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 _____	07/25/2022

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

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E 000	Initial Comments A COVID-19 Focused Emergency Preparedness Survey was conducted onsite 07/20/22 through 07/25/22. The facility was in substantial compliance with 42 CFR Part 483.73(b)(6) emergency preparedness regulations, and has implemented The Centers for Medicare & Medicaid Services and Centers for Disease Control recommended practices to prepare for COVID-19.	E 000		
F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control Survey was conducted onsite 07/20/22 through 07/25/22 . Corrections are required for compliance with 42 CFR Part 483.80 infection control regulations, for the implementation of The Centers for Medicare & Medicaid Services and Centers for Disease Control recommended practices to prepare for COVID-19. In addition, Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Immediate Jeopardy, in the area of Quality of Care at a Scope and Severity Level 4, isolated which constituted Substandard Quality of Care, was found to start on 07/20/2022, called on 7/21/22 at 4:02 PM, and removed on 7/22/22 at 5:10 PM. An extended survey was conducted 07/22/22 through 07/25/22. No complaints were investigated during the survey. The census in this 130 certified bed facility was 122 at the time of the survey. The survey sample	F 000		

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

Electronically Signed | 08/11/2022

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 000	Continued From page 1 consisted of 13 resident reviews and 11 employee reviews.	F 000		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(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. (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 observation, interview, and clinical record review the facility staff failed to review and revise the care plan to include interventions to mitigate a reoccurrence of sunburn for 1 Resident	F 657	The statements made in the following plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. The facility sets	8/16/22

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F 657	Continued From page 2 (#9) in a survey sample of 13 Residents. The findings included: For Resident #9 the facility staff failed to put in place interventions to prevent sunburn after a known sun exposure resulting in sunburn. On the morning of 7/21/22 record review as conducted on Resident #9, the record review revealed that Resident #9 has diagnoses that include status post cerebral infarction (stroke) with right sided deficits, seizure disorder, aphasia, dysphasia. The Resident's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 7/5/22 coded Resident #9 as having a BIMS (Brief Interview of Mental Status) score of 0 out of 10 indicating severe cognitive impairment. On 7/22/22 during clinical record review it was noted that Resident #9 had been leaving the facility and sitting in the sun long enough for his skin to be "red". The facility entered the following progress notes related to Resident #9: The Medical Director's notes included the following excerpts: "06/29/22 at 4:30 PM- Note Text-: c/o redness over legs and knees and little pain after being in the sun "ROS: limited conversation due to aphasia , denies any fall or injury to legs or fever or chills" "EXT- diffuse redness over knees and legs, no edema or cyanosis ." "Avoid sun exposure" "Use skin protective cream"	F 657	forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility□s allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated. F 657 1. Residents #9 care plan revised, and physician order obtained for sunscreen on 8/9/22. 2. Current residents have the potential to be affected. 3. Director of Nursing or designee will educate licensed nurses and MDS staff on process to review and revie care plans to include interventions to mitigate risk for sun exposure and/or sunburn for residents that sit outside. 4. Unit Managers or designee will conduct weekly audits to verify care plans include interventions to mitigate risk of sun exposure and sunscreen for residents that sit outside. 5. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator/Director of Nursing are responsible for implementation of the plan of correction. 6. Date of compliance 8/16/2022	

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F 657	Continued From page 3 A review of the physicians orders revealed that Resident #9 had no orders for "skin protective cream" (sunscreen). A review of the care plan revealed no mention of Resident going outside and no mention of sunscreen usage. A review of the "Care Plan Policy" revealed that updates should be made to the care plan with each change in condition of the Resident. On 7/22/22 at approximately 10:30 PM an interview with the DON was conducted and she stated care plans should be updated with any changes in conditions, or treatments for the individual Resident. On 7/22/22 during the end of day meeting the Administrator was made aware of concerns and no further information was provided.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview, clinical record review and facility documentation, the facility staff failed to ensure care provided met the professional standards of care for 5 Residents (#'s 4, 7, 11, 12, 13) in a survey sample of 13 Residents. The findings included	F 658	F658 1. Residents #4 and #12 are no longer residents in the center. Residents #7, #13 and # 11 have physician orders for COVID vaccination. 2. Current residents have the potential to	8/16/22

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F 658	Continued From page 4 For Resident #'s 4, 7, 11, 12, & 13 the facility staff failed to ensure physicians orders were obtained prior to administering the COVID-19 vaccine. On 7/21/22 during a Focused Infection Control survey a sample of 13 Residents were chosen. Among the 13 Residents chosen the Resident clinical review findings are as follows: Resident #4 -No order to administer vaccine was found. The order was not present on the Medication Administration Record. No note in chart to say the vaccine was administered. However, the line listing gave the date of completion of vaccine as 7/8/22. Resident #7 - No order for vaccine administration was found. No order to administer vaccine was found. The order was not present on the Medication Administration Record. However, the line listing gave the date of completion of vaccine as 6/17/22. Resident # 11 - No order to administer vaccine was found. The order was not present on the Medication Administration Record. However, the line listing gave the date of completion of vaccine as 7/14/22. Resident #12 - No order to administer vaccine was found. The order was not present on the Medication Administration Record. However, the however the line listing gave the date of completion of vaccine as 7/24/22. Resident #13 - No order to administer booster vaccine was found. The order was not present on the Medication Administration Record.	F 658	be affected. 3. Director of Nursing or designee will educate Licensed Nurses on the procedure for obtaining physician orders for COVID- 19 vaccinations and/or boosters for residents prior to administration. 4. Unit Managers or designee will audit orders weekly for residents who consent for COVID-19 vaccination or booster has physician orders prior to administration 5. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator/Director of Nursing are responsible for implementation of the plan of correction. 6. Date of compliance 8/16/2022	

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However the line listing gave the date of completion of vaccine as 6/17/22.

On 7/22/22 the facility policy entitled, "Policy and Procedure Covid 19 Vaccination for Residents," was reviewed and excerpts are as follows:

"Policy : Interpretation and Implementation"
"1. The Resident and RP (responsible party) will be informed of the COVID-19 vaccine, risk and the importance of protecting the resident from COVID 19 infection."
"2. The physician order will be obtained for the administration of the COVID-19 vaccine if the resident or RP consents and/or it is not contraindicated."

On 7/22/22 at approximately 11:00 AM Employee C was interviewed and she stated that she has not seen orders on the POS (physician order sheets) or the MAR's (Medication Administration Record) for "COVID 19 Vaccines or Boosters."

According to Lippincott online [https://www.nursingcenter.com/ncblog/may-2011/8-rights-of-medication-administration] Rights of Medication Administration include:

"2. Right medication -Check the medication label.- Check the order"

"3. Right dose - Check the order. Confirm appropriateness of the dose using a current drug reference. If necessary, calculate the dose and have another nurse calculate the dose as well."

On the afternoon of 7/22/22 an interview was conducted with LPN C who stated " You always have to have a physicians order to give any

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F 658	Continued From page 6 medication or vaccine." On 7/22/22 at the end of day meeting the Administrator was made aware of the concerns and no further information was provided.	F 658		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, clinical record review and facility documentation the facility staff failed to ensure freedom from accidents and hazards for 2 Residents (#'s 9 & 4) in a survey sample of 13 Residents. Immediate Jeopardy was found to start on 07/20/2022, called on 7/21/22 at 4:02 PM, and removed on 7/22/22 at 5:10 PM. The findings included: 1. For Resident #9 the facility staff failed to ensure the Resident was provided a safe smoking environment and supervised by staff for safety while smoking. On 7/20/22 at approximately 3:00 PM Surveyors B, C, and D were walking to their respective vehicles and it was observed 2 Residents sitting in wheelchairs in the parking lot area, smoking by	F 689	F689 1. Resident #4 and #9 was provided staff supervision and a safe smoking environment on 7/21/22. 2. Current residents have the potential to be affected. On 7/21/22 an audit was conducted to identify smokers and a smoking assessment completed to determine if staff supervision required while smoking in the designated smoking area. 3. Education to facility all staff was initiated on the revised smoking policy and procedure by the Administrator and designee on 7/21/22. 4. Unit Managers or designee will audit new admissions to determine their smoking status. Any residents identified as smokers will have a smoking assessment completed to determine if	7/25/22

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the dumpsters. Surveyor C interviewed Resident #9 who had obvious speech impairment and right sided deficits. Resident #9 was asked his name and he stated it with difficulty. When asked if he was a Resident at the facility he nodded. When asked if staff knew he was outside he nodded. When asked if he was new at the facility he pointed to his mouth with his left hand and said "Speech." When asked if he had difficulty with speech he nodded "yes". When asked if had previously had a stroke he nodded "yes" again.

On 7/20/22 at approximately 3:10 PM an interview was conducted with the Administrator and the DON informing them of the 2 residents outside smoking. The Administrator acknowledged that the facility was a "Non-Smoking facility." The DON stated that they do not conduct safe smoking assessments because they are non-smoking facility. She stated the non-smoking status of the facility is in the Resident's Admission Contract signed by the Resident and / or Representative on admission.

On the morning of 7/21/22, a record review as conducted on Resident #9. The record review revealed that Resident #9 was admitted to the facility 2/12/22 with diagnoses that include status post cerebral infarction (stroke) with right sided deficits, seizure disorder, aphasia, dysphasia, and schizophrenia. This Resident's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 7/5/22 coded Resident #9 as having a BIMS (Brief Interview of Mental Status) score of 0 out of 15 indicating severe cognitive impairment. Section G of the MDS coded the Resident as requiring limited assistance with physical assist of 1 staff for all aspects of ADL care with the exception of eating, which he

staff supervision is required in the designated smoking area.
5. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator/Director of Nursing are responsible for implementation of the plan of correction.

6. Date of compliance 7/25/2022

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requires set up only. This Resident was not his own Responsible Party.

On 7/21/22 at 10:15 AM an interview was conducted with the ADON who stated that PCC (Point Click Care - Electronic Health Record program) has a section to be filled out on the "Admission Screen" for Residents who are smokers or former smokers. When asked how the nurse would know if the Resident was a smoker or former smoker the ADON responded, "You would ask the Resident or family member and you would look in the discharge summary from the hospital or the history and physical."

A review of the clinical record revealed the following excerpt from the admission progress note:

"2/12/22 3:56 PM -Respiratory: Nail beds are normal. Lips/mucous membranes appear pink. No respiratory symptoms noted. No oxygen orders are present. No tracheostomy present. Unable to determine smoking history."

Excerpts of his hospital discharge summary dated 2/12/22 are as follows:

"He does follow simple commands. He is not able to provide any info. I spoke with the administrator of [Assisted Living facility name redacted] who reports he's been there for 10 years. States at baseline he has limited verbal interaction and often "signs" for communication."
"Patient was a smoker as recent as 9 months ago."

A review of the clinical record revealed the following progress note by the DON:

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"7/20/2022 4:57 PM - Note Text - : Resident was noted by visitors smoking outside in parking area. Resident was educated that we are a no smoking facility and was offered a nicotine patch instead. MD was notified and new order for Nicotine Patch 14 mg x 14 days and then 7 mg x 14 days was given."

On 7/21/22 at approximately 9:55 AM a "Safe Smoking Evaluation" and a BIMS evaluation for Resident #9 were submitted to the surveyors. The Safe Smoking Evaluation indicated that Resident #9 was "An independent smoker. Capable and independent, requires no supervision to smoke." This document was signed by the DON. An interview was conducted with the DON at that time and she stated that she did the smoking evaluation herself on 7/20/22. The BIMS document also signed by the DON scored the Resident as having a BIMS of 10 / 15 indicating moderate cognitive impairment.

The progress note written by the DON read:

"7/20/22 at 4:42 PM -Safe Smoking Evaluation - Safe smoking evaluation completed on [Resident #9 name redacted]. Short-term memory appears intact. Some difficulties noted with long-term memory. Able to make consistent and reasonable decisions. [Resident #9 name redacted] is able to effectively communicate and/or make needs known. Vision is adequate; able to see without difficulty. [Resident #9 name redacted] has no physical limitations noted related to safe smoking techniques. Able to maintain balance while sitting/standing. During observation, safe smoking techniques were observed including holding and lighting a cigarette as well as proper

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disposal. Remained alert while smoking. No evidence of burn injuries or holes noted on clothing or wheelchair. Interview showed an understanding of designated smoking times and areas. [Resident #9] verbalized understanding that smoking accessories would be secured by the center staff when not in use. Understands safety risks associated with smoking. Based on evaluation, {Resident #9] is an independent smoker requiring no supervision to smoke."

On 7/21/22 at 1:55 PM Resident #9 was observed propelling self out of door and headed toward the dumpster area.

On 7/21/22 at approximately 2:06 PM Surveyors B and C observed Employee C and LPN E perform a "Safe Smoking Evaluation" on Resident #9. When Employee C asked Resident #9 where he gets the cigarettes he gestured with his left hand to his leg. Employee C asked him if he got them from another Resident who is a known smoker and wears a bandage to his leg he nodded. He then said "Check, month" when asked if he pays the other Resident for cigarettes when he gets his check every month, he nodded his head "yes".

Excerpts are as follows:

" 1. Cognitive Function"
"a. Short term memory is ok able to recall events after 5 minutes? Yes"
"b. Long term memory is Ok recall of long past events ? No"
"c. Able to make decisions regarding the tasks of daily life e.g. decisions are consistent and reasonable. Yes"

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F 689	Continued From page 11 "3. Physical Function" "a. Patient is free from physical limitations interfering with the ability to perform safe smoking techniques, e.g. able to grasp and handle cigarettes , lighter or matches without assistance? NO" "b. Patient is able to maintain balance while sitting or standing? Yes." "4. Observations" "a. Patient demonstrates safe smoking techniques: holding cigarette, lighting cigarettes (NO), extinguishing matches, (NO) lighter and cigarette after use and disposal of ashes. No" "5. Interview" "a. Patient understands that smoking may only take place at designated times and in designated smoking areas? NO"\ "c. Patient is able to communicate safety risks associated with smoking? NO" "6. Determination" "b. At risk smoker Requires staff, family member or friend for physical support or supervision to smoke." 2. For Resident #4, the facility staff failed to ensure the Resident was provided a safe smoking environment and supervised by staff for safety while smoking. Resident #4 was a current resident of the facility diagnoses that include but are not limited to: altered mental status, unspecified; muscle weakness (generalized); and unsteadiness on feet.	F 689		

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On 07/21/22 at approximately 10:15 a.m., Resident #4 was observed smoking outside of the facility near the dumpster without direct 1:1 supervision. That is, there was no staff standing within a hands reach of Resident #4.

About 20 feet beyond the rear of the dumpster where Resident #4 was observed smoking there were facility staff observed smoking in the shade of the trees. There were approximately four facility staff sitting on milk crates smoking, but were not interacting with Resident #4.

07/22/22 at approximately 11:00 a.m., Resident #4 was observed outside on a bench. The resident appeared to be having a conversation with himself. There were no staff present.

On 7/22/22 at approximately 2:00 p.m., interviewed the Assistant Director of Nursing (ADON). The ADON stated that smoking assessment were completed for resident who had a history of smoking prior to entering the facility.

07/22/22 at approximately 3:00 p.m., an electronic health record (EHR) review was conducted:

On 6/30/22 at 1:35 p.m., a safe smoking evaluation was conducted with a determination that Resident #4 was an at risk smoker. Which means that Resident #4 requires staff, family, or friend for physical support or supervision to smoke.

A Nurse's progress note on 7/21/22 at 10:25 a.m., showed that Resident #4 was noted outside of the building smoking by the dumpster in the

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parking lot.

The care plan was reviewed and there was not care plan with regard to smoking.

Immediate Jeopardy was found to start on 07/20/2022 and was called at 4:02 PM on 7/21/22. The facility presented the following removal plan.

"1. The corrective action for the alleged deficient practice will be accomplished by:

Resident #9 and Resident #4 had skin assessments performed and no injuries were noted due to smoking. Residents #9 and #4 had updated smoking assessments completed. Any residents smoking outside of the facility will be monitored by facility staff to ensure safety of smoking occurs regardless of completed smoking assessment. The identified supervise smokers that are deemed at risk will be supervised by the facility staff while in the designated smoking area by the activity staff or designee. Smoking aprons will be provided for residents deemed unsafe to smoke. Facility administrator met with residents who identified to smoke and educated on facility policy related to smoking which includes implementation of monitor and safekeeping of smoking paraphernalia by the staff. Safekeeping of smoking paraphernalia include cigarettes lighters labeled and secured in a locked filing cabinet at the receptionist desk and the smoking aprons are individually separated with name labeled on bag for identification located at the receptionist desk. The receptionist, Administrator, DON, first floor nursing station will have keys to unlock the filing cabinet to retrieve smoking paraphernalia, cigarettes and lighters and

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replacing after smoking. The designated smoking times will be at 8 AM through 8 PM and the designated smoking area is the courtyard. The residents and staff were informed on 7/22/22 of the current designated times of 8 AM through 8 PM and then in two weeks on 8/4/22 the designated times will be 9:30 AM, 2 PM, 4 PM and 6 PM. Residents were informed of the designated smoking times on 7/21/22 by the administrator. The designated smoking area is in the courtyard with shaded roof area, posted signage to indicate that it is a designated smoking area with a fire extinguisher available and a receptacle/bin for extinguishing and discarding cigarettes. Staff education initiated on 7/21/22 administrator or designee and ongoing until completed and will not be allowed to work until education was received. A list of residents that smoke is located on the nursing units and at the reception desk to know who smokes independently or require supervision with a smoking apron and designated smoking area and times."

"2. Residents with the potential to be affected by the alleged deficient practice:

All residents who smoke have the potential to be affected by this alleged deficient practice. The facility interdisciplinary team will conduct resident smoking safety assessments on 7/21/22 assessing the residents for safe smoking criteria. All residents assessed for smoking will have smoking materials removed from the person by 7/21/22 and stored by the facility. Facility administrator will conduct individual meetings with the residents and/or responsible parties that smoke and review the facility smoking policy and

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consequences for noncompliance. All residents in the facility assessed on 7/22/22 if they smoke or need smoking cessation intervention Such as NicoDerm patch or nicotine gum per position order and any resident that is not in the facility will be assessed when he returns to the facility. If it if identified wish to smoke a smoking evaluation and BIMS will be conducted and smoking policy and agreement will be reviewed with the resident signature to indicate it was reviewed and understood and the care plan will be updated and resident informed if he's independent or supervision required with smoking apron designated smoking area and times."

"Systemic changes:

I. The interdisciplinary team (Administrator, Director of Nursing, Assistant Director of Nursing, Director of Social Work, Activities Director, Dietary Manager, Business Office Manager, Director of Maintenance, Environmental Services Manager, Human Resources and Unit Managers) will be educated by the regional Director of nursing on smoking policy, resident smoking practices, supervision with smoking and resident noncompliance with smoking policy. Starting 7/22/22 no staff will return to work unless they've completed the mandatory education on facility smoking policy, safe smoking and supervision, and noncompliance with smoking policy. A resident smoking evaluation assessment completed by licensed nurses to determine independent or at risk that require supervision while smoking. The facility staff will monitor and provide supervision while the identified supervised smoker is smoking in the designated smoking area and at times with a smoking apron on. The residents that are noncompliant with

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smoking will be monitored and redirected to the smoking area and reported to the administrator the administrator will discuss with the resident and re-educate them on smoking policies in agreement"

"II. The facility will monitor Resident for change in condition, if a resident is observed by a smoking monitor with unsafe smoking practices the resident will be stopped from smoking and have a new assessment completed to determine ability The administrator made the medical Director aware of the immediate jeopardy abatement plan via telephone on 7/21/22 at 5:55 PM"

The removal plan was accepted on 7/22/22 at 2:12 PM.

The survey team verified the following items listed in the removal plan:

The Surveyors reviewed skin assessments for the known smokers.

The Survey Team requested a list of all of the known smokers and whether or not they were deemed safe to smoke.

The Surveyors reviewed the updated smoking assessments for all of the Residents who smoke.

The Surveyors observed locked filing cabinet where smoking materials are stored.

The Surveyors verified who holds access to smoking materials (DON and Unit Managers).

The Surveyors observed courtyard with shaded roof area where Residents smoke.

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F 689	Continued From page 17 The Surveyors observed fire extinguisher in smoking area and the bin used to extinguish and discard cigarettes. The Surveyors interviewed staff for education content of smoking in-service, to include how they will know who is a smoker, how they will know who needs an apron and supervision, how they will know and to whom they will report a change in condition or ability of Resident to smoke safely. The Surveyors reviewed the care plans of Residents that are smokers. The Survey Team reviewed the in-service education sheets for staff signatures. The Surveyors reviewed the updated "Smoking Agreements" that Residents and or RP's signed, outlining the location, and times, as well as the fact that staff will secure smoking materials for the Residents. Immediate Jeopardy was removed on 7/22/22 at 5:10 PM. On 7/25/22 during the end of day meeting the Administrator was again made aware of the concerns and no further information was provided.	F 689		
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	F 880		8/16/22

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comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control 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

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F 880	Continued From page 19 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 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, electronic health record (EHR) review, and interview, the facility staff failed 1) to wear N95 masks per manufacturer's recommendation, and 2) provide adequate personal protective equipment (PPE). The findings include: 1. Facility staff failed to wear N95 masks per manufacturer's recommendation. On July 20, 2022, at approximately 09:15 a.m., upon entry, the Administrator and Director of Nursing (DON) to observed to wear their N95 masks counter to the recommendation of the manufacturer. That is, with both bands of the	F 880	F880 1. The three staff members identified were educated on appropriate mask wearing on 7/27/2022 per manufacturer recommendations. Isolation bins were stocked, and a bin placed outside of room 104 on 7-21-22. 2. Current residents have the potential to be affected. 3. Administrator or designee will in-service all facility staff on appropriate mask wearing per manufacturer recommendations and the DON or designee will in-service the licensed nurses, CNAs, and central supply on	

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F 880	Continued From page 20 mask at the nape of the neck. On July 20, 2022, at approximately 1:20 p.m., Employee E was observed in the corridor wearing mask against manufacturer's recommendation. That is, with both elastic bands of the mask at the nape of the neck. Staff E immediately positioned the elastic bands to the proper position when surveyor approached and began to discuss the proper wear of the mask. On July 20, 2022, at approximately, 1:30 p.m., Employee F was observed in the corridor wearing mask against the manufacturer's recommendation. That is, with both elastic bands of the mask at the nape of the neck. Staff F states that there has been no education as to the proper wear of the mask. On July 20, 2022, at approximately 1:35 p.m., CNA B was observed in the corridor wearing a mask against the manufacturer's recommendation. That is, with both elastic bands of the mask at the nape of the neck. On July 21, 2022, at approximately 10:10 a.m., the Director of Nursing was interviewed. The DON made known that she is aware and does strive to wear the mask correctly; but the mask is too tight when worn correctly. Director of Nursing was able to secure a box of N95 mask that are worn here at the facility. The fitting instructions on back of the package for Medline's N95 respirator. Medline's recommendation as to proper positioning of the elastic bands of the mask (N95 respirator) is to stretch the elastic bands over the back of the head, positioning bottom band behind neck below	F 880	restocking isolation bins with PPE supplies including gowns, gloves, N-95, face shield or goggles and the location of isolation bins with residents on transmission-based precautions. 4. DON or designee will conduct weekly observation audits of 10 facility staff to verify wearing mask per manufacturer recommendations and will audit isolation bins 5 x weekly to verify are stocked with PPE supplies. 5. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator/Director of Nursing are responsible for implementation of the plan of correction. 6. Date of compliance 8/16/2022	

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F 880	Continued From page 21 the ears and top band near crown of head. 2. The facility staff failed to provide personal protection equipment (PPE) bins. On July 21, 2022, at approximately 11 a.m., observed the lack of PPE at room 104. Room 104 housed two residents of interest for COVID-19. Interviewed Assistant Director of Nursing (ADON). The ADON acknowledged the residents of concern were residents of interest for COVID-19. Equally, the ADON acknowledged there should be a PPE cart present, and verbalized intent to place a PPE bin at outside of said resident doorway. Upon follow-up observation PPE bin was in place.	F 880		
F 886 SS=E	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in	F 886		8/16/22

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this paragraph with symptoms
consistent with COVID-19 or with known or suspected exposure to COVID-19;
(iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county;
(v) The response time for test results; and
(vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19.

§483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests;

§483.80 (h)((3) For each instance of testing:
(i) Document that testing was completed and the results of each staff test; and
(ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test.

§483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms
consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19.

§483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested.

§483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages,

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F 886	Continued From page 23 contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review, the facility staff failed to conduct testing of staff for COVID-19 for one staff member (Staff 9) out of a sample size of 3 staff members. Specifically, Staff 9's vaccination status was not up-to-date on COVID-19 and the facility staff failed to provide evidence that Staff 9 was tested for COVID-19 in accordance with The Centers for Disease Control and Prevention (CDC) guidance. The findings included: Review of the CDC document entitled, "Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes" updated on 02/02/2022, was reviewed. An excerpt of the document read, "In nursing homes, HCP [healthcare providers] who are not up-to-date with all recommended COVID-19 vaccine doses should continue expanded screening testing based on the level of community transmission as follows: In nursing homes located in counties with substantial to high community transmission, these HCP should have a viral test twice a week." On 07/20/2022, the facility staff provided a copy of their staff vaccination matrix. According to the matrix, Staff 9 (a certified nursing aide) received the first COVID-19 vaccination on 04/14/2021, the second COVID-19 vaccine on 05/14/2021, and declined the booster.	F 886	F886 1. No action was taken for Staff #9 due to the time frame has already passed 2. Current residents and staff have the potential to be affected. 3. Director of Nursing or designee will educate Infection Preventionist, LPN/RNs on current CDC COVID testing guidelines for staff not up to date and completing an employee vaccine declination form. 4. The Assistant Director of Nursing or designee will audit testing logs weekly to ensure all staff who are not up to date with recommended COVID-19 vaccine doses are tested per CDC COVID-19 testing guidelines. 5. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator/Director of Nursing are responsible for implementation of the plan of correction. 6. Date of compliance 8/16/2022	

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F 886	Continued From page 24 On 07/21/2022 at 9:10 A.M., Staff 9 was interviewed. Staff 9 verified that they declined the COVID-19 booster. When asked about testing, Staff 9 indicated that they get tested twice a week and that testing is every Monday and Thursday. On 07/22/2022, the facility staff provided a copy of their COVID-19 community transmission logs from October 2021-current. According to the logs, the community transmission rate has been "high", with the exception of 04/11/2022 through 04/25/2022 which was at a rate of "substantial." 07/22/2022, the facility staff provided a copy of all COVID-19 testing results for Staff 9 since October 2021. There were 4 occurrences of Staff 9 being tested for COVID-19 (01/31/22, 06/02/22, 06/06/22, and 07/18/22). On 07/25/2022 at 9:25 A.M., the Director of Nursing (DON) was interviewed. When asked about the process when staff decline a booster, the DON stated that those who decline a booster will be tested twice a week. When asked about COVID-19 testing for Staff 9, the DON stated that Staff 9 should have been tested for COVID-19 twice a week but was not tested.	F 886		
F 947 SS=E	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year.	F 947		8/16/22

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

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F 947	Continued From page 25 §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on facility documentation review and staff interview, the facility staff failed to ensure staff competence with education and training for one staff (Staff 4) out of a sample size of 5 staff members. Specifically, Staff 4 did not have education and training in abuse prevention or dementia care. The findings included: On 07/22/2022, the facility staff provided training records for Staff 4, a certified nursing aide with a hire date of 04/07/2022, as requested. There was no evidence Staff 4 received abuse prevention or dementia care education and training. On 07/22/2022 at approximately 4:30 P.M., the administrator and Director of Nursing were notified of findings. The administrator indicated they would look into it. On 07/25/2022 at 9:25 A.M., the Director of Nursing confirmed there was no evidence of abuse prevention or dementia care training for	F 947	F947 1. Staff member #4 is no longer an employee with the center. 2. Current residents and staff have the potential to be affected. An audit will be conducted on active CNAs to verify dementia care and abuse training was completed. 3. The Administrator will educate the DON, ADON and Unit Managers regarding CNAs education requirements during orientation and annual training on Dementia Care and Abuse Prevention and retained in employee file. 4. Assistant Director of Nursing or designee will audit weekly new hire CNA educational records to verify Dementia Care and Abuse Prevention training was completed during the orientation process. 5. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The	

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 _____	07/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 947	Continued From page 26 Staff 4. On 07/25/2022, the facility staff provided a copy of their policy entitled, "Orientation Program for Newly Hired Employees, Transfers, Volunteers." The policy did not explicitly document that the orientation program included dementia care and abuse prevention.	F 947	Administrator/Director of Nursing are responsible for implementation of the plan of correction. 5. Date of compliance 8/16/2022	