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WONDER CITY REHABILITATION AND NURSING CENTER	905 COUSINS AVENUE HOPEWELL, VA 23860

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid Abbreviated standard survey was conducted 6-24-21 through 6-25-21. One complaint was investigated. Complaint VA00051816 was substantiated with deficiency. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The census in this 130 certified bed facility was 114 at the time of the survey. The survey sample consisted of 30 residents.	F 000		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(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. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.	F 755		7/16/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 07/14/2021

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F 755	Continued From page 1 §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, clinical record review and in the course of a complaint investigation, the facility staff failed to re-order medications timely, and failed to utilize the emergency medication box or back-up pharmacy to obtain medication for one resident (Resident #1) in a survey sample of 30 residents. The findings included: Resident #1 was admitted to the facility on 12/16/2019, with a most recent readmission date of 3/16/2020. Resident #1 was discharged from the facility on 5/5/21. Diagnoses for Resident #1 included, but were not limited to: pain in right shoulder, non-chronic ulcer of unspecified part of left lower leg, polyneuropathy, chronic pain syndrome, severe chronic lymphedema with xerosis and wounds with MRSA infection, and osteoarthritis degenerative changes in bilateral knees and ankles. Resident #1's most recent MDS (minimum data set) with an ARD (assessment reference date) of 03/25/2021, was a quarterly assessment. Resident #1 was coded as having short and long-term memory intact and independent with daily decision making. Resident #1 was coded with a BIMS (brief interview for mental status	F 755	F755: Pharmacy 1.Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #1 no longer resides in the facility. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected by this alleged deficient practice. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Staffing Development Coordinator or designee will educate licensed nursing staff on process for reordering medications timely and utilizing emergency medication box, Cubex or backup pharmacy if a medication is not available. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Unit Manager or designee will audit Order Summary Report to ensure medications do not run	

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F 755	Continued From page 2 score) of 15 out of 15. On 6/24/21 and 6/25/21, a record review was conducted of Resident #1's closed clinical record. This review revealed the following physician orders for pain management: 1. "Gabapentin Capsule 300 mg. Give 1 capsule by mouth every 8 hours for peripheral neuropathy". This order had an effective date of 2/1/21 and continued until Resident #1's discharge on 5/5/21. 2. "Oxycodone HCL Solution 5 mg/5 ml. Give 7.5 mg by mouth every 6 hours for pain". This order had a start date of 11/24/2020 and continued until Resident #1's discharge on 5/5/21. 3. "Lidocaine Patch 5 %, Apply to Right shoulder topically one time a day for pain of shoulder on for 12 hours off for 12 hours", which had a start date of 7/25/20 and continued until Resident #1's discharge. Review of the MAR (Medication Administration Records) from March 1-May 5, 2021, revealed the following: 1. The Gabapentin capsule 300 mg was not administered on the following dates: 3/14/21, 3/15/21- 2 doses were not given, 3/26/21, 3/30/21, 4/6/21, 4/7/21- 2 doses were not given, 4/19/21- 2 doses were not given, 5/1- 2 doses were missed, 5/2- 2 doses were missed. Further review of the clinical record, which included narcotic sheets revealed the following: The Gabapentin supply was exhausted on 3/14/21, when the dose was given at 1:00 PM.	F 755	out prior to reordering weekly times 4 weeks and monthly times 2 months. Any identified issues will be immediately corrected. Results will be reported to Quality Assurance committee for analysis and revision x 3 months	

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This supply was not replenished, until 3/15/21 at 5:00 PM, therefore Resident #1 missed his scheduled dose at 10 PM on 3/14, his 6 AM dose on 3/15, and his 2 PM dose on 3/15.

On 6/25/21 at 1:43 PM, an interview was conducted with Employee F, the pharmacist at the facilities' pharmacy. Employee F stated that on 3/1/21, Resident #1's prescription for Gabapentin was filled for 30 tabs. Employee F stated that the facility would have to call to refill prescriptions prior to running out, they do not automatically send out medications. An interview was then conducted with Employee G, the pharmacy manager who gave the following details: "the supply sent out on 3/1/21, was a 10 day supply. It was a last fill on the prescription, we put a neon sticker that there were no refills and a new prescription was needed. The next prescription was written on 3/12/21, received at the pharmacy on 3/15/21, at 9:00 AM, via fax and was filled 3/15/21, was filled at 10:59 AM, and delivered to the facility on 3/15/21 at 4:58 PM."

The MAR indicated the facility staff had called the doctor and obtained an order to "hold" the scheduled Gabapentin doses on 3/14 and 3/15 due to lack of medication to administer.

On 3/26/21, Resident #1 did not receive his 10 PM, dose of Gabapentin. The MAR was not signed off, it was blank, and there was no entry on the narcotic record that the medication had been administered.

On 3/30/21 Resident #1 did not receive his 10 PM, dose of Gabapentin and the MAR indicated, "see nursing notes". The nursing notes entry read, "Gabapentin capsule 300 MG, give 1

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capsule by mouth every 8 hours for peripheral neuropathy medication should be on next delivery from pharmacy."

On 4/6/21 at 10 PM, Resident #1 did not receive his Gabapentin dose and then missed the 6 am and 2 PM, doses on 4/7/21. There were no corresponding notes in the nursing notes for this medication not being administered. The MAR indicated that a "hold order" was obtained.

On 6/26/21, during an interview with Employees F and Employee G, two pharmacists, one who was the pharmacy manager, it was revealed that the pharmacy "got a new prescription that was filled on 4/7/21 and delivered to the facility on 4/8/21 at 2 AM."

On 4/19/21, Resident #1 missed his scheduled Gabapentin dose at 6 AM, and 2 PM. The pharmacy manager stated, "on 4/19/21 we got a phone call from the facility to refill it and the facility received it on 4/20/21 at 7 AM." There was a nursing note entry on 4/19/21 at 13:54 that read, "Gabapentin... awaiting arrival from RX (pharmacy)."

On 5/1/21 Resident #1 missed his scheduled dose of Gabapentin at 6 AM, and 2 PM. On 5/2/21, he missed the dose at 6 AM and 2 PM. The MAR indicated to "see nursing note". A nursing note written 5/1/21 at 16:21 read, "medication not available". An entry on 5/2/21 at 5:26 AM, read, "medication not available". On 5/2/21 at 14:09 PM, the nursing note entry read, "awaiting pharm" (sic).

Interview with Employee G conducted on 6/24/21, revealed that the pharmacy "on 5/2/21 at 4:47

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AM, received an electronic refill request by [RN B's name redacted] it was delivered that afternoon at 4:46 PM on 5/2/21."

Review of the "weights and vital summary" report provided by the facility staff following the end of day meeting it revealed on 5/1/21 at 12:20 AM, and on 5/2/21 at 2:19 PM, Resident #1 reported a pain score of 7 on a scale of 1-10. According to the legend on the MAR pain at a 7 is considered "moderate".

On 6/25/21, an interview was conducted with Employee G, the pharmacy manager. When asked what the risks are of Resident #1 missing multiple doses and times, several consecutive doses of his Gabapentin, Employee G stated, "it depends on their own tolerance and if his pain is well controlled. For some people they wouldn't notice a missed dose and for others it would be very noticeable".

On 6/25/21, the facility provided a list of medications retained in-house/on-hand in their emergency medication supply box. Review of the "Inventory on Hand" list for the "CubexRX" [emergency medication box] housed at the facility revealed that "Gabapentin 100 mg cap" was listed with a quantity on hand of "10" being listed. There was no indication that this had been utilized to provide Resident #1 his medications as ordered.

2. The Oxycodone Solution was not administered on the following occasions: 4/18/21- two of the four scheduled doses were not given.

The MAR for April 2021 revealed that on 4/18/21, Resident #1 was not administered his 6 AM and 12 Noon doses of Oxycodone. The MAR had an

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indication to "see nursing notes". Nursing notes for this day revealed entries that read, "medication not available". An entry on 4/18/21 at 3:46 AM, read, "suboptimal dose available for full administration. Med reordered 4/16/2021; contacted pharmacy to check status of delivery. Pharmacy notified us that the order cannot be refilled; a new script must be submitted. Called NP (nurse practitioner) x 2 and texted MD (medical doctor). Gave remaining amount in the bottle; equivalent to 2.5 mg."

A nursing note written 4/18/21 at 7:59 AM, read, "spoke with NP in regards to emptied medication. Total of two doses have been missed and attempt to refill completed on 4/16/21 however pharmacy could not fulfill prescription as there was no new order in place. Per NP this was something that could wait until the morning. Script faxed over at approximately 0800 and pharmacy called to deliver stat (urgent)."

On 6/24/21 an interview was conducted with Employee G, the pharmacy manager. The pharmacy manager stated that on "4/4 we received a phone call at 4:30 PM, we filled 300 ML of Oxycodone solution, which went out on 4/4. It would have been about a 10 day supply at his current dose. A new prescription was written on 4/18/21 which we filled on 4/18/21." When asked about the side effects of missing doses of Oxycodone, Employee G stated, "missing doses of pain medication can be hard to quantify, at this dose I would not expect full on withdrawal symptoms but if he missed doses he would definitely notice something."

On 6/25/21, the facility provided a list of medications retained in-house/on-hand in their

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emergency medication supply box. Review of the "Inventory on Hand" list for the "CubexRX" [emergency medication box] housed at the facility revealed that "Oxycodone 5 mg tab" was listed with a quantity on hand of "4" being listed. There was no indication that facility staff had asked the provider if they could utilize this emergency stock to provide Resident #1 his medications as ordered.

3. The Lidocaine patch was not applied as ordered on: 4/14/21, 4/15/21, 5/2/21.

Review of the MAR revealed that on 4/14/21 and 4/15/21 the Lidocaine patch had not been applied as ordered. The MAR indicated "See nursing notes".

Review of the nursing notes on these dates revealed the following entries: 4/14/21 at 2:49 PM, "Lidocaine Patch 5%.... on order." On 4/15/21 at 8:47 AM, "Lidocaine Patch 5%... awaiting arrival from pharmacy." 5/2/21 9:40 AM, "Lidocaine Patch 5%... awaiting pharm [pharmacy]."

On 6/25/21 at 9:09 AM, an interview was conducted with Employee B, the Director of Nursing (DON). The DON was asked what her expectation is if a medication is not available, she stated, "they would obtain it from the cubex (emergency medication supply), notify the MD (medical doctor), notify the RP (responsible party of Resident) and attempt to get the medication in." When asked how often the pharmacy delivers to the facility, the DON stated, "[pharmacy name redacted] does two runs they used to do three, but because of COVID they went down to two. They do one around 4 PM and

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then another after mid-night." The Administrator was present for this interview and stated, "we have a back-up pharmacy that they can call, if they [routine pharmacy] can't deliver the medications."

On 6/25/21 at 9:35 AM, an interview was conducted with LPN B. LPN B was asked what she does when a medication is not available that is ordered for a resident. LPN B stated, "if a medication is not in cart, we will call the MD and make aware of the missed dose, call pharmacy to see if they can STAT [urgently send] it out and let them know they missed a dose. First we will go to [emergency medication supply box] and see if it is in there, notify the RP, and monitor for adverse effects for missing meds."

On 6/25/21 at 9:48 AM, an interview was conducted with LPN A. LPN A was asked what she does if a medication is not available, she stated, "call the doctor and let them know or make a call to the pharmacy and get it STAT out [urgently sent]." When asked how long this takes to receive, LPN A stated, "on a good day it takes a couple of hours."

On 6/25/21 at 1:43 PM, during an interview with Employee G, the pharmacy manager, he indicated "normal protocol we ask for 72 hour before they run out of medication they request a refill,"

Review of the facility policy titled, "Medication Ordering and Receiving From Pharmacy" read, " ...reordering of medications is done in accordance with the order and delivery schedule developed by the pharmacy provider(s) ... . Reorder medication in advance of need, as

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F 755	Continued From page 9 directed by the pharmacy order and delivery schedule, to assure an adequate supply is on hand.". The facility policy titled, "Miscellaneous Special Situations: Unavailable Medications" read, "medications used by residents in the nursing facility may be unavailable for dispensing from the pharmacy on occasion. This situation may be due to the pharmacy being temporarily out of stock of a particular product, a drug recall..... The facility must make every effort to ensure that medications are available to meet the needs of each resident." The facility Administrator and DON (Director of Nursing) were made aware of these concerns during an end of day meeting on 6/26/21. The DON stated, "he received all of his doses of Oxycodone and the Gabapentin was on hold several days". When asked why the medication would be held, she stated, "maybe for lethargy or something else No further information was provided prior to the conclusion of the survey.	F 755		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control	F 880		7/16/21

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program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct

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F 880	Continued From page 11 contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, facility documentation and clinical record review the facility staff failed to maintain infection control practices to prevent the spread of COVID-19 for 2 of 19 residents (Resident #'s 6 and 12) housed on the 2nd floor north unit (COVID observation unit). The findings included: On 6/24/21 the Administrator and Director of Nursing (DON) were interviewed and asked if there were any active cases of COVID19 in the building. The DON stated that there was not. She was then asked if they quarantined new admissions; she stated that there was an observation unit located on the first floor. This was used for anyone suspected of COVID as well as new admissions that were not fully vaccinated At 9:35 the second floor north hallway was	F 880	F880 Infection Prevention and Control 1.Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #6 and #12; staff received education on Droplet Precautions (Full PPE). 2.Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All Residents on transmission based precautions have the potential to be impacted. 3.Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Education by the Staff Development Coordinator or Designee will educate all staff on appropriate requirements for PPE	

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(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 880	Continued From page 12 observed with the DON. The double doors at the entrance to the north hallway were closed and there was a sign on the door that read, "Stop yellow zone observation rooms do not enter without full PPE including N95." The DON was about asked about this sign she stated full PPE (personal protective equipment) was not needed in the hallways, only when entering the resident rooms. The DON then stated they had a staff member who tested positive almost 2 weeks ago. She stated they contacted the epidemiologists for their local health department who advised them to put all of the residents that were on that staff member's assignment on droplet precautions for two weeks. At 9:52 AM, LPN (licensed practical nurse) A was interviewed. When asked what PPE was required for care of the residents on the observation unit she stated "Full PPE is required when going into a resident's room; in the hallway we just need an N 95." At 9:56 AM, Employee C was observed entering Resident #12's room without donning PPE and wearing only a cloth facemask. LPN A was observed entering Resident #6's room without donning PPE. At 10:01 AM an interview was conducted with Employee C and LPN A. Employee C was asked about donning PPE and she stated that they used to have the bins in the hallway and that they changed it that morning, indicating the bins were now inside the patient room. LPN A was asked about the reason for isolation	F 880	while providing care for Residents on Observation for COVID-19 including DON/DOFF procedures and wearing of the appropriate face mask. 4.Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: (A) Unit Managers or designee will complete audit on 15 staff members for appropriate use of PPE while providing care for a Resident on Observation for COVID-19 weekly x 4 weeks and monthly x 2 months. Plan of correction information and audits will be reviewed in the quality assurance and performance improvement process for tracking/trending and any necessary additional interventions. All deficits identified will be forwarded to QAPI Monthly and automatically trigger continuation of audits until full compliance is achieved. (B) Unit Managers or designee will complete audit on 15 staff members for DON/DOFF procedures appropriate when entering/exiting Observation rooms -Staff having appropriate facemasks on when entering an Observation room weekly x 4 weeks and monthly x 2 months. Plan of correction information and audits will be reviewed in the quality assurance and performance improvement process for tracking/trending and any necessary additional interventions. All deficits identified will be forwarded to QAPI Monthly and automatically trigger continuation of audits until full compliance is achieved.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495123	A. BUILDING _____ B. WING _____	C 06/25/2021

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and droplet precautions and she stated that the residents on the unit were under observation for coming in contact with COVID positive staff. She also stated "Yeah I think we should have put on PPE before entering the room."

At 10:10 AM, Resident #6 was interviewed. Resident #6 stated this was the second week of COVID isolation because "Someone came in that had it." Resident #6 was asked if the staff come into the room dressed in gown, gloves, N95, face shield, hair and shoe covers. Resident #6 stated "Sometimes but not always." No PPE observed in the room nor a trash can to dispose of PPE. There were no PPE stations in the hallway or the room; however, the room door had a sign stating the resident was on droplet precautions.

On 6/24/21 approximately 11:00 AM, the Administrator was interviewed and stated CNA (certified nursing assistant) A tested positive on 6/14/21 at the hospital. When asked if the CNA was symptomatic she said "No she went to the hospital because she just didn't feel right." CNA A had not been vaccinated for COVID 19. When asked when CNA A may return to work the Administrator said "We will call her tomorrow to see if she is having symptoms."

The Administrator provided documentation that 81% of residents and 62% of staff had been vaccinated.

On 6/24/21 at 11:55 AM, north hall on 2nd floor was observed. PPE bins were in the hallways outside of each resident's door.

On 6/24/21 at approximately 1:00 PM an interview was conducted with RN (registered

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nurse) A (the Infection Preventionist) who stated that residents who are admitted and not fully vaccinated are quarantined for 14 days. Residents that have been exposed are quarantined for 14 days.
Staff were to wear full PPE when entering a resident room who was quarantined. The staff should don PPE prior to entering the resident's room and doff prior to exiting. The PPE should be disposed of in the room.

On 6/25/21 at 9:59 AM, Employee E (therapy staff) was observed in Resident #6's room with PPE on but no eye protection. Employee E came out into hall to ambulate the resident with the use of a cane. They walked the length of the north hall to the fire doors and turned around to return. The Unit Manager told Employee E she wasn't allowed to have Resident #6 in hall and they returned to the room at 10:04 am.

On 6/25/21 at approximately 10:30 AM, an interview was conducted with Employee D (PT - physical therapist) who stated that treatments were being provided in the gym for residents not on observation. Residents on observation were treated in their rooms. Equipment was taken into the room, and was cleaned before and after use with bleach wipes.

On 6/25/21 the facility submitted copies of the emails from the local health department's epidemiologist that document on 6/14 /21 at 12:06 PM, RN A, the Infection Preventionist, notified the local health department of one staff member testing positive at the hospital and the facility entering outbreak testing.

On 6/15/21 at 8:30 AM, the epidemiologist sent a

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return email asking for more information about the employee's title role and contact with residents.

On 6/15/21 at 9:10 the RN A emailed back that the CNA A's best friend, CNA B, who works at the facility has also tested positive.

On 6/15/21 at 1:54 PM the epidemiologist returned the email that read: "When you enter outbreak testing, you must test every 3-7 days until no new cases are identified for 14 days (2 weeks). During this time, if you have completed the first round of testing all residents and staff regardless of vaccination status (vaccinated and unvaccinated) with no new cases in the impacted area then visitation can resume OUTSIDE of the impacted area. The unit exposed should remain in quarantine and FULL PPE should be used for 14 days past the last day of exposure."

On 6/25/21 a review of the facility policy entitled "Isolation - Initiating Transmission Based Precautions" was conducted and excerpts are as follows: Page 1 paragraph 3 E: "Ensures that protective equipment (i.e., gloves, gowns, masks, etc.) is maintained outside the resident's room so that anyone entering the room can apply the appropriate equipment. Page 1 paragraph 3 G : "Ensures that an appropriate linen barrel/ hamper and waste container, with appropriate liner are placed in or near the resident's room."

On 6/25/21 at 4:11 PM, LPN C was observed on the observation unit wearing a vented cloth mask while passing medications.

On 6/25/21 during the end of day meeting the Administrator was made aware of the concerns

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F 880	Continued From page 16 and no further information was provided.	F 880		