STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0126	A. BUILDING: _____ B. WING _____	06/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CEN	905 COUSINS AVENUE HOPEWELL, VA 23860

(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) COMPLETE DATE
F 000	Initial Comments An unannounced biennial State Licensure Inspection and Medicare/Medicaid Abreviated survey was conducted 6-24-21 through 6-25-21. The facility was not in compliance with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. One complaint was investigated during the survey. The census in this 130 bed facility was 114 at the time of the survey. The survey sample consisted of 30 Resident reviews.	F 000		
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: The facility was not in compliance with the following Virginia Rules and Regulations for the Licensure of Nursing Facilities: Surveyor: Balkus, Crystal 12VAC5-371-220 (B) Cross reference to F-755 12VAC5-371-300 (A) Cross reference to F-755 12VAC5-371-110 (B)(3) Cross reference to F-880 12VAC5-371-180 (A) Cross reference to F-880 12VAC 5-371-340 (B) Based on observation, interview, and facility documentation the facility staff failed to have a full time Food Protection Manager as outlined in	F 001	12VAC 5-371-340 (B) 1.Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: No residents were affected by the deficient practice. Full-Time Dietitian was hired in-house on 7/5/21. 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: Regional Director of Operations will educate Licensed Nursing Home Administrator Requirements for a Certified Dietary Manager.	7/16/21

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

Electronically Signed | 07/14/21

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F 001	Continued From page 1 12VAC5-421-60. The findings included: On 6/25/21 at approximately 10:30 AM an interview with Employee H the dietary manager who was asked if the had a CDM (Certified Dietary Manager) Certificate and he stated that he did not. Employee H provided the "Serve Safe" certificates for himself and the other kitchen staff. When asked if the facility has a full time dietician Employee H stated that they did but she worked remotely. When asked how often she visits the building, he stated that he has never met her. On 6/25/21 at approximately 11:00 AM an interview was conducted with the Administrator who stated that they had a contract with a dietician who "Keeps in touch" with our dietary manager. When asked if she comes to the facility the Administrator stated "No she is remote." The Administrator stated that she was unaware of needing a full time CDM when she had a dietician contracted for consults. On 6/25/21 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided. COV 32.1-126.01 (A) (Sworn Statement or CRC) 12 VAC 5 371 140 (E) (3) (B) Policies and Procedures Based on the Code of Virginia, employee record review and staff interview, the facility staff failed to obtain a Criminal Background Check prior to hire for two (Employee # 16 and # 23) of 25 in the Employee Review Sample. For Employees # 16, and #23 the facility staff	F 001	4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Licensed Nursing Home Administrator or designee will audit Dietitian hours 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. 12 VAC 5 371 140 (E) (3) (B) Policies and Procedures 1.Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: No residents were affected by the deficient practice. 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 will educate Director of Human Resources on completing background checks prior to hiring new employees. Audit to be completed on new hires within the last 4 months. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Director of	

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F 001	Continued From page 2 failed to ensure a criminal background check was completed at the time of hire. The findings include: 1. On 06/23/2021, Employee Record Reviews were conducted. Review of the personnel records revealed Employee # 16 was hired on 01/08/2021 as a Licensed Practical Nurse. The Criminal Background Check was conducted on 2/25/2021. An interview was conducted with the Human Resources Director on 06/25/2021 at 10:58 a.m. The Human Resources Director stated Employee # 16's Personnel file did not have any other documents regarding a Criminal Background Check at the time of employment at the facility. The Human Resources Director stated Criminal Background Checks should be conducted prior to the date of hire. The facility Administrator was informed of the findings on 6/25/2021 at 11:05 a.m. and during the end of day debriefing. No further information was provided. 2. Review of Employee # 23's Personnel Record was conducted on 6/24/2021. The employee file revealed that Employee # 23 was hired as a Certified Nursing Assistant on 3/11/2021. The date of the Criminal Background Check was 6/24/2021 with the name of another facility listed as the requester of the search. Employee # 23's Criminal Background Check was not performed prior to hire according to the documentation provided. On 6/25/2021 at 1:58 PM, an interview was	F 001	Human Resources or designee will audit new hires to ensure a criminal background check was process prior to hire date 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. 12 VAC 5 371 250 (G) 1.Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #7 care plan was revised on 6/25/2021. 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: Regional Director of MDS or designee will educate IDT team on ensuring nutritional care plans have measurable goals. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: MDS Coordinator or designee will audit new admissions nutritional care plan to ensure a measurable goal is in place weekly times 4 weeks and monthly times 2 months. Any identified issues will be	

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F 001	Continued From page 3 conducted with the Administrator and Human Resources Director. The Human Resources Director stated there were no other records in the personnel file regarding a Criminal Background Check at the time of hire. The Administrator stated the other facility listed on the form dated 6/24/2021 was one of their sister facilities whose staff members were trying to help get the facility's records up to date. During the end of day debriefing on 6/25/2021, the facility Administrator again was informed there was no documentation of a Criminal Background Check at the time of hire for employee # 23. The Administrator stated she had no questions about the findings. 12 VAC 5 371 250 (G) Resident Assessment and Care Planning Based on the Code of Virginia, staff interview , clinical record review, the facility staff failed to complete a comprehensive care plan with measurable objectives for one (Resident # 7) of 30 residents in the survey sample. For Resident # 7, the facility staff failed to have measurable goals for the problem of nutritional status and underweight. The findings include: Resident # 7 was admitted to the facility on 05/14/2021. Diagnoses included but were not limited to Anorexia, Pneumonia, Chronic Obstructive Pulmonary Disease, Hypertension, Chronic Kidney Disease Stage 4, Schizophrenia, Bipolar Depression and Anxiety.	F 001	immediately corrected. Results will be reported to Quality Assurance committee for analysis and revision x 3 months.	

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F 001	Continued From page 4 Resident #7's most recent MDS (Minimum Data Set) with an Assessment Reference Date of 05/21/2021 was coded as an Admission assessment. The Brief Interview for Mental Status was coded as "15" out of possible "15" indicating no cognitive impairment. Functional status for bed mobility, transfers, toileting, dressing, and personal hygiene were coded as requiring extensive assistance from one staff persons. For eating, Resident # 1 was coded as requiring supervision and set up only. Review of the clinical record was conducted on 6/24/2021. Review of the weights revealed Resident # 7 was 67 inches tall with a most recent weight of 85.8 pounds. Her Body Mass Index was 13.4 equaling Underweight Category. Further review of the weight revealed Resident # 7 weighed 79.0 pounds on admission and had gained weight during her stay. Review of the care plan revealed documentation of the problem: "Nutritional status as evidenced by actual/potential weight loss/gain related to inadequate oral intake, underweight, GERD (Gastroesophageal Reflux Disease, COPD (Chronic Obstructive Pulmonary Disease, HTN (Hypertension), CKD4 (Chronic Kidney Disease Stage 4, Schizophrenia, Bipolar Depression and Anxiety. One of the Goal/Objectives was listed as "will consume appropriate amounts of food and fluids to maintain nutritional status." On 6/25/2021 at 12:45 p.m., an interview was conducted with the Administrator who stated care plan goals should be measurable. The Administrator stated the above goal was not measurable.	F 001		

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F 001	Continued From page 5 On 6/25/2021 at 2:38 p.m., an interview was conducted with the Director of Nursing who stated she had been informed of the findings of a goal related to nutritional status and underweight that was not measurable for Resident # 7. The Director of Nursing stated the care plan was written by using a template. The Director of Nursing stated the goals/objectives should be measurable. No further information was provided.	F 001		