STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495414	A. BUILDING _____ B. WING _____	07/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA OBICI SPECIALTY REHABILITATION CENTER	2800 GODWIN BOULEVARD SUFFOLK, VA 23434

(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 standard survey was conducted 07/6/17. The facility was in substantial compliance with 42 CFR Part 483 Federal Long Term Care requirement(s). The Life Safety Code survey/report will follow. No complaints were investigated during the survey. The census in this 8 certified bed facility was 1 at the time of the survey. The survey sample consisted of 1 current resident review (Resident #1).	F 000		
F 167 SS=C	483.10(g)(10)(i)(11) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE (g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and	F 167		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Elizabeth A Brown | TITLE: Administrator | (X6) DATE: July 21, 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 167	Continued From page 1	F 167		

accessible to the public.

(iv) The facility shall not make available identifying information about complainants or residents.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, and facility document review, the facility staff failed to have the three (3) preceding years of survey results readily available to residents, families and visitors upon request.

The facility staff failed to provide a copy of the two (2) preceding years of survey results, 2014 and 2015, upon request. A copy of the most current survey results in 2016 was posted on the unit bulletin board.

The findings included:

On 7/6/17 at 11:05 am, a facility tour was conducted with the RN (Registered Nurse) Transition Coordinator. Based on observation, a copy of the most recent facility survey results in 2016 was found posted on the bulletin board near the nurse's station. The RN Transition Coordinator was requested to provide a copy of the 2014 and 2015 survey results and she stated that they were in a book located in the Director of Nursing's (DON) office. The DON was on vacation at the time and her office door was locked. She had to find someone to unlock the door.

On 7/6/17 at 11:10 am, the Director of Ortho/Spine arrived and assisted in locating the survey results. She stated that she was not sure where the book was but will search for it. The book was found in the DON's office but it did not

F-167 Survey Results – Readily Accessible

1. Survey results and Plans of Correction for 2014 and 2015 surveys were posted adjacent to the Survey Results and Plan of Correction for the 2016 survey on the SSRC Bulletin Board.
2. All residents have the potential to be affected by this deficient practice.
3. All SSRC staff were educated on the requirement for and the presence of two (2) additional years of survey results.
4. The Director of Nurses and/or designee will audit presence of 3 years' survey results once per week for two weeks; then once per month for 1 month.
5. Date Certain: August 17, 2017

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F 167	Continued From page 2	F 167		

have a copy of the 2014 and 2015 survey results. She stated that they will continue to search.

On 7/16/17 at 11:15 am, LPN (Licensed Practical Nurse) #1 was interviewed and was asked how a resident, family or visitor would access the 3 preceding years of survey results upon request. She stated that they usually have a notice at the nurses' station where to locate the survey results. She presented the notice and it stated, "Our most recent Survey Results are posted on the SSRC (Sentara Specialized Rehab Center) Bulletin Board." This notice was displayed prominently on a round table at the center of the Nurses' Station. On the SSRC bulletin board, LPN #1 found a copy of the 2016 survey results posted. She was asked how an individual would access the 2014 and 2015 survey results upon request and she stated, "I don't know. I assume they're in the DON's office in her file."

On 7/6/17 at 11:17, a copy of the 2015 survey results was found in a folder labeled "Survey" in the DON's office.

On 7/6/17 at 11:40 am, the Rehab Coordinator presented the 2014 survey results and stated that it was found in a file cabinet in the DON's office.

A copy of the facility policy that addressed posting and accessibility of the survey results was requested from the Administrator. On 7/6/17 at 2:10 pm, the Administrator stated that the facility did not have a policy and added that the facility practice would be to call either the DON or the Administrator and the survey results would be available in 5 minutes. She stated that all staff will be trained regarding this practice.

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F 167	Continued From page 3 On 7/6/17 at 6:15 pm, the above findings were presented with the Administrator, QA (Quality Assurance) Director and the RN Transition Coordinator. No further information was provided.	F 167		
F 371 SS=F	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (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 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 observation, staff interview and facility document review the facility staff failed to store food in accordance with professional standards for food service safety.	F 371		

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F 371	Continued From page 4 The food service staff failed to ensure foods stored in refrigerated units were dated and labeled appropriately, and outdated foods were discarded. The findings included: A kitchen inspection was conducted on 7/6/17 at 11:05 a.m. The Executive Chef/Certified Food Protection Manager accompanied this inspector. Multiple food items were observed stored in refrigerated units that were inappropriately marked after opening with a date or time and/or exceeded the maximum holding time as allowed, as follows: 1. Cook's Cooler-walk in refrigerator were one large clear bin of pimento cheese and one large clear bin of fruit cocktail with no date opened, one large clear bin of chocolate pudding dated as opened on 6/29/17 good through 7/2/17, one container of chopped black olives dated as opened on 6/29/17 good through 7/3/17, one container of chopped grated carrots dated opened on 7/1/17 good through 7/4/17. one clear container of tropical fruit dated opened on 6/27/17 good through 6/30/17. 2. Reach in freezer located near salad prep station were opened food items out of the original container that were not labeled when opened such as: breaded chicken, salmon patties, and hamburger patties. 3. Walk in bread and pastry freezer were six (6) one quart containers of various chicken wings sauces dated as opened on 6/12/17 with no good through date on the label, a bundle of french baguettes unlabeled when opened. 4. Walk in meat freezer two bins of sausage gravy, one large bin of corned beef hash, one large container of cooked apples, and one	F 371	**F-371 Refrigerated food items dated and labeled, outdated foods discarded** 1. All unlabeled/opened refrigerated food and all outdated refrigerated food was immediately discarded. 2. All residents have the potential to be affected by this deficient practice. 3. Kitchen staff were educated on requirement to properly label all food packages when opened. Kitchen staff were educated on requirement to discard food on or before "use by" dates. Storage guidelines were posted next to each storage area. 4. The Food Service Manager (Designee) will inspect opened refrigerated packages of food to ensure that they are properly labeled twice weekly for four (4) weeks, then monthly for three (3) months. The SSRC Administrator/Designee will inspect refrigerators once monthly for two (2) months. Findings of inspections will be reported to SSRC Administrator and Director of Nurses monthly. Findings will be reported to each QAPI meeting for the duration of this monitoring. 5. Date Certain: August 17, 2017	

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F 371	Continued From page 5 container of oatmeal not dated. The Executive Chef discarded the above items. He stated the dietary staff have annual online education to include labeling and safe storage of foods. The above findings was shared with the Administrator prior to exit on 7/6/17. The facility policy titled "Food And Supply Storage" with a revised date of 1/17 read, in part: Policies-All food, non-food items and supplies used in food preparation shall be stored in such a manner as to prevent contamination to maintain the safety and wholesomeness of the food for human consumption. Procedures-Cover, label and date unused portions and open packages...Products are good through the close of business on the date noted on the label.	F 371		
F 520 SS=D	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other	F 520		

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F 520	Continued From page 6 individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews and review of the facility documentation, the facility staff failed to follow the facilities Quality Assurance (QA) process on the monitoring for labeling and dating of open food items as part of their action plan. The findings included: On 07/06/17 at approximately 3:55 p.m., an interview was conducted with the Administrator who was asked, "How do you ensure issues that	F 520	**F-520 QAA Committee follow QA process on action plan** 1. The Dietary Manager was educated on the need to report results of monitoring to the QAPI committee. 2. All patients have the potential to be affected by the deficient practice. 3. Dietary Manager has agreed to attend SSRC QAPI meetings or send a designee. 4. Administrator/designee will review QAPI attendance list and report compliance to QAPI through 2017. 5. Date Certain: August 17, 2017	

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F 520	Continued From page 7	F 520		

have been identified are monitored and corrected." The Administrator replied, "For example, if there's a problem in the dietary department, we as a committee will bring the problem(s) to the Quality Assurance (QA) meeting and together we will decide on an action plan to correct the problem then will bring the issue or problem back to next QA meeting for re-evaluation." The Administrator also stated, "During the next follow up QA meeting, the committee will review the previous concerns or issues and develop an audit/action plan to fill in the loops that may have been missed."

The Administrator acknowledges that she was aware of the current issues found by the surveyor during the initial tour inspection of the kitchen on 07/06/17 (food items without dates when opened, outdated items and food items not labeled); some of the same issues was identified during last year's survey (07/6/16 through 07/07/16).

According to the facilities Plan of correction for survey ending 07/07/16 indicated the following: "The food service manager (Designee) will inspect dry storage for opened packages of food to ensure that they are securely covered and labeled. This monitoring will occur twice weekly for four (4) weeks, then monthly for three (3) months. Findings will be reported to Quality Assurance and Performance Improvement (QAPI)."

Review of the facilities QAPI dated 07/11/16 indicated the chef will check storage daily and address any violations and the dietary director (manager) will monitor twice weekly and use a utilizing tracking document to monitor problems areas.

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F 520	Continued From page 8	F 520		

An interview was conducted with the Dietary manager on 07/06/17 at approximately 4:40 p.m. The surveyor asked the dietary manager who is responsible for making sure food items that are outdated and unlabeled are being monitored, he replied, "The chef usually walks through looking for expired or outdated food items but can say it's being done on a daily basis.

The surveyor requested the facilities completed tracking documents showing the facility followed through with their plan of correction (POC) for the monitoring of outdated or unlabeled food items. On the same day, the dietary manager stated, "I was unable to locate any of the completed forms showing we checked the storage daily for outdated or unlabeled food items.

Review of the facilities (QAPI) meeting attendance record indicated a meeting was held on the following days: 7/25/16, 10/24/16, 1/23/17 and 4/24/17 but the dietary manager only attended the meeting held on 07/25/16.

During an interview with the Administrator on 07/06/17 at 5:10 p.m., the surveyor stated, "During the review of the attendance record, it was noted the dietary manager only attended one (1) QA meeting (07/25/16) until present. The Administrator was asked who brings concerns or issue to the QA meeting when the dietary manager is absent, she replied, "No one, we need to make sure when the dietary manager is absent; dietary concerns get to the QA meeting for follow up." The surveyor then asked who followed up with the POC from the survey ending on 07/07/16 to monitor unlabeled and outdated food items. The Administrator reviewed all the

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F 520	Continued From page 9 QA meetings for 7/25/16, 10/24/16, 1/23/17 and 4/24/17 and stated, "I did not see where anyone every followed up with the Plan of Correction (POC) from survey ending on 07/07/16" she then replied, "It could be it never got fixed or it just fell through the cracks." The facility's Administrator, QA (Quality Assurance) Director and RN Transition Coordinator were informed of the findings during a briefing on 07/06/17 at approximately 6:15 p.m. The facility did not present any further information about the finding.	F 520	This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by State and Federal Law.	