, Mental Retardation/Intellectual Disability, or Related Conditions" dated 1/20/16. The document stated Resident #17 does not have a diagnosis of a developmental disorder, cerebral palsy, an autistic disorder or "mental retardation" which was manifested prior to age 18; therefore, no active treatment needs were required and the resident doesn't meet the applicable criteria for serious mental illness, or MR/ID or related condition.

Review of the 1/14/17 Annual MDS assessment coded the resident at "A1500" as not having a serious mental illness and/or intellectual disability ("mental retardation") or a related condition The "no" answer at "A1500" allowed the staff to skip to question "A1550", where the staff again failed to code the resident for organic conditions "A1550b" Autism and "A1550e" other organic condition which would have included cerebral palsy.

If the appropriate coding had been made at "A1500" then "A1510b and A1510c" mental retardation/intellectual disability and other other related conditions could have been coded.

An interview was conducted with the Discharge Planner on 9/7/17 at approximately 11:00 a.m., who was responsible for coordinating the screening assessments. The Discharge Planner stated the facility staff conducted an audit of the Screening for Mental Illness, Mental Retardation/Intellectual Disability, or Related Conditions assessments and the assessments were completed 10-15 at a time until all were

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F 278	Continued From page 8 completed. After review of Resident #17's screening assessment for Mental Illness, Mental Retardation/Intellectual Disability the Discharge Planner stated it was inaccurate and she was responsible for reviewing the assessment for accuracy after the intern completed it. The above findings were shared with the Administrator, Director of Nursing and Corporate Nurse Consultant on 9/7/17 at approximately 11:30 a.m. The Corporate Nurse Consultant stated the screening assessment was incorrect and the MDS assessment was not accurate therefore; a new screening assessment would be completed and the MDS assessment would be modified to reflect the resident's status.	F 278		
F 280 SS=D	RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP CFR(s): 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the	F 280		10/18/17

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plan of care.

(iv) The right to receive the services and/or items included in the plan of care.

(v) The right to see the care plan, including the right to sign after significant changes to the plan of care.

(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must--

(i) Facilitate the inclusion of the resident and/or resident representative.

(ii) Include an assessment of the resident's strengths and needs.

(iii) Incorporate the resident's personal and cultural preferences in developing goals of care.

483.21
(b) Comprehensive Care Plans

(2) A comprehensive care plan must be-

(i) Developed within 7 days after completion of the comprehensive assessment.

(ii) Prepared by an interdisciplinary team, that includes but is not limited to--

(A) The attending physician.

(B) A registered nurse with responsibility for the resident.

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F 280	Continued From page 10 (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interviews, facility documentation review and clinical record review the facility staff failed to update a comprehensive person centered care plan after a fall for one of 26 residents (Resident #10) in the survey sample. The facility staff failed to revise Resident #10's comprehensive care plan to include a fall on 02/12/17. The findings included: Resident #10 was originally admitted to the facility on 03/18/12. Diagnosis for Resident #10 included but not limited to muscle weakness (1)	F 280	1. The comprehensive care plan for Resident #10 has been revised and updated to reflect current fall interventions. 2. Residents with a fall will be reviewed at the weekly fall committee meeting for revision of the care plan and initiation of new interventions as appropriate. 3. Licensed Nurses will be educated to document review of a resident□s care plan for a fall and to develop and put into place a new intervention to prevent further falls when appropriate. 4. Unit managers will monitor the care plan of a resident who has had a fall to	

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F 280	Continued From page 11 and Alzheimer's (2). The current Minimum Data Set (MDS), a comprehensive assessment with an Assessment Reference Date (ARD) of 08/15/17 coded the resident with a 6 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment. In addition, the MDS coded Resident #10 with extensive assistance of two with bed mobility, dressing, toilet use and personal hygiene and extensive assistance of one with bathing. The comprehensive care plan was reviewed on 12/12/16; the care plan did not address Resident #10's fall on 2/12/17 to include new interventions to prevent another fall. An interview was conducted with LPN #2 on 09/07/17 at approximately 2:45 p.m., who stated, "The nurse who is actually involved with the resident's fall is responsible for care planning their fall." The facility's administration was informed of the finding during a briefing on 09/08/17. The surveyor asked the Director of Nursing (DON), what is your expectations for care planning falls, she replied, "I expect for my unit manager to educate the floor nurses on how to care plan falls because they are not here 24 - 7. The DON proceeded to say, she expects the unit managers to follow up the very next business day to make sure all falls have been care planned and if they are not care planned; to care plan them. The facility's policy: "Resident Assessment and Care Planning" (Effective 11/28/16). Procedure:	F 280	ensure that the care plan has been reviewed and to ensure a new intervention is in place as appropriate. Issues noted will be referred to the Quality Assurance Committee for review and recommendation. 5. Completion date: 10/18/2017	

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F 280	Continued From page 12 "4. Computerized care plans will be updated by each discipline on an ongoing basis as changes in the patient occur, and reviewed quarterly with the quarterly assessment. Falls Management Program (Effective 02/01/15). Falls Committee: 5. The Unit Manager verifies care plan revisions, patient monitoring, appropriate referrals, and communication to staff for all recommendations." Definitions: 1). Muscles weakness is reduced strength in one or more muscles (https://medlineplus.gov/ency/article/007365.htm). 2). Alzheimer's is the common form of dementia. A progressive disease beginning with mild memory loss possibly leading to loss of the ability to carry on a conversation and respond to the environment (Source: http://www.cdc.gov/aging/aginginfo/alzheimers.htm).	F 280		
F 371 SS=E	FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY CFR(s): 483.60(i)(1)-(3) (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent	F 371		10/18/17

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F 371	Continued From page 13 facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observations, facility document review and staff interviews the facility staff failed to prepare, store, distribute and serve food in a safe, sanitary manner. The facility staff failed to ensure that the kitchen was free from pests to include roaches and drain flies, maintain a clean stove and oven that were free from copious amounts of grease and burnt debris, and ensure that an air gap was in place from the two food steamer units drain pipe to the floor drain. The findings included: On 9/6/17 at 7:55 a.m. during the initial kitchen tour the following observations were made: The two kitchen food steamer units were connected to one water drain pipe that was flush with and touching the floor drain. There was no visible air gap present. The six burner stove was	F 371	1. The kitchen is free from pests. The stove and oven are clean and free of debris. An air gap is in place from the two food steamer units drain pipe to the floor drain. 2. The facility prepares, stores, distributes, and serves food in a safe, sanitary manner. 3. Dietary staff were educated on monitoring and addressing pests, cleanliness of the stove and oven, and maintaining an air gap from the two food steamer units drain pipe to the floor drain. 4. The Dietary Manager will monitor the kitchen for presence of pests, cleanliness of the stove and oven, and maintenance of the air gap from the two food steamer units drain pipe to the floor drain. Issues noted will be referred to the Quality Assurance Committee for review and recommendation. 5. Completion date: 10/18/17	

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F 371	Continued From page 14	F 371		

noted to have large pieces of crusty burnt debris and a thick grease layer on and around all the burner. The three ovens were observed to have burnt/spillage debris on the oven floors and the oven racks were coated in thick black grease with raised areas of burnt food debris visible. One dead roach was observed on the floor between a three sink compartment unit and the pan drying rack. Also two live roaches were observed crawling up the wall in the main kitchen area under the sinks and crawling on the walls. In the dishwasher area five gray drain flies were observed crawling on the top and inside of the grease trap drain. There was also a large amount of dirt and debris present on the floors up under the dishwasher and the coffee maker table. The six well food steam table in the resident dining room was noted to have have debris and dirty water in all six wells and the heat lights above the food wells were covered in burnt food debris.

On 7/6/17 at 11:30 a.m. the above findings were shared with the Dietary Manager. The Dietary manager was asked when and how often are the kitchen floors and ovens cleaned. The Dietary Manager stated, "We deep clean and mop every Wednesday, but we have been slacking lately. I have been working 14 hour shifts myself and my staff are doing double shifts. It's hard to find staff and keep them."

The Dietary Manager provided the operation manual for the two steamer units titled "Vulcan Installation & Operation Manual" dated 2/06 which documented in part, as follows:

"Drain Connections:

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The drain connection must be 1 1/2 inches down, preferably with one elbow only, maximum length of 6 inches and piped to an open gap type drain.

CAUTION: In order to avoid any back pressure in the steamer, do not make a solid connection to any drain. FAILURE TO DO SO CAN DAMAGE THE STEAMER AND VOIDS THE WARRANTY.

A vent must be installed to avoid creating a vacuum or pressure in the cooking chamber."

The facility policy titled "General Cleaning" effective date 4/27/16 is documented in part, as follows:

"Policy: Routine cleaning will be done to maintain a sanitary work environment. A cleaning schedule will be posted in the department.

Procedure:

1. The Dining Services Manager/designee is responsible for posting a cleaning schedule to designate items to be cleaned on a daily, weekly, or monthly basis.

3. The Dining Services Manager/designee will check the cleaning schedule at the end of each shift to assure assignments have been completed."

The facility policy titled "Sanitation" effective date 4/27/16 is documented in part, as follows:

"Policy: Storage areas and premises shall be free from rodent and insect infestations, odors, dust and other sources of contamination.

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Procedure:

1. The kitchen and storage areas shall be regularly sprayed and maintained by an exterminating company for insects and rodents as often as deemed necessary.

2. Food is stored in a manner that protects food at all times from dust, flies, rodents, and other vermin.

6. Any food spilled shall be cleaned up immediately.

7. The floors shall be kept free from any debris or liquids at all times."

On 9/7/17 at 3:00 p.m. the Administrator was made aware of the above findings and was asked what he would have expected in the kitchen. The Administrator stated, "I have known the sanitary inspection to be good so that's hard for me to answer. We have reinstated the cleaning schedule and we have a company that cleans the oven hoods and we are going to contract with them to clean the drains and deep clean the floors. We are also going to have the exterminator come more often."

Prior to exit no further information was shared.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION	(X5) COMPLETION DATE
F 431 SS=D	DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS CFR(s): 483.45(b)(2)(3)(g)(h)	F 431		10/18/17

The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit

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F 431	Continued From page 17 unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked,	F 431		

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F 431	Continued From page 18 permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and facility documentation review the facility staff failed to date two open multidose vials of insulin for 2 out of 26 residents (Resident #19 and Resident #20) in the survey sample. 1. The facility staff failed to date an opened multidose vial of Novolog (1) insulin (Resident #19). 2. The facility staff failed to date an opened multidose vial of Humalog (2) insulin (Resident #20). The findings included: 1. Resident #19 was originally admitted to the facility on 12/06/12 with diagnosis to include but not limited to Type 2 Diabetes Mellitus (3) (DM). The current Minimum Data Set (MDS) a quarterly assessment with an Assessment Reference Date (ARD) of 08/19/17 coded the resident with a score of 99 indicating severely impaired with daily decision making. On 09/7/17 at 9:10 a.m., during inspection of the medication room on Unit 1, located in the medication refrigerator was one unlabeled	F 431	1. The insulin vials for Resident□s #19 and #20 were removed and destroyed. 2. All insulin vials/pens were reviewed to ensure dating when opened on the label. 3. Licensed Nurses will be educated to date all vials of insulin and all insulin injection pens when opened and to check the vial/pen for a date prior to using. 4. Unit managers will monitor weekly for compliance. Issues noted will be referred to the Quality Assurance Committee for review and recommendation. 5. Completion date: 10/18/2017	

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F 431	Continued From page 19	F 431		

multidose vial of Novolog insulin. The surveyor asked LPN #1, when was the insulin opened, she replied "I don't see an open date; there should be a date written on the vial once opened."

On 09/07/17 at approximately 10:45 a.m., an interview was conducted with the Corporate Nurse who stated all insulin should be dated once open.

2. Resident #20 was admitted to the facility on 05/05/17 with diagnosis to include but not limited to Type 2 Diabetes Mellitus (DM).

The current Minimum Data Set (MDS) a quarterly assessment with an Assessment Reference Date (ARD) of 07/26/17 coded the resident with a 09 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating moderate cognitive impairment.

On 09/7/17 at 9:25 a.m., during inspection of the medication room on Unit 3, located in the medication refrigerator was one unlabeled multidose vial of Humalog insulin. The surveyor asked RN #1 should the vial of Humalog have an open date, she replied, "Yes, it should have been dated once open." The surveyor asked, "How long in Humalog good for once open" RN replied, "Good for 28 days after it's opened."

On 09/07/17 at approximately 10:45 a.m., an interview was conducted with the Corporate Nurse who stated all insulin should be dated once opened.

The facility administration was informed of the findings during a briefing on 09/08/17. The facility

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F 431	Continued From page 20 did not present any further information about the findings. The facility's policy: "5.3 Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles" (Revision Date: 05/10/10). "Procedure: 5. Once any medication or biological package is opened. Facility should follow manufacture/suppliers guidelines with respect to expiration date for opened medications. Facility should record the date opened on the medication container when the medication has a shortened expiration date once opened." Definitions: 1). Novolog is used to treat diabetes (condition in which the body does not produce insulin and therefore cannot control the amount of sugar in the blood) (https://medlineplus.gov/druginfo/meds/a605013.html). 2). Humalog is used to treat diabetes (condition in which the body does not produce insulin and therefore cannot control the amount of sugar in the blood) (https://medlineplus.gov/druginfo/meds/a605013.html). 3). Type 2 Diabetes Mellitus is a lifelong (chronic) disease in which there is a high level of sugar (glucose) in the blood (https://medlineplus.gov/ency/article/007365.htm).	F 431		
F 469	MAINTAINS EFFECTIVE PEST CONTROL	F 469		10/18/17

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F 469 SS=E	Continued From page 21 PROGRAM CFR(s): 483.90(i)(4) (i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observations, facility document review and staff interviews the facility staff failed to maintain an effective pest control program to ensure the facility is free of pests. 1. The facility staff failed to ensure that the kitchen was free from pests to include roaches and drain flies. 2. The facility staff failed to ensure the facility was free from ants. The findings included: On 9/6/17 at 7:55 a.m. during the initial kitchen tour the following observations were made: One dead roach was observed on the floor between a three sink compartment unit and the pan drying rack. Also two live roaches were observed crawling on the floor in the main kitchen area under the sinks and crawling on the walls. In the dishwasher area five gray drain flies were observed crawling on the top and inside of the grease trap drain. On 9/6/17 at 8:15 a.m. an interview was conducted with the Dietary Aide. The Dietary Aide was asked if there are issues with roaches and pests in the kitchen. The Dietary Aide stated, "We have them every now and then. The bug man comes in and sprays."	F 469	1. The facility was treated for pests on 9/8/17. 2. Sanitation rounds were completed to ensure that the facility is free of pests. 3. Facility staff were educated on reporting of pest sightings. 4. Maintenance will monitor reports of pest sightings to ensure that the sightings are addressed. 5. Completion date: 10/18/17	

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On 7/6/17 at 11:30 a.m. the above findings were shared with the Dietary Manager. The Dietary manager was asked when and how often are the kitchen floors and ovens cleaned. The Dietary Manager stated, "We deep clean and mop every Wednesday, but we have been slacking lately. I have been working 14 hour shifts myself and my staff are doing double shifts. It's hard to find staff and keep them."

The facility policy titled "Sanitation" effective date 4/27/16 is documented in part, as follows:

"Policy: Storage areas and premises shall be free from rodent and insect infestations, odors, dust and other sources of contamination.

Procedure:

1. The kitchen and storage areas shall be regularly sprayed and maintained by an exterminating company for insects and rodents as often as deemed necessary.

2. Food is stored in a manner that protects food at all times from dust, flies, rodents, and other vermin.

6. Any food spilled shall be cleaned up immediately.

7. The floors shall be kept free from any debris or liquids at all times."

On 9/7/17 at 3:00 p.m. the Administrator was made aware of the above findings and was asked what he would have expected in the kitchen. The Administrator stated, "I have known the sanitary

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F 469	Continued From page 23 inspection to be good so that's hard for me to answer. We have reinstated the cleaning schedule and we have a company that cleans the oven hoods and we are going to contract with them to clean the drains and deep clean the floors. We are also going to have the exterminator come more often." Prior to exit no further information was shared. 2. Ants were observed in the conference room during the three days of the survey. Ants were observed in the window sills and crawling along the radiators in the conference room. Ants were also observed on the conference room table and cabinet like vanity. During an interview on 9/7/17 at 11:00 A.M. with the administrator he stated he was not aware ants were in the window. The facility staff failed to have an effective pest control program.	F 469		
F 504 SS=D	LAB SVCS ONLY WHEN ORDERED BY PHYSICIAN CFR(s): 483.50(a)(2)(i) (a) Laboratory Services (2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews and facility documentation the facility staff failed	F 504	1. Resident #1 had a BMP and HGBA1C completed on 9/7/2017.	10/18/17

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F 504	Continued From page 24 to ensure labs were obtained as ordered for one out of 26 residents (Resident #1) in the survey sample. The facility staff failed to ensure labs were obtained as ordered for the following: Basic Metabolic Panel (BMP) (1) and Hemoglobin A1C (2) for the month of August 2017. The findings included: Resident #1 was originally admitted to the facility on 11/27/14. Diagnosis for Resident #1 included but not limited to Type 2 Diabetes Mellitus (3) and Heart Failure (4). Resident #1's most recent MDS assessment was a comprehensive assessment with an ARD of 5/31/17. The Resident was coded with a Brief Interview for Mental Status (BIMS) score of 15 out of a possible 15, indicating no cognitive impairment. In addition, the MDS coded Resident #1 requiring total dependence of one with bathing, extensive assistance of two with transfers, extensive assistance of one with bed mobility, dressing, toilet use and personal hygiene. Resident #1's comprehensive care plan documented Resident #1 with a diagnosis of DM. The goal: the resident will have no complications related to diabetes. Some of the intervention to manage goal included but not limited to: Labs as ordered. The clinical record revealed the most recent physician order to draw labs of the following: BMP every 6 months in February and August and HGB A1C every 3 months in February, May,	F 504	2. Laboratory orders were reviewed to ensure that the tests were completed as ordered. 3. Licensed nurses will be educated on the Lab Log, to include printing lab requisitions, maintaining the lab log and documenting completion on the lab log and MD notification of the results. 4. The Unit Managers will complete a random weekly review of ordered labs to ensure that the labs were obtained as ordered. Issues noted during the review will be referred to the Quality Assurance Committee for review and recommendation. 5. Completion date: 10/18/2017	

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F 504	Continued From page 25	F 504		

August and November.

During medical record review, the surveyor was unable to locate the BMP and HGB A1C for the month of August on Resident #1's chart or in the medical record.

An interview was conducted LPN #1 on 09/07/17 at approximately 12:25 p.m., who stated she was unable to locate the BMP and HGB A1C in Resident's #1's clinical record. The surveyor asked what is the process and procedure for drawing upcoming labs, the LPN replied "We have a lab book and inside the lab book is a tracking form where we put the resident's name and the date the labs needs to be obtain. The surveyor asked who draws the labs, she replied, (name of company) pharmacy comes over; reviews the lab book and draws all the labs.

During the review of the lab tracking form for August 2017 did not have Resident #1's name listed to have labs drawn.

The facility's Administration was informed of the findings during a briefing on 09/08/17. The facility did not present any further information about the findings.

The facility's policy: "Laboratory/Diagnostic Testing" (Effective Date: 11/21/16).

"Policy: Laboratory, radiology and diagnostic services are provided to the Center by way of written contractual agreements. The contracted service vendor is to provide services to the Center that ensure safe and effective patient testing and timely delivery of laboratory, radiology and other diagnostic testing results.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING ____ B. WING ____	C 09/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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Procedure:

-A licensed nurse will obtain laboratory, radiology, or other diagnostic services to meet the needs of its patients as ordered by the physician or physician extender.

-A licensed nurse will monitor and track all physicians or physician extender ordered laboratory, radiology, and other diagnostic test; ensure that test are complete as ordered and communicate results to the physician in a timely manner."

Definitions:

1). BMP is used to check the status of a person's kidneys and their electrolyte and acid/base balance, as well as their blood glucose level - all of which are related to a person's metabolism (https://medlineplus.gov/ency/article/007365.htm).

2). Hemoglobin A1C is a blood test for type 2 diabetes and prediabetes. It measures your average blood glucose, or blood sugar, level over the past 3 months (https://medlineplus.gov/ency/article/007365.htm).

3). Diabetes Mellitus Type II is a lifelong (chronic) disease in which there is a high level of sugar (glucose) in the blood (https://medlineplus.gov/ency/article/007365.htm).

4). Heart failure is a condition in which the heart can't pump enough blood to meet the body's needs. Heart failure does not mean that your heart has stopped or is about to stop working. It means that your heart is not able to pump blood

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F 504	Continued From page 27 the way it should. It can affect one or both sides of the heart (https://medlineplus.gov/ency/article/007365.htm	F 504		
F 514 SS=D	RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE CFR(s): 483.70(i)(1)(5) (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and	F 514		10/18/17

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F 514	Continued From page 28 (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to accurately document medical record information for one of 26 residents (Resident #17), in the survey sample. The facility staff failed to accurately document information on Resident #17's Screening for Mental Illness, Mental Retardation/Intellectual Disability, or Related Conditions assessments. The findings included: Resident #17 was originally admitted to the facility 10/15/1998 and readmitted 9/25/2000 after an acute illness resulting in hospitalization. The current diagnoses included; a developmental disorder, cerebral palsy, an autistic disorder and "mental retardation" (MR). The quarterly MDS assessment with an assessment reference date (ARD) of 7/14/17 coded the resident as not having the ability to complete the Brief Interview for Mental Status (BIMS). The staff interview was coded for long and short term memory problems as well as severely impaired daily decision making abilities. The resident was also coded as having no speech, rarely to never understands what's said to him and rarely to never can make himself understood. Resident #17 was coded as having no mood or behavior problems and requiring total care of 1-2 people with all activities of daily living.	F 514	1. An accurate Screening for Mental Illness, Mental Retardation/Intellectual Disability, or Related Conditions assessment has been completed for Resident #17. 2. Residents with a diagnosis of developmental disorder, cerebral palsy, autism, and mental retardation were reviewed to ensure that the Screening for Mental Illness, Mental Retardation/Intellectual Disability, or Related Conditions assessment is accurate. 3. Discharge Planners will be educated on accurate completion of the Screening for Mental Illness, Mental Retardation/Intellectual Disability, or Related Conditions assessment. 4. A random review of Screening for Mental Illness, Mental Retardation/Intellectual Disability, or Related Conditions assessments will be completed by a Registered Nurse on a weekly basis to ensure accuracy of the assessment. Issues noted will be referred to the Quality Assurance Committee for review and recommendation. 5. Completion date: 10/18/2017	

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A Physician's progress note dated 7/13/17, listed past medical history as follows; infantile cerebral palsy, mental retardation, severe autism, and cerebral anoxia at birth.

Review of Resident #17's clinical record revealed a document titled "Screening for Mental Illness, Mental Retardation/Intellectual Disability, or Related Conditions" dated 1/20/16. The document stated Resident #17 does not have a a diagnosis of a developmental disorder, cerebral palsy, an autistic disorder or "mental retardation" which was manifested prior to age 18; therefore, no active treatment needs were required and the resident doesn't meet the applicable criteria for serious mental illness, or MR/ID or related condition.

Review of the 1/14/17 Annual MDS assessment coded the resident at "A1500" as not having a serious mental illness and/or intellectual disability ("mental retardation") or a related condition The "no" answer at "A1500" allowed the staff to skip to question "A1550", where the staff again failed to code the resident for organic conditions "A1550b" Autism and "A1550e" other organic condition which would have included cerebral palsy.

If the appropriate coding had been made at "A1500" then "A1510b and A1510c" mental retardation/intellectual disability and other other related conditions could have been coded.

An interview was conducted with the Discharge Planner on 9/7/17 at approximately 11:00 a.m., who was responsible for coordinating the

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screening assessments. The Discharge Planner stated the facility staff conducted an audit of the Screening for Mental Illness, Mental Retardation/Intellectual Disability, or Related Conditions assessments and the assessments were completed 10-15 at a time until all were completed.

After review of Resident #17's screening assessment for Mental Illness, Mental Retardation/Intellectual Disability the Discharge Planner stated it was inaccurate and she was responsible for reviewing the assessment for accuracy after the intern completed it.

The above findings were shared with the Administrator, Director of Nursing and Corporate Nurse Consultant on 9/7/17 at approximately 11:30 a.m. The Corporate Nurse Consultant stated the screening assessment was incorrect and the MDS assessment was not accurate therefore; a new screening assessment would be completed and the MDS assessment would be modified to reflect the resident's status.