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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 07/09/23 through 07/14/23. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 07/09/23 through 07/14/23. An extended survey was conducted 07/13/23 through 07/14/23. Immediate Jeopardy was identified in the area of Quality of Care at a Scope and Severity Level 4 isolated, which constituted Substandard Quality of Care. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Two complaints were investigated during the survey: VA00054695- substantiated with deficient practice VA00052781- substantiated with deficient practice The census in this 130 certified bed facility was 123 at the time of the survey. The survey sample consisted of 61 resident reviews and 25 employee reviews.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced	F 554		8/17/23

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

Electronically Signed | 08/01/2023

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 554	Continued From page 1 by: Based on observation, interview, clinical record review and facility documentation the facility staff failed to assess for appropriateness of self-administration of medications for 1 Resident (Resident #119) in a survey sample of 61 Residents. The findings included: For Resident #119 the facility allowed Resident #119 to have Chlorhexidine Gluconate, a prescription disinfecting mouthwash used to treat periodontal disease, in her room, at the sink, without first assessing the Resident's ability to self-medicate. On 7/12/23 at approximately 10:00 AM, Resident #119 was noted to have Chlorhexidine Gluconate mouthwash at the sink in the room, unsecured. On 7/12/23 at approximately 10:05 AM, an interview was conducted with Resident #119. The Resident reported she has been using the medication for several weeks and uses after every episode of brushing her teeth. The Resident further reported she has always kept it in her room. A clinical record review was conducted. This review revealed a physician order dated 6/8/23, that read, "Chlorhexidine Gluconate Solution 0.12 %; Give 15 ml orally after meals for mouth care Swish undiluted for 30 seconds then expel. Not intended for ingestion & should be expectorated after rinsing". Review of Resident #119's care plan revealed no indication that she had been assessed for the	F 554	The facility sets 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 deficiencies cited have been or will be corrected by the date or dates indicated. F554 1. Resident #119 has been assessed and noted have the ability to self-administer the medicated mouth wash as ordered. An order for self-administration has been obtained, care plan revised, and appropriate means of storage provided. 2. All current Residents have been reviewed to identify anyone with a preference to self-administer medications with order to self-administer, assessment of ability, care plan review, and provision of appropriate storage. An audit was done of all Resident rooms to identify the presence of medications at bedside. 3. The SDC/designee will educate all nurses to identify Residents wishing to self-administer medications, assessing ability to self-administer, obtaining an order for self-administration, revision of the care plan, and appropriate storage of medications in the Resident□s room. The SDC/designee will educate all staff to report any medication found in a Resident□s room to the supervisor, UM or DON.	

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 554	Continued From page 2 ability to self-administer medications. Review of the facility policy titled; "Self-Administration of Medication at Bedside" was conducted. This policy read, "1. The patient may request to keep medications at bedside for self-administration in a lock box. 2. Verify physician's order in the patient's chart for self-administration of specific medications under consideration. 3. Complete self-administration safety screen. 4. The interdisciplinary team will review the assessment and will document during care plan...". On 7/12/23, during the end of day meeting, the Administrator and Director of Nursing were made aware of the concern and no further information was provided.	F 554	4. The UM/designee will round weekly times 4 to monitor for medications at bedside. The IDT will review Resident ability to self-administer medications quarterly during the care plan meeting. Results of rounding and self-administration needs identified during the care plan meeting will be reviewed at the monthly QA meeting times 2. 5. Completion date: August 17, 2023	
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.	F 582		8/17/23

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 582	Continued From page 3 §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility documentation review, the facility staff failed to issue appropriate notices when skilled services were ending for 1 Resident (Resident	F 582	F582 1. Resident #10 ended skilled services as of January 5, 2023. She currently resides in the facility and is receiving	

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 582	Continued From page 4 #10) in a survey sample of 3 Residents, reviewed for such notices. The findings included: For Resident #10 the facility staff failed to issue an Advance Beneficiary Notice (ABN) when skilled services were ending. On 7/9/23, the facility Administrator was asked to provide a listing of Residents who were discharged from Medicare Part A services. From this listing a sample was selected which included Resident #10. The notices issued to these Residents were reviewed and revealed the following: For Resident #10, the facility staff failed to provide a SNF ABN notice prior to skilled care services ending. Only a Notice of Medicare Non-Coverage (NOMNC) was issued. Resident #10 was under skilled care with Medicare Part A as her primary payer from 1/3/23-1/13/23. Upon skilled care ending, Resident #10 remained a Resident of the facility and therefore should have been issued an SNF ABN in addition to the NOMNC. On 7/10/23 at 3:10 PM, an interview was conducted with the social worker (SW)/Employee E. The SW confirmed that she is responsible for the ABN and NOMNC forms. When asked to explain the purpose of the forms and when they are issued, the SW said, "One is for when services will end here, and we can't bill their insurance anymore. The ABN is the same thing". When asked how she knows when to issue the forms, the SW said, "We talk about everyone on case load in our meeting". When asked about	F 582	non-skilled services. The Resident has been made aware of the notice not being provided as required. 2. Residents who receive skilled services are at risk. 3. The Social Worker/Discharge Planner has been educated by the Corporate SWDP Specialist on Advance Beneficiary Notices. 4. Residents whose skilled services have ended will be audited by the Administrator/designee on a weekly basis times 4 to ensure that the Advance Beneficiary Notice was given in a timely manner. Results of the audits will be reviewed at the monthly QA meeting times 2. 5. Completion date: August 17, 2023	

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 582	Continued From page 5	F 582		

the issuing the specific forms, she said, "In Connecticut they got both, here I give the NOMNC". When asked, when is an ABN issued, the SW said, "Unless I get it from their insurance company, I don't issue an ABN at all". When asked why not, the SW was unable to answer. The SW did have an ABN form in her office available for use.

The facility policy titled; "Advanced Beneficiary Notice (ABN)" reviewed. This policy read, "The Advanced beneficiary Notice will be used to properly notify a Medicare Part A or Medicare Part B patient and/or responsible party of the clinical determination that the patient no longer meets the Medicare criteria for skilled services... 2. The Social Work and Discharge Planner or designee issues the notice to the beneficiary or their representative in person or by telephone of the upcoming non-coverage status based on clinical team recommendations. a. This notification must be made at least 2 days in advance of non-coverage status for Part A recipients...".

In the CMS document, "Form Instructions Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNFABN)". This instruction sheet read, "...The SNFABN provides information to the beneficiary so that s/he can decide whether or not to get the care that may not be paid for by Medicare and assume financial responsibility. SNFs must use the SNFABN when applicable for SNF Prospective Payment System services (Medicare Part A) ...". Accessed online at: https://www.cms.gov/Medicare/Medicare-General-Information/BNI/FFS-SNF-ABN-

On 7/10/23, during the end of day meeting, the facility Administrator was made aware of 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 _____	C 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 582	Continued From page 6 above findings. No further information was provided.	F 582		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State	F 583		8/17/23

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 583	Continued From page 7 law. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview and facility documentation review, the facility staff failed to provide privacy during care for 1 of 61 residents (Resident #123). The findings include: For Resident # 123 the facility staff failed to use the privacy curtain and failed to close the door to provide privacy during incontinent care. On 7/11/23 at approximately 11:00 AM an interview was conducted with Resident # 123 who stated that she gets hot, so she sleeps in the nude with only a sheet on her at night. She stated that the CNA's on nightshift come in to change her and they don't close the door or the privacy curtain, the just pull the sheet down and change her. She stated that when she complained the CNA's will say, " Isn't nobody coming down this hall at this time of night." The roommate of Resident #123 confirmed that they do not close the privacy curtain and they do not close the door on night shift they just change Residents in full view of anyone in the hall or in the room. When asked if there was a specific CNA who did this both Resident #123 and her roommate stated, "All of them do it on night shift." A review of the Policy entitled "Resident Rights" revealed the following excerpt: "The Right to:" "12. Be treated with consideration, respect and full recognition of his / her dignity or individuality,	F 583	F583 1. Resident #123 is receiving incontinent care with privacy provided by closing of the curtain and the door. 2. Residents who receive incontinent care are at risk. 3. The SDC/designee will educate all nurses and CNAs on provision of privacy during care to include closing of the curtain and door. 4. The UM/designee will round weekly times 4 to monitor maintenance of dignity during provision of care and interview 5 incontinent Residents regarding privacy weekly times 4. Results of the rounds and interviews will be reviewed at the monthly QA meeting times 2. 5. Completion date: August 17, 2023	

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 583	Continued From page 8 including privacy in treatment and in care of his / her personal needs." On 7/12/23 at 1:00 PM an interview was conducted with CNA B who stated that the CNA should close the curtain until the care is done. She also stated that if a Resident chooses to sleep without clothing the CNA should leave the sheet covering her top at least so that she does not feel totally exposed. On 7/14/23 during the end of day meeting the DON was asked about the expectation for CNA's providing privacy during care. She stated that the CNA's should be utilizing the privacy curtain and or the door to provide privacy for the Residents. On 7/14/23 during the end of day meeting the Administrator was made aware and no further documentation was provided.	F 583		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in	F 585		8/17/23

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 585	Continued From page 9	F 585		

accordance with this paragraph.

§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.

§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 585	Continued From page 10	F 585		

written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;
(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and
(vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.
This REQUIREMENT is not met as evidenced by:
Based on interview, record review, and facility

F585

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 585	Continued From page 11	F 585		

policy review, the facility failed to promptly respond to resolve resident grievances about resident clothing being lost in the laundry and clothing not being returned from the laundry in a timely manner for seven of seven (Residents (R) R42, R59, R82, R85, R95, R98 and R119) sampled residents reviewed for grievances.

Findings include:

Review of the facility's policy titled. "Grievances," dated 01/23/20, revealed, "The patient has the right to voice/file grievances/complaints (orally, in writing or anonymously) without fear of discrimination or reprisal. The Administrator serves as the grievance official of the Center and is responsible for overseeing the grievance process and for receiving and tracking to their conclusion."

Review of R82's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 06/01/23, located in the resident's electronic medical record (EMR) under the "MDS" tab revealed a "Brief Interview for Mental Status (BIMS)" score of 15 of 15, which indicated the resident was cognitively intact.

During an interview on 07/09/23 at 4:57 PM, R82 voiced a concern about her clothing getting lost when it goes to the laundry to be washed. R82 stated at a recent Resident Council meeting, staff discussed a new system that involved resident clothing being placed on an inventory list to prevent clothing from being lost in the laundry. R82 stated the residents already label their clothing with their names, so she did not understand how putting their clothing on an inventory list would help resident clothing from

1. Resident #42 no longer resides at the facility. Grievances for Residents #82, #59, #85, #95, #98, and #119 have been resolved.
2. All Residents have the potential to be affected. A Resident Council meeting has been held to identify any new grievances.
3. The SDC/designee will educate all staff on documenting and communicating a grievance and the grievance process to include attempts of resolution to the grievance.
4. The Administrator/designee will monitor Resident Council minutes and written grievances to ensure that attempts of resolution to the grievance weekly times 4. Results of the monitor will be reviewed at the monthly QA meeting times 2.
5. Completion date: August 17, 2023

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 585	Continued From page 12 getting lost in the laundry. A group interview meeting was conducted on 07/10/23 at 3:00 PM, with six residents whom the facility identified as reliable historians. During the meeting, six of the six residents (R42, R59, R82, R85, R95, and R98) voiced complaints about their clothing getting lost in the laundry and that it takes a long time to get your clothes back from the laundry. The residents stated sometimes it takes two to three weeks for the laundry to return your clothes. The residents stated these laundry issues have been brought up at previous Resident Council meetings and are an ongoing issue that has not been resolved. Review of the minutes from the Resident Council meeting minutes, dated 06/26/23 revealed three residents (R42, R98 and R119) voiced concerns about missing clothing. During an interview on 07/12/23 at 2:30PM, the Director of Laundry stated residents have their names written on all their clothing. This helps us keep track of the residents' clothing and make sure residents get the right clothing. If any resident clothing is missing, a CNA will search in the laundry room with the help of a laundry staff. If they cannot find the resident clothing, either myself or the CNA will report to the administrator. The Director of Laundry stated no paperwork was used, only verbal communication.	F 585		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:	F 609		8/17/23

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 609	Continued From page 13 §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review and facility documentation review, the facility staff failed to report an injury of unknown origin involving one Resident (Resident #18) in a survey sample of 61 Residents. The findings included: Resident #18 had an x-ray of her foot that revealed a dislocation at the metatarsophalangeal joint (MTPJ) of the fifth toe and the facility staff failed to report the injury of unknown origin.	F 609	F609 1. A facility reported incident report was filed with all required agencies on July 14, 2023, regarding the dislocation of Resident #18□s toe. Investigation revealed that the dislocation was a result of disease process, and no abuse was involved. 2. All Residents have the potential to be affected. All Residents with documentation of an injury of unknown origin were reviewed to ensure that a	

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 609	Continued From page 14 On 7/13/23, during an electronic health record review, the following was noted: On 7/7/23, an x-ray was performed of Resident #18's foot. The x-ray report read, "There is dislocation at the MTPJ of the fifth toe with the proximal phalanx positioned medially. Postsurgical change is seen involving the phalanges of the second and fourth toes and possibly the third although I do not see the distal portion of the proximal phalanx of the third toe adequately to exclude osteomyelitis. The tarsometatarsal articulations are unremarkable...". On 7/13/23, Surveyor C reviewed all the abuse allegations, injuries or unknown origin and allegations of neglect that the facility staff had reported to the regulatory agencies for the past year. There was no report of Resident #18's injury. On the morning of 7/13/23, the facility Administrator was asked to provide any evidence he had with regards to Resident #18's injury being reported to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities. On the afternoon of 7/13/23, the facility Administrator and Director of Nursing reported that such injuries "should be reported within 2 hours to the [state survey agency], adult protective services, ombudsman, and police". They further stated that they had nothing to provide that this had been done with regards to Resident #18's dislocation at the MTPJ of the fifth toe.	F 609	report was filed with the State agency. 3. The SDC/designee will educate all staff on reporting injuries of unknown origin to the Administrator, DON, or UM to ensure that timely notification to all required agencies is completed. 4. The Administrator/designee will monitor reports of injury on a weekly basis times 4 to ensure that any injury of unknown origin was reported to the appropriate State agency. Results of the monitoring will be reviewed at the monthly QA meeting times 2. 5. Completion date: August 17, 2023	

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 609	Continued From page 15 Review of the facility's abuse policy, titled, "Reporting Requirements/Investigations" was conducted. An excerpt from this policy read, "...1. Immediately upon notification of any alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, the Administrator will immediately report to the State Agency, but not later than 2 hours after the allegation is made, if the events that caused the allegation involves abuse or results in serious bodily injury, or not later than 24 hours if the events that caused the allegation do not involve abuse and do not result in serious bodily injury...". No further information was provided.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 610		8/17/23

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 610	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review and facility documentation review, the facility staff failed to conduct an investigation with regards to an injury of unknown origin involving one Resident (Resident #18) in a survey sample of 61 Residents. The findings included: Resident #18 had an x-ray of her foot, that revealed a dislocation at the metatarsophalangeal joint (MTPJ) of the fifth toe and the facility staff failed to conduct an investigation into an injury of unknown origin to determine the cause and/or if abuse/neglect had occurred. On 7/13/23, Resident #18 was visited in her room. Resident #18 was not interviewable, as she was in a "persistent vegetative state", as noted in her clinical chart. On 7/13/23, during an electronic health record review, the following was noted: On 7/7/23, an x-ray was performed of Resident #18's foot. The x-ray report read, "There is dislocation at the MTPJ of the fifth toe with the proximal phalanx positioned medially. Postsurgical change is seen involving the phalanges of the second and fourth toes and possibly the third although I do not see the distal portion of the proximal phalanx of the third toe adequately to exclude osteomyelitis. The tarsometatarsal articulations are unremarkable...". Nursing notes, physician notes, physician orders,	F 610	F610 1. An investigation was completed for Resident #18 on July 21, 2012. 2. All Residents have the potential to be affected. All Residents with a documented injury of unknown origin within the past 30 days were reviewed to ensure that an investigation was completed. 3. The SDC/designee will educate all staff on requirements of investigating an injury of unknown origin to include notification of the injury to the DON and Administrator. 4. The Administrator/designee will complete an audit of injuries of unknown origin weekly times 4 to ensure that an investigation is completed. Results of the audits will be reviewed at the QA meeting monthly times 2. 5. Completion date: August 17, 2023	

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 610	Continued From page 17	F 610		

and the care plan of Resident #18 were reviewed. There was no mention of an investigation, or any further evaluation having been conducted, other than a progress note from the nurse practitioner dated 7/11/23, which noted the x-ray results and stated that an orthopedic consult was being ordered.

On 7/13/23, Surveyor C reviewed all the facility investigations. There was no evidence of an investigation of Resident #18's injury.

On the morning of 7/13/23, the facility Administrator was asked to provide any evidence they had with regards to Resident #18's injury being investigated. No information was submitted.

On the evening of 7/13/23, an interview was conducted with Employee N, the attending physician for Resident #18. The doctor stated that he had ordered additional/repeat x-rays for further clarification/information. The physician stated he didn't feel that the dislocation was a result of an incident because typically in such a patient, you would see fractures. The doctor further agreed that additional studies and investigation into the etiology were needed.

Review of the facility's abuse policy, titled, "Reporting Requirements/Investigations" was conducted. An excerpt from this policy read, "...2. The Administrator and/or Director of Nursing will immediately initiate a thorough internal investigation of the alleged/suspected occurrence. The investigation protocol will include, but not be limited to, collecting evidence, interviewing alleged victims and witnesses, and involving other appropriate individuals, agents, or

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 610	Continued From page 18 authorities to assist in the process and determinations...". On the afternoon of 7/13/23, the facility Administrator and Director of Nursing reported that such injuries should be investigated immediately, and they had nothing to submit. No further information was provided.	F 610		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would	F 623		8/17/23

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 623	Continued From page 19	F 623		

be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 623	Continued From page 20 and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interview, record review and facility policy review, the facility failed to ensure two of three sampled residents (Resident (R) 38, and R91) and/or their Resident Representative (RR), reviewed for a facility-initiated emergent hospital transfer, were provided with a written transfer/discharge notice that stated the reason for transfer, the place of transfer, and other information regarding the transfer. This failure had the potential to affect the resident and their	F 623	F623 1. Resident #38 was last transferred to the hospital on April 19, 2023. Resident #91 was last transferred to the hospital on May 30, 2023. The Residents have been notified that the required notice was not issued. 2. All Residents have the potential to be affected. Residents transferred to the hospital in the past 30 days were reviewed	

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 623	Continued From page 21 Resident Representative by not having the knowledge of where and why a resident was transferred, and/or how to appeal the transfer, if desired. Findings include: Review of the facility's policy titled, "Notice of Transfer/Discharge," dated of 01/06/20, specified, "When the Center initiates a notice of transfer/discharge to a patient and/or responsible party, Social Work and Discharge Planning staff will pursue timely and appropriate transfer/discharge notifications as well as discharge planning initiatives to ensure a safe and orderly discharge from the Center." 1. Review of the "Progress Notes" located in the EMR revealed R38 had an emergency transfer and was admitted to the hospital on 04/19/23 with diagnoses of respiratory failure and hypercapnia. Further review of the EMR revealed no documentation that written notification containing information as to the reason for the facility-initiated hospital transfer was provided to the resident and/or the RR. 2. Review of the "Progress Notes" located in the EMR revealed R91 was transferred to the hospital on 04/18/23 when a chest x ray showed a possible large plural effusion. Further review of progress notes revealed R91 was also transferred to the hospital on 05/30/23 and was admitted with a diagnosis of continuous bladder irrigation. Review of the EMR revealed no documentation that written notification containing information as to the reason for R91's facility-initiated hospital transfers on 04/18/23 and 5/30/23 was provided to the resident and/or the	F 623	to determine if the Transfer/Discharge documentation was completed. Any Residents not receiving notice were notified that the required notice was not issued. 3. The Corporate SWDP Specialist will educate the SW/DP on completion of the Transfer/Discharge notification and documentation of the notification. The SWDP will alternate with the Assistant SWDP to address weekend transfers/discharges. 4. The Administrator/designee will audit transfers/discharges on a weekly basis to ensure that the Transfer/Discharge notification was completed and documented. Result of the audits will be reviewed at the QA meeting monthly times 2. 5. Completion date: August 17, 2023	

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 623	Continued From page 22 RR. During an interview on 07/11/23 at 3:50 PM, the Social Worker (SW) stated she notified the Ombudsman of R38 and R91's but did not provide written notification to the resident and/or the RR of either of these transfers. The SW stated she thought the nursing staff was responsible for notifying the resident and/or the RR in writing when a resident was transferred to the hospital. During an interview on 07/12/23 at 3:40 PM, the Director of Nurses (DON) stated it was the SW's responsibility to provide written notification to the resident and/or the RR when a resident was transferred to the hospital. During an interview on 07/12/23 at 3:43 PM, the SW stated she worked at the facility since March 2023, and was not informed that it was her responsibility to provide written notification to the resident and/or the RR for a facility-initiated resident transfer to the hospital. The SW again stated she did not provide R91, R38 and/or the RR with written notification of the resident's hospital transfers. During an interview on 07/12/23 at 3:47 PM, the Administrator stated the SW was responsible for providing written notification to the resident and/or the RR for a facility initiated resident transfer to the hospital.	F 623		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the	F 641		8/17/23

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 641	Continued From page 23 resident's status. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the Resident Assessment Instrument (RAI) Manual, the facility failed to ensure the accuracy of the "Minimum Data Set (MDS)" assessments for antipsychotic use for two of five sampled residents (Residents (R) 47 and R91) reviewed for unnecessary medications. These failures placed the residents at risk of having unmet care needs and services. Findings include: Review of the RAI Manual 3.0, dated 10/19, revealed, " ...If an MDS assessment is found to have errors that incorrectly reflect the resident's status, then that assessment must be corrected ..." 1. Review of the "Admission Record" found on the "Profile" tab of the electronic medical record (EMR) revealed R47 was admitted to the facility with a diagnosis of major depressive disorder. Review of R47's physician's orders found on the "Orders" tab of the EMR revealed an order for a 10-milligram tablet of Abilify (an antipsychotic medication) each day. This order was initiated on 07/05/22. Review of the resident's June 2023 monthly Medication Administration Record (MAR) revealed R47 received Abilify every day from 06/01/23 to 06/12/23. Review of R47's quarterly "MDS" assessment with an Assessment Reference Date (ARD) of	F 641	F641 1. Resident #47 and Resident #91□s MDS assessments were modified to include the receipt of an antipsychotic medication during the assessment reference period. 2. All Residents currently receiving antipsychotic medication were reviewed to ensure that the MDS coding accurately reflects receipt of the antipsychotic. Modification to the MDS was completed as needed. 3. The Regional Director of MDS/designee will educate the MDS Coordinators on accuracy of coding for receipt of antipsychotic medications. 4. The MDSCs will audit coding of MDS for receipt of antipsychotic medications weekly times 4. Results of the audits will be reviewed at the QA meeting monthly times 2. 5. Completion date: August 17, 2023	

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 641	Continued From page 24	F 641		

06/12/23 revealed, the assessment's "Antipsychotic Medication Review" section specified R47 had not received an antipsychotic medication since her admission/entry or reentry or the prior OBRA assessment, whichever was more recent.

2. Review of the "Admission Record" found on the "Profile" tab of the EMR revealed R91 was admitted to the facility with diagnoses which included schizophrenia and unspecified psychosis.

Review of R91's physician's orders found under the "Orders" tab of the EMR revealed an order for the resident to receive a 1 milligram tablet of Risperdal (an antipsychotic medication) twice a day. This order was initiated on 06/05/23.

Review of the resident's June 2023 monthly MAR revealed R91 received Risperdal every day from 06/05/23 to 06/11/23.

Review of R91's quarterly "MDS" assessment with an ARD of 06/11/23 revealed, the assessment's "Antipsychotic Medication Review" section specified R91 had not received an antipsychotic medication since her admission/entry or reentry or the prior OBRA assessment, whichever was more recent.

During an interview on 07/12/23 at 2:30 PM, MDS Coordinator (MDSC)1 reviewed R47 and R91's EMR and confirmed the "Antipsychotic Medication Review" quarterly MDS was inaccurate because it did not reflect the residents had received an antipsychotic medication.

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 641	Continued From page 25 MDSC1 stated she would submit a correction for this MDS assessment error.	F 641		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and policy review the facility failed to make a referral for a Level II Preadmission Admission Screening and Resident Review (PASARR) evaluation after a resident experienced a significant change in mental health status which included being newly diagnosed with major depressive disorder, psychosis, and mood affect disorder, and experiencing hallucinations. The failure to ensure the required PASARR screening and review was completed affected one (Resident (R) 38) of three sampled residents reviewed for PASARR Level II	F 644	F644 1. A Level I PASARR evaluation has been initiated for Resident #38. 2. Residents with Level I and experiencing a significant change in mental health status are at risk will be reviewed to determine if a Level II PASARR evaluation has been initiated. 3. The Corporate SWDP Specialist/designee will educate the SW/DP on initiation of a Level II PASARR evaluation for Residents experiencing a	8/17/23

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 644	Continued From page 26	F 644		

evaluations.

Findings include:

Review of the facility's policy titled, "Level I PASRR-Virginia," dated 01/06/20, revealed, "The preadmission Level I PASARR remains valid for the duration of the patient's care in the center unless there is a significant change in a patient's status affecting his/her mental health or mental retardation needs. a. A significant change can be in the form of a discovery of mental illness, mental retardation or a related condition after the preadmission Level I was preformed by the transferring agent; an increase in behavior problems or symptoms; . . . b. A significant change affecting a patient's mental health may include acute psychosis, behavioral changes such as physical assault, acute suicidal thoughts/actions, and audio/visual hallucinations, delusional thought processes etc. c. If there is a status change an MDS [Minimum Data Set] for significant change will be completed by the Center and the Social Worker and Discharge Planner must immediately notify the PASRR contractor . . . of the significant change and request a PASRR Level II evaluation."

Review of R38's "Admission Record," located in the resident's EMR under the "Profile" tab, revealed R38 was admitted to the facility in 2019 with diagnoses which included anxiety disorder and chronic obstructive pulmonary disease. Further review of the resident's Admission Record, which contained R38's current medical diagnoses, revealed on 03/09/22 R38 was diagnosed with major depressive disorder, and psychosis, and on 06/24/22, R38 was diagnosed with mood affective disorder.

significant change in mental health status.
4. The Administrator/designee will audit Level II Residents on a weekly basis times 4 to determine if a needed Level II PASARR evaluation was initiated. Results of the audits will be reviewed at the QA meeting times 2.
5. Completion date: August 17, 2023

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 644	Continued From page 27	F 644		

Review of R38's PASARR information, located in the resident's electronic medical record (EMR) under the "Misc[ellaneous]" tab, revealed R38 had a PASARR Level I screen completed on 07/10/19. Review of R38's 07/10/19 PASARR Level I screen revealed the resident did not have a current serious mental illness and meet the criteria for nursing facility admission.

Review of R38's current care plan, located in the EMR under the care plan tab, revealed a "Focus" area that was created on 07/05/22 that specified, "At risk for changes in mood related to anxiety, depression, psychosis, mood disorder." The goals specified "Will accept care and medication as prescribed" and "Will maintain involvement with ADL (Activities of Daily Living) performance and social activities. Approaches included "Administer medication per physician orders," "Assess for physical/environmental changes that may precipitate change in mood," "Observe for mental status/mood state changes when new medication is started or with dose changes," and "Offer choices to enhance sense of control."

Review of R38's Annual "MDS," with an Assessment Reference Date (ARD) of 03/13/23, located in the resident's EMR under the "MDS" tab, specified R38 was not currently considered by the state level II PASARR process to have serious mental illness and/or intellectual disability or a related condition.

However, review of R38's medical record revealed a PASARR level II evaluation could not be found.

Review of R38's quarterly "Minimum Data Set

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 644	Continued From page 28	F 644		

(MDS)," with an Assessment Reference Date (ARD) of 06/04/23, located in the resident's EMR under the "MDS" tab, specified R38 did not experience hallucinations, delusions, or behaviors during the review period.

Review of documentation located in R38's EMR under the "Progress Notes" tab, revealed the following notes from 06/17/23 to 07/08/23:

Review of a Health Status Note, dated 06/17/23 at 3:15 AM, revealed R38 was at the nurse's station since 1:00 AM due to constant yelling and making several attempts to get out of bed.

Review of a Health Status note dated 06/17/23 at 5:00 AM, revealed when nursing staff "attempted to put resident to bed when she began screaming and yelling stating that she did not want to go to bed in this room because the lady in the other bed was calling the aliens to come and get her and that the police were coming through the window and we needed to call 911."

Review of a Health Status note dated 06/23/23 at 6:12 AM revealed ". . . After midnight resident began yelling & hallucinating, resident sat at nursing station until [3:30 AM] and returned to bed after she calmed down & was no longer yelling/hallucinating . . ."

Review of a Behavior note dated 06/30/23 at 2:41 PM revealed, Resident was stating "There is a man in my room and ya'll act like you can't see him, but I can. He got a camera and he can repeat everything I say. Why ya'll hiding from me, come get me from this man."

Review of a Health Status note dated 07/08/23 at

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 644	Continued From page 29 9:31 PM revealed, "Resident continues on behavior charting for yelling out. Resident continues to yell out and thinks there is corpse in her room that have [sic] to be removed by a mortician . . ." During an interview on 07/11/23 at 3:55 PM, the Social Worker stated she was not aware R38 was currently experiencing behaviors including hallucinations and yelling out. The SW stated she was responsible for requesting Level II PASARR screens for residents. The SW stated she had worked at the facility since March 2023 and had not requested a Level II screen for R38. During an interview on 07/12/23 at 11:18 AM, the SW stated a PASARR Level II screen had not been previously requested for R38. The SW stated she reviewed the facility's "Psych book" and noticed the resident's hallucinations and yelling behaviors had recently increased. Additionally, the SW stated when she visited R38 she observed the resident having a hallucination. The SW stated she would request a PASARR level II screen for R38 based on the resident exhibiting a significant change with increased behaviors.	F 644		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health	F 645		8/17/23

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 645	Continued From page 30	F 645		

authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission,
(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services; or
(ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission-
(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.

§483.20(k)(2) Exceptions. For purposes of this section-
(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.
(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-
(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 645	Continued From page 31 (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on observation, interview, clinical record review and facility documentation, the facility staff failed to ensure a PASARR (Pre-Admission Screening and Resident Review) was completed for 1 Resident (#76) in a survey sample of 61 Residents. The findings included: For Resident # 76, the facility staff failed to ensure a PASARR was completed. Resident # 76 was admitted to the facility on 12/3/21 with diagnoses that included but were not limited to PTSD (Post Traumatic Stress Syndrome) and Depression. On 7/14/23 approximately 1:45 PM an interview was conducted with the DON who was asked	F 645	F645 1. Resident #76 has a PASARR completed. 2. Residents with mental disorder or intellectual disability were reviewed to ensure that a PASARR is available. 3. The Corporate SWDP Specialist/designee will educate the SW/DP on ensuring that a PASARR is available for newly admitted Residents with mental disorder or intellectual disability. 4. The Administrator/designee will audit PASARR availability for newly admitted Residents with mental disorder of intellectual disability weekly times 4 to ensure that the PASARR is available. Results of the audit will be reviewed at the QA meeting monthly times 2.	

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 645	Continued From page 32 who ensures the PASARR's are completed she indicated that the Social Worker handled that part of the admission. On 4/14/23 at approximately 2:00 PM an interview was conducted with the Social Worker who stated that she did not have a PASARR for Resident #76. On 7/14/23 during the end of day meeting the Administrator was made aware and no further information was provided	F 645	5. Completion date: August 17, 2023	
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.	F 657		8/17/23

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 657	Continued From page 33 (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 interview, clinical record review and facility documentation the facility staff failed to review and revise the care plan for 2 Residents (#'s 13 & 123) in a survey sample of 61 Residents. The findings included: For Resident # 13 the facility staff failed to update the care plan to include interventions from the latest fall on 6/2/23. Resident # 13 had diagnoses that included but was not limited to difficulty in walking, dizziness, syncope and collapse, history of falling, orthostatic hypotension, and dementia with behavioral disturbance. Resident #13 had a BIMS (Brief Interview of Mental Status) score of 7 of 15 indicating severe cognitive impairment. On 7/13/23, a review of the clinical record revealed that Resident #13 sustained a fall on 5/30/23 at 4:00 PM. The staff filled out an Situation-Background-Assessment-Recommendation (SBAR) form to notify the physician and the staff notified the family, however there was no update to the care plan. Resident #13 was care planned for falls, but no updates were made to the care plan for new interventions for falls. On 7/13/23 at approximately 2:00 PM, an interview was conducted with the DON who stated that it was her expectation that the care	F 657	F657 1. Resident #13□s care plan has been reviewed and revised to include appropriate fall interventions. Resident #123□s care plan has been reviewed and revised to include the preference for showering and to discontinue the antibiotic use, PICC line, and isolation. 2. All Residents have the potential to be affected. Residents with a fall, antibiotic use, PICC line, or orders for isolation for the past 30 days were reviewed to ensure that the care plan was reviewed and revised as needed. 3. The Interdisciplinary Team will be educated by the DON/designee on review and revision of the care plan as Resident conditions change. 4. The UM/designee will audit falls, antibiotic use, PICC line, and isolation on a weekly basis times 4 to ensure that the care plan was reviewed and revised as needed. Results of the audits will be reviewed at the QA meeting monthly times 2. 5. Completion date: August 17, 2023	

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 657	Continued From page 34	F 657		

plan be updated to include new interventions after a fall. When asked if there was a timeframe for this to be completed, she stated as soon as possible once the Resident has been evaluated and the cause of the fall has been determined the care plan would be updated accordingly.

The following is an excerpt from the care plan policy:

"5. Computerized care plans will be updated by each discipline on and ongoing basis as changes in the patient occur and reviewed quarterly with the quarterly assessment."

On 7/13/23 during the end of day meeting the Administrator was made aware of the concerns and no further information as provided.

2. For Resident #123 the facility staff failed to Review and revise the care plan to 1) address bathing in the ADL care goals; 2) discontinue or resolve IV antibiotics when stopped and PICC line removed; and 3) resolve the isolation for C-Diff when the specimen results were resulted as negative.

On 7/13/23 a review of the clinical record revealed the care plan had not 1) addressed the Resident's preference to be showered rather than bed bathed. The Resident did not receive any showers until after the start of survey when the Resident requested this be brought to staff attention. Further review of the care plan revealed that the Resident had 2) a PICC (Peripherally Inserted Central Catheter) and 3) was supposed to be on precautions for C Diff.

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 657	Continued From page 35	F 657		

On 7/13/23 at 11:45 AM an interview was conducted with Resident #123 who stated that she had her PICC line removed early in June when the antibiotics stopped. When asked about C-Diff she stated that she had not actually been positive for it they were worried that she had it because she had so much diarrhea however the results were negative. When asked if she was on isolation precautions, she stated that she was put on isolation at that time, but it was taken down after the results came back negative. She stated she would like to see a GI specialist because she has had diarrhea "Off and on since I arrived here and it's not getting any better."

On 7/13/23 at approximately 2:00 PM, an interview was conducted with the DON who stated that it was her expectation that the care plan be updated to include new interventions when a Resident's condition changes or when new meds or procedures begin or end. She stated that the care plan should be updated to reflect any changes in care. When asked if there was a timeframe for this to be completed, she stated as soon as possible once the Resident had been evaluated and the changes to orders or medications are made then care plan would be updated accordingly.

The following is an excerpt from the care plan policy:

"5. Computerized care plans will be updated by each discipline on and ongoing basis as changes in the patient occur and reviewed quarterly with the quarterly assessment."

On 7/13/23 during the end of day meeting 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 _____	C 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 657	Continued From page 36 Administrator was made aware of the concerns and no further information as 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 observation, resident interview, staff interview, clinical record review, and facility documentation review, the facility staff failed to provide care and services in accordance with professional standards for 1 resident, Resident #65, of 61 sampled residents. The findings included: For Resident #65, facility staff failed to administer medications as ordered by the physician. On 7/9/23 at approximately 2:30 PM, an interview was conducted with Resident #65. Resident #65 stated, "I have a history of bowel problems, loose stools, and I have managed it with medication, the doctor told me that I could have it when I need it, I have requested the medication both yesterday and today but the nurses just tell me that they are all out of it, I had diarrhea all over my bed early this morning and I know it would not have happened if they had given me the medicine yesterday when I asked, I have to leave here early tomorrow morning for a follow-up doctor's appointment about my broken arm, I am worried that I will have an accident [bowel movement]	F 658	F658 1. Resident #65 is receiving prn medication as ordered and per her request. 2. All Residents have the potential to be affected. 3. The SDC/designee will educate all nurses on administration of prn medications per Resident request and as ordered. 4. The DON/UM/designee will interview 5 Residents weekly times 4 to ensure that prn medications are administered per Resident request and as ordered. Results of the audits will be reviewed at the QA meeting on a monthly basis times 2. 5. Completion date: August 17, 2023	8/17/23

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 658	Continued From page 37	F 658		

because I can't get my medication". Resident #65 stated that she asked for the medication "around noon today".

On 7/9/23 at approximately 2:45 PM, an interview was conducted with LPN B who confirmed that Resident #65 had requested medication for loose stools and stated, "I need to double check all that with the doctor, I can't just give it, I need his 'ok'".

On 7/9/23 at approximately 3:15 PM, an interview was conducted with the Director of Nursing (DON) who confirmed the availability of antidiarrheal medication in the medication storage room. The DON stated the doctor would not have to be notified if an active order for antidiarrheal medication was already obtained and should be administered upon request and as indicated.

On 7/9/23 at approximately 3:30 PM, Resident #65's clinical record was reviewed and revealed a physician's order dated 6/15/23 that read, "Loperamide HCl Oral Capsule 2 mg, give 2 mg by mouth as needed for diarrhea 4 times a day as needed". The Medication Administration Record revealed that one dose was given previously on 7/4/23 at 9:18 AM.

Documentation also revealed on 7/8/23, Resident #65 had an "incontinent" episode of a "large" amount of "loose/diarrhea" at 12:38 PM and again on 7/9/23 at 1:59 PM.

According to Lippincott Manual of Nursing Practice, 11th edition, 2019, page 15, "Standards of Practice-General Principles", item 1, read, "The practice of professional nursing has standards of practice setting minimum levels of acceptable performance for which its practitioners are

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 658	Continued From page 38 accountable" and Box 2-1, "Common Legal Claims for Departure from the Standards of Care", item 8, read, "Failure to implement a physician's, advanced practice nurse's, or physician assistant's order properly or in a timely fashion". On 7/9/23 at the end of day de-briefing, the Facility Administrator and Director of Nursing (DON) were updated on the findings. The DON stated, "It is my expectation for Resident #65 to have received the medication that she had requested because there was a valid doctor's order and she had experienced loose stools, there was no reason for her to not have received it, I will be re-educating her nurse immediately". No further information was provided.	F 658		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, clinical record review, and facility documentation, the facility staff failed to provide necessary services to maintain good grooming and personal hygiene for 3 Residents (# 123, 63, & 65) in a survey sample of 61 Residents. The findings included: 1. For Resident #123 the facility staff failed to give the Resident choice about bed bath or showers and failed to give shower upon resident request	F 677	F677 1. Resident #123 is receiving two showers per week and showers per request. Resident #63 is receiving two showers per week and showers per request. Resident #65 is receiving timely incontinence care as needed. 2. All Residents have the potential to be affected. 3. The SDC/designee will educate all nurses and CNAs on provision of showers, bathing and grooming, and	8/17/23

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 677	Continued From page 39 after episode of diarrhea incontinence. On 7/9/23 at approximately 3:00 PM, an interview was conducted with Resident #123 who stated that she has been told by staff "You cannot have a shower, it is not your shower day." Resident #123 stated she requested the shower on a day where she had a large diarrhea incontinent episode. She stated the CNA was cleaning her up, but she stated it was just making a bigger mess smearing it up her back. She requested the CNA just take her to the shower. Resident #123 stated the CNA refused telling her that it was not her shower day. Resident #123 stated that she never gets showers on her shower day, she stated she only gets bed baths. She stated she could not remember the last time her hair had been washed. On 7/9/23 at approximately 4:00 PM an interview was conducted with LPN D who stated that the process is that when a CNA gives a shower, he or she fills out a shower sheet and places it back in the book. A review of the shower book revealed that Resident #123 had no shower sheets in the book for June or July. When asked if there is another place the sheets are kept, LPN D stated that there was not. On 7/9/23 a review of the clinical record revealed that Resident #123 had not been getting showers she had only been getting bed baths since admission on 5/3/23. On 7/10/23 at 5:00 PM, an interview was conducted with the DON who stated that Residents are scheduled 2 showers a week. When asked if she was aware of CNA's refusing to give a Resident a shower, she stated she was	F 677	provision of incontinence care to include provision of a shower when the Resident requests a shower at a time other than their scheduled shower days. 4. The UM/designee will audit provision of showers, bathing and grooming, and incontinence care weekly times 4. The UM/designee will interview 5 Residents weekly times 4 to ensure that showers are given as requested. The results of the audits will be reviewed at the QA meeting monthly times 2. 5. Completion date: August 17, 2023	

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 677	Continued From page 40	F 677		

not. When asked what her thoughts on that situation she said, "Well the patient should let the nurse know that the CNA refused to give her a shower."

The DON was notified at that time that the Resident would like to start getting in the shower as opposed to bed bathing,

On 7/11/23 at approximately 12:00 PM, an interview was conducted with Resident #123 who stated "I feel like a million bucks. I got a shower and my hair washed last night."

On 7/11/23 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.

2. For Resident #63, the facility staff failed to provide adequate bathing and grooming, thus leaving the Resident looking unkempt and having body odor about him.

On 7/9/23 at 2:00 PM Resident #63 was observed in bed with a hospital gown on him and his hair did not appear to have been combed and during the interview with Resident #63 he stated he did not get in the shower they only bed bathed him. When asked if bed bathing is his choice, he stated that he has not been asked if he would like to get in the shower. He stated he was not aware he had a choice. Resident #63 had a strong body odor about him.

On 7/9/23 at approximately 4:00 PM an interview was conducted with LPN D who stated that the process is that when a CNA gives a shower, he or

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 677	Continued From page 41	F 677		

she fills out a shower sheet and places it back in the book. A review of the shower book revealed that Resident #63 did not have any shower sheets in the book.

7/10/23 at 3:00 PM Resident Council meeting was held, and 6 Residents attended. When asked about bathing and personal hygiene the results were as follows:

1 of 6 Residents stated he only receives one shower per month. Another Resident stated he was unsure if the shower even worked when he first came to the facility because he was not receiving any showers. He stated he now gets 1 shower per week and would like more if possible. He stated he does not know his shower schedule and how often he was to receive showers.

On 7/10/23 a review of the clinical record revealed that there were no showers given only bed baths since admission on 4/27/23.

On 7/11/23 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.

3. For Resident #65, facility staff failed to provide incontinence care in a timely manner.

On 7/9/23 at approximately 2:30 PM, Resident

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 677	Continued From page 42	F 677		

#65 was observed sitting in a wheelchair next to her bed which had been stripped of all linens. Resident #65's right arm was in a sling. Resident #65 stated that her day had not started out well earlier that morning as she had been incontinent of both bladder and bowel overnight and could not get assistance in getting cleaned up, stating, "the nurses told me they were busy and would come back, but they never did...I was wet, dirty, and uncomfortable". She stated, "I hate to be a bother but I have a broken right arm and it is difficult for me to clean myself right now...my bed had to be stripped because it was soiled as well, I guess it will get made when the nurses have time...I will be able to take a nap then".

Resident #65 further stated that around 9:00 AM, Employee T, a Certified Occupational Therapy Assistant (COTA) had come to her room to begin her therapy session, however she was still in bed, in pajamas, waiting for help to be cleaned up from the overnight incontinence episode. Resident #65 stated that Employee T told her that she would try to find a nurse's aide to help her with getting cleaned up and would return later to start her therapy session. Resident #65 stated that Employee T returned a couple of hours later for her therapy session, however she was still soiled from overnight so Employee T assisted her in getting cleaned up and assisted her with bathing.

On 7/9/23 at approximately 2:45 PM, LPN B was interviewed and confirmed that Resident #65 was located on her assigned nursing unit. LPN B stated Resident #65 had episodes of incontinence and was able to make her needs known. LPN B stated she was aware that Employee T had assisted Resident #65 to get

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 677	Continued From page 43	F 677		

cleaned up earlier that day but was unaware that the bed remained stripped of linen. LPN B stated, "I expect the CNAs [Certified Nursing Assistants] to check the incontinent residents first thing each morning and to help them get cleaned up if needed, we have all been busy today".

On 7/10/23 at approximately 10:00 AM, a review of Resident #65's clinical record revealed an Occupational Therapy Treatment Encounter Note dated 7/9/23 at 3:11 PM authored by Employee T which read, "First attempt pt [patient] stated she couldn't do therapy just yet because she hadn't been cleaned, second attempt around 11 AM, therapist asked pt if it was ok to do ADLs [Activities of Daily Living] with her since that's a part of OT, pt willing...".

On 7/10/23 at approximately 10:30 AM, an interviewed was conducted with Employee T who confirmed her first encounter with Resident #65 on 7/9/23 was "around 9 AM...she was still in bed and asked me to come back because she needed to be cleaned up before doing anything else...I put the call light on for her and I attempted to find an aide but was unable to see anyone, I figured they would respond to her call light though".

Employee T verified that she returned to Resident #65 "around 11 o'clock and she still had not been cleaned up, at that point I helped her get out of her soiled brief and gown and assisted her with bathing, her right arm is broken and in a sling so she cannot clean herself up independently yet".

On 7/10/23 at the end of day de-briefing, the Facility Administrator and Director of Nursing (DON) were notified of the findings. A facility

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 677	Continued From page 44 policy regarding ADLs or Incontinence Care was requested, however no additional information was received.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, clinical record review and facility documentation the facility staff failed to ensure Residents receive care and services in accordance with professional standards and the comprehensive care plan and Resident choices for 1 Resident (#123) in a survey sample of 61 Residents. The findings included: For Resident # 123, the facility staff failed to ensure the Resident was provided transportation to her follow up surgeon appointments, causing her to miss 2 appointments. On 7/12/23 at approximately 2:00 PM an interview was conducted with Resident #123 who complained that she missed 2 of her last 3 appointments due to transportation issues. She stated she was supposed to go at the end of May, but it got rescheduled to June 8th and she made	F 684	F684 1. Resident #123 was transported to her most recent appointment on July 17, 2023. 2. Residents with appointments are at risk. Appointments scheduled for the past 30 days were reviewed to determine transportation issues. 3. The SDC/designee will educate nurses, clerk, and medical records staff on making transportation arrangements for Resident appointments. 4. The UM/designee will audit appointments on a weekly basis times 4 to ensure that transportation arrangements were made and successful. Results of the audits will be reviewed at the QA meeting on a monthly basis x 2. 5. Completion date: August 17, 2023	8/17/23

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 684	Continued From page 45 it to that one. She stated she then had a follow up June 22nd and it got rescheduled to June 28th, because transportation did not arrive and the one on June the 28th got rescheduled because of transportation too. When asked how she is transported she stated that she is supposed to go in a wheelchair. A review of the clinical record revealed that this was in fact true Resident #123 did miss two of the last 3 appointments. On 7/13/23 at approximately 4:00 PM an interview was conducted with the Social Worker who stated that she does not arrange transportation that Employee P is responsible for that. On 7/13/23 at 4:10 PM an interview was conducted with Employee P who stated that she is the person who arranges transportation for appointments. When asked what she does if the transportation does not show up, she stated that she will call the company and see if there is a reason for the delay if they are not coming then she will call the doctor's office and reschedule the appointment. She stated there is not much else I can do other than reschedule. On 7/13/23 at 5:00 PM an interview was conducted with the DON who stated that it is ultimately the facility's responsibility to get the resident to their doctor appointments timely. On 7/13/23 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.	F 684		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer	F 686		8/17/23

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 686	Continued From page 46 CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review and facility documentation review, the facility staff failed to provide care and services to prevent the development and worsening of pressure ulcers for 2 Residents (Resident #18 and #21), resulting in harm for both Residents, in a survey sample of 61 Residents. The findings included: 1. For Resident #18, a Resident who was in a persistent vegetative state, the facility staff failed to implement preventative measures to prevent the development of a pressure sore. Resident #18 developed a pressure sore that was found at an advanced stage of stage III, this constituted harm. On 7/13/23, during a clinical record review the	F 686	F686 1. Resident #18□s pressure ulcer healed by July 26, 2023, and preventive measures implemented as indicated. Resident #21□s pressure ulcer is improving without complications as assessed by the wound practitioner on July 26, 2023, and preventive measures implemented as indicated. 2. All Residents have the potential to be affected and have been reviewed for the presence of pressure ulcers. Residents with pressure ulcers have been reviewed to ensure that interventions are in place as identified in the care plan. 3. The SDC/designee will educate all nurses and CNAs on ensuring that identified interventions for care and services to prevent and/or treat pressure ulcers are in place to include dressings and identified interventions. All nurses	

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 686	Continued From page 47 following was noted: A physician order dated 3/9/23, read, "PREVALON boots to bilateral feet as tolerated - remove during ADL care and skin checks- directions: every shift". A nursing note dated 07/10/23 said Resident #18 had a pressure ulcer that was found on her left foot at an advanced stage. Review of the care plan revealed that Resident #18 was identified as being at risk for wound development and indicated her wounds were healed. Some of the interventions included: "Bilateral Prevalon Boots at all times-remove for care and skin checks each shift". The record review revealed no evidence of skin checks being performed each shift. On 7/13/23, Surveyor C was accompanied by one of the Clinical Nurse Consultants/Employee O. Employee O stated she had looked at the wound on Resident #18's left third toe and that it was a Stage III wound. Surveyor C observed the wound, and this observation revealed a full thickness tissue loss with no bone or muscle visible. However, full observation was difficult due to Resident #18's impaired mobility and the location of the wound. Resident #18 was observed with the wound open to air, foot being floated by a pillow. Employee O stated that it was open to air because "they are coming to assess it and change the treatment, it was keeping it too moist". On 7/13/23 at 6:20 PM, the survey team met with the attending physician of Resident #18, Employee N. The physician was asked about	F 686	and CNAs will be educated by the SDC/designee on identification of new wounds and reporting the wound to the UM and DON. All nurses will be educated by the SDC/designee on provision of pain medication prior to treatment administration as indicated. 4. The UM/DON/designee will complete weekly audits times 4 to ensure that appropriate interventions are in place for treatment and prevention of pressure ulcers and to identify the presence of new wounds. The UM/DON/designee will complete Resident interviews weekly times 4 to ensure that pain is addressed. Results of the audits and interviews will be reviewed at the QA meeting monthly times 2. 5. Completion date: August 17, 2023	

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 686	Continued From page 48	F 686		

Resident #18's order for the "prevalon boots, remove during ADL care and skin checks, every shift". The doctor acknowledged that his expectation was that staff would be looking at the Resident's skin condition at a minimum of daily and the Prevalon boots would have to be removed to make such observations. The doctor also stated that he would expect wounds to be identified prior to being an advance stage and said, "That's the standard practice but if they have agency staff, they may not look at things".

On 7/13/23, during an end of day meeting, the facility Administrator and Director of Nursing were asked to provide any evidence of skin checks being performed each shift. No documentation was submitted to the survey team prior to conclusion of the survey.

On 7/14/23 at approximately 10:45 AM, Resident #18 was observed in bed with her feet on the bed, not being floated and Prevalon boots not on.

On 7/14/23 at 11:03 AM, CNA E accompanied Surveyor C to the room of Resident #18. CNA E confirmed that Resident #18 is total care and non-verbal. CNA E also confirmed that Resident #18 doesn't refuse care as she isn't able to engage with staff. During observations Resident #18 was observed with her feet resting on the bed, not being floated and Prevalon boots not on. When CNA E was questioned, CNA E found 1 Prevalon boot in the room but was unable to find the second one. CNA E said, she had been off the day prior (7/13/23) but had Resident #18 on 7/12/23 and had not applied the Prevalon boots that day either, as she was not aware of them and had not seen them in the room on Wednesday, 7/12/23.

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 686	Continued From page 49	F 686		

An additional clinical record review performed on 7/14/23, revealed the wound care specialist had come on the evening of 7/13/23, to assess Resident #18's newly identified wound. The note dated 7/13/23 indicated the following: "left foot third toe, Etiology: Pressure, Stage/Severity: Stage 3, Acquired in House: Yes, Date Wound Acquired: 07/07/2023, Wound Status: New... % Slough: 50-74% slough...% Granulation: 25-49% granulation... Exposed Tissue: Subcutaneous...".

The facility policy titled; "Skin Assessments" was reviewed. This policy read, "... 4. Care plan specific interventions will be developed based on skin risk assessment outcomes and individual patient needs".

On 7/14/23, during an end of day meeting, the facility Administrator and Director of Nursing were made aware of the above findings.

No further information was provided.

2. For Resident #21, who had a pressure ulcer, the facility staff failed to provide interventions and treatment to prevent the worsening of a pressure ulcer. This is harm.

On 7/9/23 at 1:55 PM, during an interview with Resident #21. The Resident reported having a sacral pressure ulcer that hurts. Resident #21 reported, "It was just starting when I came here, it has gone out of proportions now, I can tell when it is getting well, it doesn't hurt me so bad but then in a day or two it goes back the other way". The Resident reports they "put cream on it daily but

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 686	Continued From page 50	F 686		

here it is 2 o'clock and no one done nothing to it yet. I would get up every day, but I can't get them to put me back to bed when I get to hurting, they will say you have to wait, they have to get someone to come do it."

On 7/10/23, a clinical record review was conducted. This review revealed the treatment had not been performed on 7/9/23, as ordered.

On 7/11/23 at 10:10 AM, an interview was conducted with RN C, the treatment nurse. RN C was asked about Resident #21's sacral pressure ulcer and pain. RN C said, "lately it has redness around it, so I have been putting cream on the peri-wound. She has a stage III; I use lidocaine gel because I know it hurts her".

On 7/11/23 at 10:58 AM, RN C conducted the treatment and dressing of Resident #21's sacral pressure ulcer. Surveyor D observed this and noted there was no dressing on the sacral pressure ulcer when the treatment nurse rolled the Resident to her side. RN C confirmed the findings.

Following the treatment, on 7/11/23 at approximately 11:09 AM, an interview was conducted with Resident #21. Resident #21 reported that her pain was a 5, on a 1-10 pain scale. Resident #21 went on to say, "The pain pill only helps my legs. My bottom really hurts so bag, sometimes I just cry and cry. It gets better then slacks up and goes right on back". Resident #21 reported having pain medication at 6 AM. It looks like they just don't ... [resident hesitated and didn't finish statement] you have to tell them. It is so many different people coming in everyday, it is never the same people".

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 686	Continued From page 51 On 7/11/23, during an end of day meeting, the facility Administrator and Director of Nursing were made aware of the above findings. No further information was provided.	F 686		
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 interview, clinical record review and facility documentation the facility staff failed to ensure Residents received adequate supervision and assistance prevent accidents for 1 Residents (#331) in a survey sample of 61 Residents. Resident #331 who was supposed to be on one-to-one (1:1), went out a second story window and sustained injuries. Immediate Jeopardy was called for Resident #331 on 7/13/23 at 9:10 am. The Immediate Jeopardy began on 6/17/23 and was removed on 7/14/23 at 12:40 PM. The findings included: For Resident #331, the facility staff failed to continuously supervise Resident #331 and as a result, Resident #331 had time to go to her room, shut the door, remove a drawer from her closet, break the window in her room, go out the window,	F 689	F689 1. Resident #331 no longer resides at the facility. 2. All Residents with diagnoses of impaired cognition, mental disorder, depression, bipolar disorder, anxiety disorder, and behaviors requiring interventions were reviewed to determine the need for one-on-one supervision. 3. All staff were educated by Nursing Administration concerning care and services to provide appropriate care of Residents with impaired cognition, mental disorder, depression, bipolar disorder, anxiety disorder, and behaviors requiring intervention. Behaviors requiring one-on-one supervision include but are not limited to agitated pacing, agitated pacing toward any type of exit, knocking	8/17/23

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 689	Continued From page 52	F 689		

and was found on the ground below her second-floor window and sustained a thoracic fracture and intra-cranial bleed.

Resident #331 was admitted to the facility on 6/15/23 with diagnoses that included but were not limited to, Non-Traumatic Intracranial Hemorrhage, Unspecified, Psychological Condition (Unspecified Psychosis) Personal History of Traumatic Brain Injury, Unspecified Protein-Calorie Malnutrition, Restlessness and Agitation.

A review of the discharge summary dated 6/15/23 from the hospital revealed the following excerpts:

"Was evaluated by psychiatry patient lacks capacity to make her own decisions her friends are her medical POA."

"Patient has advanced directives for DNR no PEG or artificial means of nutrition. Continue meds for psychosis increase Seroquel to 50 mg [milligrams] bid [twice a day] add prn [as needed] Zyprexa continue prn Xanax Continue Depakote added by Neurology for seizure prophylaxis and mood stabilization. Family would prefer patient at VA facility and will transition to hospice -no further need for sitter at bedside - continue other supportive care."

On 7/13/23 a review of the clinical record revealed that the following psychotropic medications were ordered at the facility:

Depakote 500 mg twice per day
Seroquel 50 mg twice per day
Haldol 1 mg 3 times per day (began on 6/16/23 at 9:00 PM)

or kicking at doors or windows, physical aggression towards self or others, or objects. Behavior management includes but is not limited to notifying the practitioner of the behaviors, provision of one-to-one supervision, provision of calm, quiet environment, notification of the DON and Administrator, and initiation of emergency management by calling 911 if indicated. One-on-one supervision is defined as staying within direct line of vision of the Resident. All staff were educated that an alternate staff member will provide relief to ensure continuity of the one-on-one supervision. All staff were educated that if a Resident becomes more agitated, staff will initiate emergency management by calling 911.
4. The DON/UM will complete weekly audits times 4 to ensure that Residents with behaviors requiring one-on-one supervision received care and services to meet their needs to include one-on-one supervision. Results of the audits will be reviewed at the QA meeting monthly times 2.
5. Completion date: August 17, 2023

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 689	Continued From page 53	F 689		

Valium 2mg every 12 hours prn
Review of the Medication Administration Record (MAR) showed the Zyprexa and Xanax were not started.

On 7/14/23 at approximately 11:55 AM, an interview was conducted with the DON who stated that the nurse did make a transcription error and did not have all the medications put into the system that were ordered from the hospital.

Resident #331 arrived on 6/15/23 at 5:35 PM and according to the MAR, received her 9 PM dose of Seroquel and Depakote.

The following are excerpts from Resident #331's progress notes:

"6-16-23 at 7:47 AM - Note Text: Multiple behavior issues during the night. Wandering halls and intrusive wandering into other resident rooms. Also, trying to rummage into other resident's belongings. Exit seeking x1 this shift-has wander guard in place & functional. Disrobed completely & was wandering naked x2. Also urinated out in the hallway x1-leaned against linen cart & voided on floor. Numerous attempts to orient to facility & room without success. Also walked up to desk & laid down on floor x2. Also took sheet/blanket, put on floor, and laid down in hallway. Resident currently wandering halls at this time."

"6-16-23 at 11:59 AM Nurse Practitioner Note-Alert, standing in room naked going through another resident's closet, very manic and only able to tell me her name spoke to nurse manager and other staff outside of her door she has been this way since admission and unable to be left

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 689	Continued From page 54	F 689		

alone, requiring 1:1 very close supervision combative, verbally and physically staff currently waiting on police and EMS to transport her back to hospital in hopes to get a TDO [Temporary Detainment Order] because she is unsafe to not only herself but the staff and other resident's needs to be a locked facility"

"6-16-23 at 5:57 PM - Type of Behavior: Resident was naked in roommates' bed, unable to redirect, she became combative with CNA staff and caused a skin tear to her left arm during combative episode. She wanted to get out of room while naked she began to bang on glass window. She was redirected to other areas of the room and the banging stopped.
Non-pharmacological intervention: Writer sat 1:1 at residents' door during psychotic episode to ensure residents safety Effect: Effective till EMS, 911 arrived and they took her to ER for eval PRN Medication: Outcome: NP assessed resident in room during episode, N.O. [new order] for Haldol 1mg sublingual TID x 3days." However, Resident #331 she was not admitted on a TDO and was returned to the facility.

The following are notes included in the discharge summary from the hospital dated 6-16-23.

"6/16/23 at 5:15 PM - "She was put on meds for psychosis including Seroquel and prn Zyprexa and prn Xanax. She was discharged in [sic] a skilled nursing facility; she was sent to the facility due to increased agitation and hit a staff member. However, chair [sic] also reports that patient was standing naked being [sic] her head against the window at the facility. Patient was not given any prn medications by staff at facility."

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 689	Continued From page 55	F 689		

"Our case manager discussed with the case manager at the facility. It seems like they (the facility) did not reach out to the doctor to get any other additional medications to help out with anxiety or agitated behaviors and they can help adjust them."

The following progress note was entered into the facility clinical records about the events that took place when she returned from the hospital on the evening 6/16/23 through the morning of 6-17-23:

"6/17/23 at 9:30 AM - Description of the fall/V/S/injuries if any: Resident came back from hospital at 2300, was assigned a staff all night to watch her. Resident was restless off and on but later started sleeping early this morning at 0500. At 7:15 resident was seen pacing the hallway with her staff, she was agitated and combative, she stated that we won't let her do what she wants, and she said to get ready to call 911, I'm getting out of here. However, I kept following her around, she walked to another hall going into resident rooms exit seeking, banging on doors and windows. Resident stated she will deal with me if I don't get out of her way. Attempted to administer PRN Haldol but she wouldn't take it. Resident ran inside her room and shut the room door up. After 3 mins a call came in from downstairs stating resident was at the backyard. Rushed inside the room, searched for resident could not find her, noted her glass window was broken into pieces, looked downward through the broken window saw her kneeling with both knees while bowing down her head. Rushed downstairs go assess her while I called 911 on the phone. They stated someone already called. On arrival of 911 resident was assessed and collar placed on her neck and was transported to [hospital name redacted] Hospital.

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 689	Continued From page 56	F 689		

What interventions were in place at the time of the fall? 911 was called, resident assessed."

On 7/14/23, an interview was conducted with RN B who worked the evening of 6-16-23 (3-11) and the overnight shift (11-7). When asked to describe the events of the evening and night shift she stated that it was "Just like I put in my notes." She stated that Resident #311 was put on 1:1 supervision from evening shift until morning. She stated that the night shift CNA left at 7 AM and that the Resident was restless on and off all night but fell asleep at around 5 AM. She stated she cannot speak for the day shift CNA, however she knew for sure the night shift CNA stayed with her every step she took. RN B stated in the morning after the night shift CNA left, she (RN B) was trying to report off to the oncoming shift and there were a lot of people around, so she (RN B) did not notice if the assigned day shift CNA was following Resident #311. RN B stated she was trying to give report and in about 2-3 minutes she received a call that Resident #331 had broken the window and, "Fallen down from her second-floor window to grass below her window." RN B stated she then ran down while calling 911. She stated the Resident was alive and breathing but mumbling about some people chasing her. She stated she tried to keep the Resident calm and still until the EMS arrived.

According to a facility synopsis, Resident #331 sustained a thoracic fracture and intra-cranial bleed from the fall.

7/12/23 at 4:23 PM, an interview was conducted via telephone with the CNA D who worked the overnight shift (11 -7 on 6/16/23-6/17/23). CNA D stated that she stayed with the Resident all

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 689	Continued From page 57	F 689		

evening and night until 7 AM. She stated that the Resident was agitated and that she (CNA D) reported off to the day shift CNA that she needed close monitoring. She stated that she left and got on the elevator and the day shift CNA was sitting near the nurse's station watching the Resident from about 20 feet.

Several unsuccessful attempts were made during survey to contact CNA B during survey. CNA B is the agency CNA assigned to 1:1 with Resident #311 during the day shift on 6/17/23.

A review of the as worked schedules for 6-15-23 through 6-17-23 revealed no 1:1 specifically identified on the schedule or assignment sheet. Resident # 311 was in room 207 and was assigned to the CNA covering that hall however there was no staff listed as dedicated 1:1 with Resident #311.

The facility was notified of Immediate Jeopardy on 7/13/2023 @10:30am. The facility presented the following removal plan.

"As of 7/13/23 the facility has reviewed residents with diagnoses of impaired cognition, mental disorder, depression, bipolar disorder, anxiety disorder, and behavior requiring interventions. There are currently no residents requiring one to one supervision."

"Education will be provided by Nursing Administrations to all staff concerning care and services to provide appropriate care of residents with impaired cognition, mental disorders, depression, bipolar disorder, anxiety disorder, and behaviors requiring intervention. Behaviors requiring one to supervision include but are not

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 689	Continued From page 58	F 689		

limited to agitated pacing, agitated pacing toward any type of exit, knocking or kicking at doors or windows, physical aggression towards self or others, or objects. Behavior management includes but is not limited to notifying the practitioner of the behaviors, provision of one-to-one supervision, provision of calm, quiet environment, notification of the Director of Nursing and Administrator, and initiation of emergency management by calling 911 if indicated. One -to-one supervision is defined as staying within direct line of vision of the resident. All staff will be educated that an alternatives staff member will provide relief to ensure continuity of one-to-one supervision. All staff will be educated that if the resident becomes more agitated, staff will initiate emergency management by calling 911."

"All staff on duty have been educated and all staff coming on duty will be educated prior to the next shift."

"Completion date 7/14/23 at 10 AM."

The survey team verified the IJ removal plan as evidenced by the following:

On 7/14/23, at 10 AM, the survey team reviewed the facility's submitted credible evidence that all Residents with diagnosis to include, but not limited to, impaired cognition, mental disorders, depression, bipolar disorder, anxiety disorder, and behaviors requiring intervention, had been reviewed to identify if behaviors warranted one-on-one supervision. There were no Residents identified to need one on one services by the facility staff. The survey team observed all residents and none were observed to have

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 689	Continued From page 59 behaviors requiring intervention. The survey team reviewed the staff education provided to facility staff with regards to Residents with behaviors and how to handle one on one supervision. Staff interviews were conducted of across all departments to verify the education was provided and the staff understood one-on-one supervision and how to respond when Residents displayed behaviors that could warrant initiation of one-on-one supervision. The Immediate Jeopardy was removed on 7/14/23 at 12:40 PM.	F 689		
F 690 SS=G	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary;	F 690		8/17/23

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 690	Continued From page 60 and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility documentation the facility staff failed to provide appropriate treatment to prevent a urinary tract infection for 1 Resident (Resident #21) in a survey sample of 61 Residents resulting in harm. The findings include: For Resident #21, the resident developed a urinary tract infection. This is harm. On 07/09/23 at 01:55 PM, during an interview with Resident #21, the Resident said the facility staff replaced her Foley catheter (a flexible tube that passes through the urethra and into the bladder to drain urine) few days ago, "but something is not right, it hurts, and urine comes from around it". Resident #21 reported that she has told the nurses on several occasions and "They said they were going to come look at it but haven't come back yet". Resident #21 reported that her gown had been saturated with urine that morning from the leakage.	F 690	F690 1. The Foley catheter for Resident #21 has been discontinued and she is free of urinary tract infection. 2. Residents with Foley catheters are at risk and were reviewed to ensure that they are receiving appropriate treatment to prevent infection. Residents with orders for urinalysis were reviewed to ensure timely notification of results to the physician. Residents with Foley catheters were reviewed to ensure accuracy of diagnosis or indication for usage. 3. The SDC/designee will educate all nurses on appropriate care and treatment of Foley catheter use to include notifying the physician of leakage and absence of urine in the collection bag as well as measures to prevent infection with use of a Foley catheter. The SDC/designee will educate all CNAs to report leakage from a Foley catheter or the absence of urine in the collection bag. The SDC/designee will educate all nurses on timely notification of	

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 690	Continued From page 61 On 7/9/23 at approximately 2 PM, an interview was conducted with LPN G. LPN G confirmed that Resident #21's gown had been wet with urine that morning. LPN G said that there was urine in the catheter drainage bag, and she had advised the Resident and staff to let her know if they noted any further leakage. On 7/9/23, during the end of day meeting, the facility Administrator and Director of Nursing were made aware that Resident #21 was reporting pain at her urinary catheter and leakage. On 7/10/23 at 8:44 AM, an interview was conducted with Resident #21. Resident #21 reported the following when asked about her catheter, "They changed it last night." On 7/11/23 at 10:58 AM, Surveyor D made an observation of Resident #21's sacral wound, with RN C, the treatment nurse. During this observation, it was noted that a towel was between Resident #21's legs. When asked, Resident #21 reported that the catheter was still leaking. On 7/11/23 at approximately 11:09 AM, an interview was conducted with Resident #21. Resident #21 reported that the catheter "isn't hurting like it was, but it feels like it is pulling". Resident #21 went on to report, "they got some urine out of the bag to send to the lab, but they haven't told me the results yet". Resident #21 reported she has had the catheter for "a long time. They claim it was because I was staying wet and it was interfering with my bottom [wound on her sacrum], I've got the catheter in and I'm still wet".	F 690	urinalysis results to the physician. The SDC/designee will educate all nurses on accuracy of diagnosis/indication for usage of Foley catheters. 4. The UM/designee will audit Foley catheter usage on a weekly basis times 4 to ensure that appropriate treatment is provided to prevent infection and that the diagnosis/indication for usage is accurate. The UM/designee will audit physician notification of results of urinalysis weekly times 4 to ensure notification was timely. Results of the audits will be reviewed at the QA meeting on a monthly basis times 2. 5. Completion date: August 17, 2023	

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 690	Continued From page 62	F 690		

On 7/11/23 at approximately 11:15 AM, Surveyors C and D talked with LPN G, who was assigned to care for Resident #21. LPN G confirmed that the Resident's gown had been saturated with urine that morning and they were waiting on the results from the urine sample.

On 7/10/23 and 7/11/23, a clinical record review was conducted. Review of Resident #21's diagnosis revealed a diagnosis of neuromuscular dysfunction of bladder, but no physician notes made mention of this diagnosis and no urology notes could be found. This review revealed that preliminary results of the urine sample were available. The results had been reported to the facility at on 7/10/23 at 7:39 PM. The results were indicative of the urinary tract infection as noted by, having "turbid clarity, specific gravity of 1.006, 500 Leuk Esterase, 2+ nitrite, 3+ blood, 3+ urine bacteria, WBC [white blood count] of 21-50, and amorphous crystals present".

On 7/11/23, in the afternoon, interviews were conducted with LPN D, LPN E and LPN G. When asked about the process for labs, all of them indicated the labs are reported/loaded directly into the clinical record of each Resident and the providers [doctor and/or nurse practitioner] looks at them and will put in any orders they have". Each of the nurses interviewed indicated they do not monitor to see when results come back and notify the provider, it is the providers responsibility to check for results, except in the instance of the lab result being critical, in which case the lab will call the facility and the facility nurse will then call the provider.

During the above interview with LPN G, Surveyor

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 690	Continued From page 63	F 690		

C asked the nurse to see if Resident #21 had any labs. LPN G accessed the clinical chart and noted, "She has a urine culture to be reviewed, the doctor will review it. She is growing something; it usually takes 3 days for the culture and sensitivity to come back".

On 7/11/23 at 1:22 PM, an interview was conducted with Employee D, one of the doctors at the facility and the attending physician of Resident #21. The doctor was asked about the process for lab results. The doctor said, "The nurse will call us if the result is positive". The doctor was asked about why Resident #21 had a urinary catheter and he said it was for wound healing.

On 7/11/23, during the end of day meeting, the facility Administrator and Director of nursing were made aware that the urine lab report for Resident #21 had been received on the evening of 7/10/23, and no action had been taken despite the Resident continuing to report pain and discomfort. The urine report/result was noted to be in a status of "to be reviewed".

During the end of day meeting on 7/11/23, the director of nursing explained that having a urinary catheter must be handled with care because Residents are at an increased risk of infection. The facility staff were also asked to provide any supporting documentation with regards to the diagnosis of neuromuscular dysfunction of bladder when this diagnosis was made and by whom.

On the morning of 7/12/23, the facility staff reported that Resident #21 had been started on an antibiotic and the Foley catheter had been

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 690	Continued From page 64 removed. They also stated that Resident #21 had the Foley due to a sacral pressure wound and the diagnosis of neuromuscular dysfunction of bladder had been entered into her diagnosis listing in error. On 7/12/23, the urine culture report noted, ">100,000 CFU/ML Lactose fermenting gram negative rods, result: Escherichia coli (E-Coli)". (E-Coli is a bacteria that can cause diarrhea, urinary tract infections, respiratory illness and pneumonia, and other illnesses.) On 7/13/23 during the end of day meeting, the DON and Administrator were made aware of the above findings and no further information was provided.	F 690		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on Resident interview, staff interview, clinical record review and facility documentation review, the facility staff failed to ensure pain management was provided to 1 Resident (Resident #21) in a survey sample of 61 Residents. The findings included: For Resident #21, who reported pain from a	F 697	F697 1. Resident #21 is receiving ordered routine pain management and is offered prn pain medication as ordered. 2. All current residents have the potential to be affected and will be assessed to ensure adequate pain management. 3. The SDC/designee will educate all nurses on provision of routine pain	8/17/23

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 697	Continued From page 65 sacral pressure ulcer and a Foley catheter, the facility staff failed to respond to a physician order for an increase in pain medication and to pre-medicate prior to dressing changes and failed to notify the physician of the catheter pain. On 07/09/23 at 01:55 PM, during an interview with Resident #21, the Resident said the facility staff replaced her Foley catheter (a flexible tube that passes through the urethra and into the bladder to drain urine) few days ago, "but something is not right, it hurts, and urine comes from around it". Resident #21 reported that she has told the nurses on several occasions and "They said they were going to come look at it but haven't come back yet". Resident #21 also reported having a sacral wound that hurts. On 7/9/23, in the afternoon, an interview was conducted with LPN G. LPN G stated she was aware of Resident #21 reporting discomfort and leaking from her catheter but had not notified the doctor. On 7/11/23 at 10:10 AM, an interview was conducted with RN C, the treatment nurse. RN C was asked about Resident #21's sacral pressure ulcer and pain. RN C said, "lately it has redness around it, so I have been putting cream on the peri-wound. She has a stage III; I use lidocaine gel because I know it hurts her." On 7/11/23 at 10:58 AM, RN C conducted the treatment and dressing of Resident #21's sacral wound. Surveyor D observed this. Following the treatment, on 7/11/23 at approximately 11:09 AM, an interview was conducted with Resident #21. Resident #21	F 697	medications, offering of prn pain medications, and physician notification of new complaints of pain. 4. The UM/designee will audit provision of pain medications for all Residents and new complaints of pain to ensure physician notification on a weekly basis times 4. The UM/designee will interview 5 Residents per week to evaluate pain management. Results of the audits and interviews will be reviewed at the QA meeting times 2. 5. Completion date: August 17, 2023	

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 697	Continued From page 66	F 697		

reported that her pain was a 5, on a 1-10 pain scale. Resident #21 went on to say, "The pain pill only helps my legs. My bottom really hurts so bag, sometimes I just cry and cry. It gets better then slacks up and goes right on back". Resident #21 reported having pain medication at 6 AM. It looks like they just don't ... [resident hesitated and didn't finish statement] you have to tell them. It is so many different people coming in everyday, it is never the same people".

On 7/10/23 and 7/11/23, a clinical record review was conducted. This review revealed a progress note from the physician dated 6/30/23, that read, "advised to see her as her pain is not under control on dressing change on back". The note also stated, "...since her pain is worse only on dressing change advised to give her 2 tablets before the dressing change, patient agrees, c/w [continue with] other meds".

A nursing progress note was written that read, "Updated on residents pain management, r/t [related to] wound increase pain during wound care. Dr [physician's name redacted] ordered extra Norco and sacral x-ray".

Review of the physician orders revealed an order for "Hydrocodone-Acetaminophen Oral Tablet 5-325 MG (Hydrocodone-Acetaminophen) Give 1 tablet by mouth four times daily". Review of the narcotic sheet revealed the medication was being given as 1 pill, four times daily. The MAR [medication administration record] confirmed the same. There was no indication that the increase in dosage prior to dressing changes had been carried out.

On 7/11/23 at approximately 2:15 PM, an

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 697	Continued From page 67	F 697		

interview was conducted with LPN G. LPN G stated, "She [Resident #21] gets pain meds at 12 midnight, 6 AM, 12 noon, 6 PM, scheduled". When asked if they coordinate the pain medications with when her wound care is performed, LPN G said, "most of the time the wound nurse has her routine and does it close to the same time each day and we give the pain meds as ordered at 12, 6, 12 and 6".

LPN G was asked to access Resident #21's chart and read the progress note from the doctor dated 6/30/23. LPN G read the note and said, "I don't know who he told, I don't know if he talked with the treatment nurse". LPN G confirmed she was not aware of the increase in pain medication and order to be pre-medicated prior to wound care.

Review of the facility policy titled "Physician's orders" was conducted. This policy only discussed admission orders and didn't address order changes during the Resident's stay.

On 7/11/23, during an end of day meeting, the facility Administrator and Director of Nursing were made aware of the above findings.

On 7/12/23 at 10 AM, the facility Administrator and Director of nursing reported to the survey team that Resident #21's urinary/Foley catheter had been discontinued/removed, an antibiotic started, and the pain medication order had been transcribed. They went on to indicate they had determined which nurse had failed to carry out the change/increase in pain medication order and said, "She feels horrible".

No further information was provided.

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 698	Continued From page 68	F 698		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility menu review, the facility failed to coordinate services and provide meals and snacks for one of two sampled residents (Resident (R) 7) reviewed for dialysis and received dialysis treatments at an outside dialysis center. Findings include: Review of R7's "Admission Record," located under the "Profile" tab in the resident's electronic medical record (EMR) revealed R7 was admitted to the facility with diagnoses which included end stage renal disease (ESRD), prediabetes, and dependent on renal dialysis. Review of R7's "Physician Orders," located under the "Orders" tab in the resident's EMR, revealed current orders for R7 to receive hemodialysis on Monday, Wednesday, and Friday at 6:30 AM and to receive a renal diet. Review of R7's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 06/06/23, located in the resident's EMR, specified the resident received dialysis. The resident had a "Brief Interview for Mental Status	F 698	F698 1. Resident #7 is receiving a bagged meal with preferred foods and foods within the ordered diet to take with her to dialysis treatments. 2. Residents receiving dialysis treatments are at risk. 3. The SDC/designee will educate all nurses and CNAs on ensuring provision of bagged meal for Residents going to outside dialysis treatment. The Dietary Department will be educated by the SDC/designee on ensuring availability of bagged meals per Resident preference and according to the ordered diet for Residents going to outside dialysis treatment. 4. The UM/designee will audit Residents going to outside dialysis treatments weekly times 4 to ensure that a bagged meal with preferred foods and foods per the ordered diet was provided. Results of the audits will be reviewed at the QA meeting on a monthly basis times 2. 5. Completion date: August 17, 2023	8/17/23

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 698	Continued From page 69	F 698		

(BIMS)" score of 15 of 15, which indicated the resident was cognitively intact.

Review of R7's current care plan, located in the EMR under the care plan tab, revealed a "Focus" area initiated on 12/14/22, that specified, "Increased risk for complications secondary to requiring dialysis secondary to ESRD." The care plan's goal specified "[No] complications secondary to requiring dialysis thru review period." Care plan approaches included, "Therapeutic diet as ordered" and "Pack lunch or snacks to be sent with the resident to dialysis as needed."

Review of the facility's planned breakfast menu for 07/10/23 revealed a resident ordered to receive a renal diet was planned to be served the following: four ounces of apple juice, four ounces of hot cereal, two ounces of scrambled eggs, one slice of toasted white bread and four ounces of skim milk.

During an interview on 07/09/23 at 2:40 PM, R7 stated she was transported from the facility to her dialysis treatments every Monday, Wednesday, and Friday. R7 explained that on the days she received dialysis treatments, she left the facility between 6:15 AM to 6:30 AM. R7 stated prior to leaving the facility for dialysis she was not always served a breakfast meal. The resident stated when she was provided something to eat prior to going to dialysis it was usually something she did not like to eat, so she did not eat it. R7 stated when she returned to the facility at around 11:30 AM to 12:00 PM after her dialysis treatment she was hungry because she did not eat any breakfast.

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 698	Continued From page 70	F 698		

An additional interview with R7 on 07/10/23 at 6:07 AM revealed she was leaving her room to go for her dialysis treatment and had not received her breakfast meal.

Observation on 07/10/23 at 6:17 AM revealed R7 was seated in her wheelchair near the nurse's station when a nurse offered her a Styrofoam container. R7 was observed to look inside the container and stated that she could not eat any of the food and left the container at the nurse's station.

Interview with R7 on 07/10/23 at 6:18 AM revealed the items in the Styrofoam container were all too sweet and would "run her sugar up," so she could not eat any of it. Observation of the contents of the Styrofoam container revealed it contained a carton of whole milk, raisin bran cereal, yogurt, fruit punch, apple sauce, and a banana.

Observation on 07/10/23 at 6:22 AM revealed a nurse provided R7 with her "dialysis bag." R7 was observed to look through the bag and take out a bottle of water and hand the bag back to the nurse. R7 stated that she did not like anything in the bag except the water, because the other food and beverage in the bag were too sweet.

Observation on 07/10/23 at 6:30 AM, revealed R7 exited the facility and was assisted onto the transport van by the van driver for transport to her dialysis treatment. R7 had the bottle of water from her "dialysis bag" but did not take any food with her to the dialysis center.

Observation on 07/10/23 at 6:37 AM, of the remaining contents of R7's "dialysis bag," with 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 _____	C 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 698	Continued From page 71 Dietary Manager (DM) present, revealed it contained a peanut butter and jelly sandwich, 2 fig bars, apple sauce and cranberry juice. During an interview on 07/10/23 at 6:40 AM, the Dietary Manager (DM) stated a resident's "dialysis bag" contained food and beverages the resident was to take with them to their dialysis treatments. The DM was informed that R7 only took the bottle of water from her dialysis bag to her dialysis treatment this morning because the other food and beverage were too sweet. The DM stated that she discussed food preferences with residents, but not necessarily what foods and beverages they preferred to receive in their dialysis bags. During an interview on 07/11/23 at 2:15 PM, the DM stated prior to R7 leaving the facility for her early morning dialysis treatment on Monday, Wednesday, and Friday she should be served a breakfast meal as planned on the facility menu. The DM confirmed there were mornings when R7 was not served a breakfast meal before she left the facility for her dialysis treatment. The DM explained the kitchen opened at 5:30 AM and the dietary staff were to prepare R7 a breakfast meal as specified on the facility menu. But there were mornings when the nurse aides did not come to the kitchen to pick up R7's breakfast meal until after R7 had left the facility for her 6:30 AM dialysis treatment.	F 698		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily	F 732		8/17/23

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 732	Continued From page 72 basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility failed to post the current Nurse Staffing Information. This had the potential to affect all 123 residents residing in the facility.	F 732	F732 1. Current nurse staffing information is being posted for public review. 2. All Residents have the potential to be	

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 732	Continued From page 73 Findings include: Observation during the initial tour in the lobby area of the facility on 07/09/23 at 11:30 AM, revealed the posted Nursing Staffing Schedule was dated July 6, 2023. On 07/10/23 at 6:00 AM, the second day of the survey, in the lobby area, the Nursing Staffing Schedule was still dated July 6, 2023. An interview with the Unit Clerk on 07/10/23 at 10:25 AM was conducted. The Unit Clerk stated that the person who does the schedule posting had called-out sick on July 7, 2023. The Unit Clerk stated that she is the back-up to doing the Posted Nursing Staffing. "It was not done because I did not know that the person was out sick."	F 732	affected. 3. The SDC/designee educated the scheduler and unit clerk on posting of the nurse staffing information for public review. 4. The UM/designee will audit posting of nurse staffing information weekly times 4 to ensure that the information has been posted for public review. Results of the audits will be reviewed at the QA meeting on a monthly basis times 2. 5. Completion date: August 17, 2023	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs	F 758		8/17/23

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 758	Continued From page 74 unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview, clinical record review and facility documentation, the facility staff failed to ensure Residents are free from unnecessary psychotropic medications for 1 Resident (#63) in a survey sample of 61 Residents. The Findings included:	F 758	F758 1. The order for prn Ativan for Resident #63 has been discontinued. 2. Residents with orders for prn psychoactive medications are at risk and have been reviewed to ensure that the medication is ordered for 14 days, or 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 _____	C 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 758	Continued From page 75 For Resident #63 the facility staff failed to ensure PRN anti-anxiety medications were not for more than 2 weeks without the proper physician's documentation. On 7/12/23, a review of the clinical record revealed that Resident #63 had orders that included Buspirone HCL 15 mg (milligrams) three times a day for anxiety as well as a PRN order for Ativan 0.5 mg (an anti-anxiety drug) that was written on 5/1/2023. On 7/12/23 at approximately 11:00 AM an interview was conducted with LPN E who stated that Buspirone HCL was given routinely for anxiety. When asked what Ativan was for, she sated it was also for anxiety and agitation. She further elaborated that some Residents become agitated when they are anxious, so they need something extra like a PRN Ativan to help control the agitation. On 7/12/23 at approximately 10:00 AM an interview was conducted with the DON who was asked if she was aware of the regulation regarding PRN anti-anxiety medications such as Ativan. She indicated that she was aware that it could only be a 14-day order and had to be reevaluated by the physician and reordered after that if he wanted it to continue. When asked if she was aware that Resident #63 had an order for Ativan that was from 5/1/23 she stated that she was not. On 7/13/23 during the end of day meeting the Administrator was made aware of the concerns and no further information as provided.	F 758	physician has extended the medication order with documentation of the need to extend. 3. The SDC/designee will educate nurses that prn psychoactive medications must be ordered for 14 days or have physician documentation of the need to extend the usage. 4. The UM/designee will monitor prn psychoactive medication orders weekly times 4 to ensure that there is a stop date of 14 days or physician documentation of the need to extend usage. Results of the audits will be reviewed at the QA meeting on a monthly basis times 2. 5. Completion date: August 17, 2023	

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 761	Continued From page 76	F 761		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, clinical record review and facility documentation the facility staff failed to store medications in a secure location on 1 of 2 nursing units. The findings included: The facility staff failed to ensure medications were stored in a secure location so that only	F 761	F761 1. Resident #46□s Symbicort will be administered and stored by the nurses. Resident #119 has been provided a lock box for storage of the medicated mouth wash for self-administration. 2. All Residents have the potential to be affected. Residents who self-administer medications were reviewed to ensure that	8/17/23

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 761	Continued From page 77 persons authorized had access to the medications. On 07/09/23 at 02:24 PM, Surveyor C observed a Symbicort inhaler at the bedside of Resident #46. On 7/9/23 at 2:25 PM, an interview was conducted with Resident #46. When asked about the inhaler, the Resident said, "I use it every morning". During the end of day meeting held on 7/9/23, the facility staff were notified of the above observation. On 07/10/23 at 09:14 AM, it was noted that the facility staff had removed the Symbicort inhaler. Resident #46, reported, "they took it out". On 7/12/23 at approximately 10:00 AM, Resident #119 was noted to have Chlorhexidine Gluconate mouthwash at the sink in the room, unsecured. On 7/12/23 at approximately 10:05 AM, an interview was conducted with Resident #119. The Resident reported she has been using the medication for several weeks and uses after every episode of brushing her teeth. The Resident further reported she has always kept it in her room. A review was performed of the facility policy titled, "Storage of Medications". An excerpt from the policy read, "... 2. Only licensed nurses, pharmacy personnel, and those lawfully authorized to administer medications (such as medication aides) are permitted to access medications. Medication rooms, carts, and medication supplies are locked when they are not	F 761	a lock box has been provided for appropriate storage. 3. The SDC/designee will educate nurses on provision of a lock box for storage of medications self-administered by Residents. 4. The UM/designee will audit Residents who self-administer medications on a weekly basis times 4 to ensure that appropriate storage is provided. Results of the audits will be reviewed at the QA meeting monthly times 2. 5. Completion date: August 17, 2023	

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 761	Continued From page 78 attended by persons with authorized access...". On 7/9/23 and again on 7/12/23, during the end of day meetings, the Administrator and Director of Nursing were made aware of the above concerns with Residents having unsecured medications at the bedside. No further information was provided.	F 761		
F 802 SS=F	Sufficient Dietary Support Personnel CFR(s): 483.60(a)(3)(b) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.60(a)(3) Support staff. The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. §483.60(b) A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in § 483.21(b)(2)(ii). This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the facility's meal schedule, and facility policy review, the facility failed to have sufficient dietary staff to assure food was prepared, served, and stored in a sanitary and safe manner. Kitchen food	F 802	F802 1. The facility currently has sufficient Dietary staff. 2. Residents who eat meals served from the facility kitchen have the potential to be	8/17/23

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 802	Continued From page 79 preparation, service equipment and floors were not kept cleaned and sanitized. Dietary staff failed to cover stored food, discard hot dog buns with mold growth and serve milk from the kitchen tray line at a temperature of 41 degrees Fahrenheit or below. Additionally, there were not sufficient dietary staff to ensure resident meals were served as scheduled. The lack of dietary staff had the potential to affect 115 residents who consumed meals that were prepared from the kitchen. Findings include: Review of the facility's undated policy titled, "Resident Meal Times," revealed, the resident breakfast meal service for the first and second floor was scheduled to begin at 7:30 AM, the resident lunch meal service for the first and second floor was scheduled to begin at 12:30 PM, and the evening meal service for the first and second floor was to begin at 5:30 PM. The facility's "Resident Meal Times" policy did not provide specific times when meals were scheduled to conclude. 1. Observation during the initial kitchen walk-through on 07/09/23 from 12:00 PM to 12:45 PM revealed the kitchen was not clean. Kitchen food preparation and service equipment, food preparation pans, shelves, and floors were unclean. Opened food was not covered when stored and hot dog buns were molded. Additionally, dietary staff failed to serve milk from the tray line at an internal temperature of 41 degrees Fahrenheit or below. Cross-reference F812.	F 802	affected. 3. The Administrator/designee will educate Dietary staff on notifying the Dietary Manager of staffing issues and the need for additional coverage. The Dietary Manager will develop a plan of coverage to supplement staffing needs. 4. The Administrator/designee will monitor dietary staffing on a weekly basis times 4. Results of the audit will be reviewed at the QA meeting on a monthly basis times 2. 5. Completion date: August 17, 2023	

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 802	Continued From page 80	F 802		

2. Observation on 07/09/23 at 12:00 PM revealed there were only two dietary employees working in the kitchen, which included Cook (C)1 and Dietary Aide (DA)1.

During an interview on 07/09/23 at 12:00PM, C1 stated they were behind schedule with the resident meal service because they were working "short staffed" today. C1 explained four dietary employees should be working in the kitchen at this time to assist with preparation and service of resident meals, but he and DA1 were the only two employees working today. C1 also specified the resident lunch meal was scheduled to begin at 12:30 PM, but they were running behind schedule and the meal would be served late. C1 stated there were a total of six meal delivery carts that staff would fill with resident lunch meals and deliver to the facility's first and second floors.

Observations on 07/09/23 at 12:50 PM revealed C1 and DA1 started to serve resident lunch meals from the kitchen tray line for residents on the second floor. At 1:00 PM DA2 was observed to enter the kitchen and assisted with preparing resident meal trays on the tray line.

Observation during the lunch meal of 07/09/23, of the six meal delivery carts leaving the kitchen and arriving to the hallways revealed the following resident meals were delivered later than scheduled:

On 07/09/23 at 1:07 PM the first resident meal cart left the kitchen and arrived on the second floor at 1:10 PM.

On 07/09/23 at 1:32 PM the second resident meal cart left the kitchen and arrived on the second

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 802	Continued From page 81	F 802		

floor at 1:33 PM.

On 07/09/23 at 1:50 PM the third resident meal delivery cart left the kitchen and arrived on the second floor at 1:52 PM.

On 07/09/23 at 2:05 PM the fourth resident meal delivery cart left the kitchen and arrived on the first floor at 2:05 PM.

On 07/09/23 at 2:22 PM the fifth resident meal delivery cart left the kitchen and arrived on the first floor at 2:22 PM.

On 07/09/23 at 2:35 PM the sixth resident meal delivery cart left the kitchen and arrived on the first floor at 2:35 PM.

3. Observations during the breakfast meal of 07/10/23, of the six meal delivery carts leaving the kitchen and arriving to the hallways revealed the following resident meals were delivered later than scheduled:

On 07/10/23 at 7:50 AM the first meal cart left the kitchen and arrived on the second floor at 7:52 AM.

On 07/10/23 at 8:03 AM the second meal cart left the kitchen and arrived on the second floor at 8:05 AM.

On 07/10/23 at 8:18 AM the third meal cart left the kitchen and arrived on the second floor at 8:20 AM.

On 07/10/23 at 8:32 AM the fourth meal cart left the kitchen and arrived on the first floor at 8:32

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 802	Continued From page 82	F 802		

AM.

07/10/23 at 8:48 AM the fifth meal cart left the kitchen and arrived on the first floor at 8:48 AM.

On 07/10/23 at 9:02 AM the sixth meal cart left the kitchen and arrived on the first floor at 9:02 AM. At 9:05 am staff were observed to start serving resident meal trays from this cart. At 9:15 AM staff were observed to serve the last meal tray from this cart to R126.

4. Review of R126's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/27/23, located in the resident's electronic medical record (EMR) under the MDS tab revealed a (Brief Interview for Mental Status (BIMS) score of 15 of 15, which indicated the resident was cognitively intact.

During an interview on 07/10/23 at 11:46 AM, R126 stated resident meals were served later than scheduled. R126 stated on 07/10/23 she received her breakfast meal at 9:15 AM and breakfast was usually not served until 9:00 AM or later. R126 stated she would prefer to receive her breakfast between 8:00 AM to 8:30 AM. R126 also stated sometimes lunch was not served until after 2:00 PM which she stated occurred on 07/09/23. R126 stated she would prefer to receive her lunch meal much earlier, between 12:30 PM and 1:00 PM.

5. Review of R7's quarterly " MDS" with an ARD of 06/06/23, located in the resident's EMR under the "MDS" tab revealed a "BIMS" score of 15 of 15, which indicated the resident was cognitively

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 802	Continued From page 83	F 802		

intact.

During an interview on 07/09/23 at 2:40 PM, R7, who resided on the facility's first floor, stated meals are served late. R7 explained she wondered if she was going to receive a lunch meal today because she waited, and waited, and her lunch was finally served after 2:30 PM. R7 stated she would prefer for her lunch meal to be served at around 1:00 PM each day.

6. A group interview meeting was conducted on 07/10/23 at 3:00 PM with six residents whom the facility identified as reliable historians. During the meeting, five of the six residents (R42, R82, R85, R95, and R98) voiced complaints about their meals being served later than scheduled. The residents stated on some days their breakfast was not served until 9:00 AM or later and their lunch was not served until 2:00 PM or later.

During an interview on 07/09/23 at 3:20 PM, the Dietary Manager (DM) stated the dietary department currently had three vacant positions which included two cooks and one DA. The DM stated the department had not been fully staffed in a while and she had to work in the kitchen to cover some of the vacant positions. The DM explained when the kitchen was not fully staffed it is very hard to get everything done including the kitchen cleaning duties and to prepare and serve resident meals on time. The DM stated when the kitchen was fully staffed there would be four staff scheduled to work during the morning/afternoon shift and three staff scheduled to work during the afternoon/evening shift. The DM explained when fully staffed the schedules of these seven employees overlapped, and at 1:00 PM there

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 802	Continued From page 84 would be seven scheduled employees working in the kitchen. During an interview on 07/11/23 at 2:15 PM, the DM stated the kitchen has worked "shorthanded" since May 2023. The DM stated the resident breakfast meal service should conclude between 8:30 AM to 8:45 AM, the resident lunch meal service should conclude between 1:30 PM and 1:45 PM and the resident evening meal service should conclude between 6:30 PM to 6:45 PM. During an interview on 07/12/23 at 4:35 PM, C1 stated the kitchen needed more staff to complete cleaning duties to keep the kitchen clean and to serve resident meals on time.	F 802		
F 804 SS=F	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview, tasting of food served on a requested test tray, record review, and facility policy review, the facility failed to serve food that was palatable and hot to 10 of 12 sampled residents (Resident (R)7, R42, R47, R82, R85, R95, R98, R102, R123 and R126) reviewed for food palatability.	F 804	F804 1. Residents #7, 42, 47, 82, 85, 95, 98 102, 123, and 126 are receiving food at appropriate temperatures and palatable taste. 2. Residents who eat meals served from the facility kitchen have the potential to be affected.	8/17/23

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 804	Continued From page 85 Findings include: Review of the facility's undated policy titled, "Food Temperatures," revealed, "Food should be transported as quickly as possible to maintain temperatures for delivery and service. If food transportation time is extensive, food should be transported using a method that maintains temperatures (i.e. hot/cold carts, pellet systems, insulated bases and domes, etc.)." 1. Review of R7's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 06/06/23, located in the resident's EMR under the "MDS" tab revealed a "Brief Interview for Mental Status (BIMS)" score of 15 of 15, which indicated the resident was cognitively intact. During an interview on 07/09/23 at 2:40 PM, R7 stated the food served at the facility was not hot and did not taste good to her. 2. Review of R47's quarterly MDS with an ARD of 06/13/23, located in the resident's EMR under the MDS tab revealed a BIMS score of 15 of 15, which indicated the resident was cognitively intact. During an interview on 07/09/23 at 5:15 PM, R47 stated the facility's food did not taste good, and lacks flavor. The resident stated the mashed potatoes taste like they were made with water and the food was not hot when served. 3. Review of R82's quarterly MDS with an ARD of 06/01/23, located in the resident's EMR under the	F 804	3. The SDC/designee will educate all nurses and CNAs on serving of meals when the trays are delivered to the floor to ensure appropriate temperatures. The Dietary Manager/designee will educate all Dietary staff on ensuring that recipes are followed to ensure that the food is cooked and seasoned correctly. 4. The Administrator/designee will monitor the delivery of food weekly times 4 to ensure appropriate temperatures are served. The Administrator/designee will interview 5 residents weekly times 4 to ensure that food is palatable. 5. Completion date: August 17, 2023	

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 804	Continued From page 86	F 804		

MDS tab revealed a BIMS score of 15 of 15, which indicated the resident was cognitively intact.

During an interview on 07/09/23 at 4:57 PM, R82 stated the food served at the facility was cold when served at meals, did not taste good, and all meals (breakfast, lunch, and evening meal) were about the same.

4. Review of R102's annual MDS with an ARD of 03/29/23, located in the resident's EMR under the MDS tab revealed a BIMS score of 15 of 15, which indicated the resident was cognitively intact.

During an interview on 07/09/23 at 4:28 PM, R102 stated the food served at the facility was not hot and did not taste good when served at meals.

5. Review of R126's admission MDS with an ARD of 06/27/23, located in the resident's EMR under the MDS tab revealed a BIMS score of 15 of 15, which indicated the resident was cognitively intact.

During an interview on 07/10/23 at 11:46 AM, R126 stated she did not like the food the facility served at meals. The resident specified the food is bland, most of the time it is cold, the meat is tough, and vegetables are overcooked.

6. A group interview meeting was conducted on 07/10/23 at 3:00 PM with six residents whom the facility identified as reliable historians. During the meeting, five of the six residents (R42, R82, R85,

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 804	Continued From page 87	F 804		

R95, and R98) voiced complaints about the food. The residents stated the food the facility served at meals did not always taste good and was not always hot.

In response to resident complaints about food, a test tray was requested to be sent to the facility's hallway which included Rooms 100 to 110 for the breakfast meal of 07/12/23. Observations revealed before the tray cart left the kitchen at 8:44 AM temperature monitoring of food being served from the kitchen's tray line was at acceptable levels, of greater than 140 degrees Fahrenheit. The meal trays were placed on an enclosed cart with no heating element. The meal cart with the test tray was observed to arrive to the hallway (Rooms 100 to 110) at 8:45 AM. Staff was observed to complete the resident meal pass for this hallway at 8:57 AM. However, observations on 07/12/23 at 8:57 AM revealed multiple unserved resident meals were still on the meal delivery cart that was on the hallway for resident Rooms 123 to 133.

During an interview on 07/12/23 at 8:57 AM, the DM stated the resident meal trays for the hallway (Rooms 123 to 133) left the kitchen approximately at 8:30 AM which was 15 minutes earlier than the meal cart (Rooms 100 to 110) that contained the test tray. The DM stated staff should have already served the resident meals to residents who resided in Rooms 123 to 133 to keep their food hot. The DM stated she did not know why these resident meals were not served by staff.

On 07/12/23 at 8:58 AM the DM transferred the test tray to the meal cart, with unserved resident meal trays, on the hallway for Rooms 123 to 133.

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 804	Continued From page 88 Observations on 07/12/23 at 9:05 AM revealed staff completed the meal pass on this hallway (Rooms 123 to 133). At this time, the test tray was sampled in the presence of the facility's Dietary Manager (DM). Observation and tasting of the food revealed the following: The scrambled eggs served on the test tray tasted barely warm. The DM tasted the scrambled eggs and confirmed the eggs were not hot. During an interview on 07/12/23 at 3:30 PM, the Director of Nurses (DON) stated staff should serve resident meals in the order the meal carts were delivered to the hallways from the kitchen. The DON explained it should be "All hands-on deck" and staff were expected to promptly serve resident meal trays when they arrived on the hallway so resident meals were hot when served. During an interview on 07/12/23 at 4:35 PM, Cook (C)1 stated the kitchen had standardized recipes available for all menu items and the cooks were expected to use recipes when they prepared resident meals to ensure food was cooked and seasoned correctly.	F 804		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar	F 806		8/17/23

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 806	Continued From page 89 nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to honor the food preferences for three of six sampled residents (Resident (R) 42, R82, and R95) reviewed for choices. Findings include: Review of R82's electronic medical record (EMR) revealed a quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 06/01/23 located under the "MDS" tab. The assessment recorded a "Brief Interview for Mental Status (BIMS)" score of 15 of 15 for R82, which indicated the resident was cognitively intact. An observation on 07/10/23 at 8:53 AM, revealed R82 was eating breakfast in her room. Observation of the resident's breakfast meal revealed she was served grits, one hard-boiled egg, hash browns, half of a banana, orange juice and coffee on her tray. Review of the resident's tray slip, that was provided with this meal, revealed the resident's breakfast preferences included cold cereal, two hard boiled eggs and two eight-ounce waters that were not served on her meal tray. During an interview on 07/10/23 at 8:55 AM, R82 stated the kitchen does not honor her food preferences. R82 stated she would not eat the grits she received because she preferred cold cereal at breakfast, and she requested two hard	F 806	F806 1. Residents #42, 82, and 95 are receiving food according to their preferences. 2. Residents who eat meals served from the facility kitchen have the potential to be affected. 3. The Dietary Manager/designee will educate Dietary staff on provision of food on meal trays according to Resident preferences as listed on the tray slip. 4. The Administrator/designee will audit meal trays weekly times 4 to ensure that foods are served according to preferences listed on the tray slip. Results of the audits will be reviewed at the QA meeting on a monthly basis times 2. 5. Completion date: August 17, 2023	

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 806	Continued From page 90 boiled eggs at breakfast but was only served one at this meal. R82 stated the kitchen often does not serve her preferred foods and beverages that are listed on her tray slip at meals. During a group interview on 07/10/23 at 3:00 PM, with six residents whom the facility identified as reliable historian, revealed three of the six residents (R42, R82, and R95) specified their food preferences were not honored at mealtimes. These residents stated they were served food at meals they previously informed staff they did not like to eat and at times were not served food they previously requested to receive at meals. During an interview on 07/12/23 at 4:10 PM, the Dietary Manager (DM) stated when a resident was admitted to the facility, staff obtain the resident's food and beverage preferences. These preferences were entered into the computer so they would print on the resident's meal tray slip and staff should honor these preferences when they prepare the resident's meal tray. The DM reviewed R82's food and beverage preferences and confirmed R82 should have been served cold cereal, two hard boiled eggs and water with her 07/10/23 breakfast meal.	F 806		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(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	F 812		8/17/23

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 812	Continued From page 91 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. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review, the facility failed to cover stored food, discard hot dog buns with mold growth, keep kitchen equipment and areas clean including the dry storage can rack, food preparation pans, and floors, and serve milk from the tray line at an internal temperature of 41 degrees Fahrenheit (F.) or below. This failure had the potential to affect all 115 residents who consumed food prepared from the facility's kitchen. Findings include: Review of the facility's undated policy titled, "Sanitation," specified, "The food service area shall be maintained in a clean and sanitary manner." "1. All kitchens, kitchen areas and dining areas shall be kept clean, free from litter and rubbish and protected from rodents, roaches, flies and other insects. 2. All utensils, counters shelves and equipment shall be kept clean and maintained in good repair . . ." Review of the facility's undated policy titled, "Food Temperatures," specified, "All cold items must be	F 812	F812 1. The facility is currently preparing, serving, and storing food in a safe, sanitary, and timely manner. 2. Residents who eat meals served from the facility kitchen have the potential to be affected. 3. The Registered Dietician/designee will educate Dietary staff on keeping food preparation, equipment, and floors clean and sanitized, food covered, food discarded if spoilage is noted, milk served at or <41 degrees, and food served at scheduled times. 4. The Administrator/designee will monitor food preparation, serving, and storage weekly times 4 to ensure that food is prepared, served, and stored in a safe, sanitary, and timely manner. Results of the audit will be reviewed at the QA meeting on a monthly basis times 2. 5. Completion date: August 17, 2023	

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 812	Continued From page 92	F 812		

stored and served at a temperature of 41 [degrees] F. or below."

1. Observation during the initial kitchen inspection on 07/09/23 from 12:00 PM to 12:45 PM revealed only two dietary employees were working in the kitchen. The following concerns with food storage were observed:

a. Observation of foods stored in the kitchen's dry storage area revealed an uncovered large plastic container with flour stored inside, an uncovered large plastic container with breadcrumbs stored inside, an uncovered large plastic container with sugar stored inside, and an uncovered large plastic container with food thickener stored inside. The contents in each of these four uncovered storage containers were unprotected from possible contamination.

b. Observation of the large can storage rack in the kitchen's dry storage area revealed shelves on the rack, with cans stored on them, were unclean with a white powdery substance.

c. Observation of bread stored on the kitchen's bread rack revealed four packages of hot dog buns with mold growth on the buns inside each of these packages.

d. Observation of food stored in the kitchen's walk-in refrigerator revealed an uncovered box of bacon not protected from possible contamination.

During an interview on 07/09/23 at 3:00 PM, the Dietary Manager (DM) confirmed the uncovered foods, unclean can rack and molded hot dog buns observed during the initial kitchen inspection. The DM stated staff were expected to

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 812	Continued From page 93	F 812		

completely cover all stored food, keep the can rack clean and to discard any food with signs of spoilage.

2. Observation during the initial kitchen inspection on 07/09/23 from 12:00 PM to 12:45 PM, revealed the following unclean stored food preparation equipment:

a. Eight of 10 food preparation pans that were stored stacked together on a shelf, and ready for use, had a very greasy residue on them.

b. Four of the five large sheet pans that were stored stacked together on a shelf, and ready for use, had a very greasy residue on them.

During an interview on 07/09/23 at 3:00 PM, the DM confirmed the stored food preparation and sheet pans were unclean with a very greasy residue on them. The DM stated staff were expected to make sure pans were clean and grease free prior to storing them for use.

3. Observation during the initial kitchen inspection on 07/09/23 from 12:00 PM to 12:45 PM revealed the floor behind the kitchen's ovens, deep fat fryer and stove top was very unclean with greasy residues and accumulated food debris and trash.

During an interview on 07/09/23 at 3:00 PM, the DM confirmed the floor behind the kitchen's ovens, deep fat fryer and stove top was very unclean. The DM stated staff were expected to keep the kitchen floor clean.

During an interview on 07/09/23 at 3:20 PM, 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 _____	C 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 812	Continued From page 94 DM stated the dietary department currently had three vacant positions which included two cooks and one dietary aide. The DM stated the department had not been fully staffed in a while and she had to work in the kitchen to cover some of the vacant positions. The DM explained when the kitchen was not fully staffed it is very hard to get everything done including the kitchen cleaning duties and to prepare and serve resident meals on time. 4. Observation on 07/10/23 at 8:35 AM of food and beverages being served from the kitchen's breakfast tray line revealed cartons of milk being served from plastic containers on a cart that were not covered in ice. Temperature monitoring of one of these cartons of milk revealed it had an elevated internal temperature of 52.3 degrees F. During an interview on 07/10/23 at 8:35 AM, the DM stated when staff serve cartons of milk from the kitchen tray line, they are expected to keep the milk completely covered in ice to maintain its internal temperature at 41 degrees F. or below.	F 812		
F 814 SS=E	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review, the facility failed to properly dispose of garbage and refuse. One of two outside facility trash dumpsters contained uncovered and mounded garbage that was above the top of the dumpster because it did not have a lid to cover	F 814	F814 1. The outside facility trash dumpsters now have lids to cover the garbage and refuse. 2. All Residents have the potential to be affected.	8/17/23

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 814	Continued From page 95 and contain the garbage placed inside by staff. Findings include: Review of the facility's policy titled, "Food Related Garbage and Rubbish Disposal," dated December 2008, specified, "Food-related garbage and rubbish shall be disposed of in accordance with current state laws regulating such matters. . . . 2. All garbage and rubbish containers shall be provided with tight fitting lids or cover and must be kept covered when stored or not in continuous use. . . . 5. Garbage and rubbish containing food wastes will be stored in a manner that is inaccessible to vermin. . . . 7. Outside dumpsters provided by garbage pick up will be kept closed and free of surrounding litter." Observation on 07/09/23 at 6:30 PM of the facility's outside dumpster area, revealed two trash dumpsters. One of the dumpsters was uncovered and contained bags of trash mounded above the top of the dumpster. Closer observation of this uncovered dumpster revealed a bag of trash was hanging off the back and the dumpster did not have a lid to cover the trash inside. During an interview on 07/09/23 at 6:40 PM, the Administrator viewed the outside dumpster and confirmed the dumpster did not have a lid to cover the garbage inside. The Administrator stated garbage in the dumpsters should be covered and he was unaware one of the dumpsters did not have a lid to cover the garbage. The Administrator stated he would discuss the concern with the company that provided the facility with the dumpsters and trash pickup.	F 814	3. The Maintenance Director/designee will educate all staff to report damage to outside trash dumpster lids that would prevent the lid from covering the garbage and refuse. 4. The Maintenance Director/designee will audit the outside trash dumpsters weekly times 4 to ensure that the lids cover the garbage and refuse. Results of the audits will be reviewed at the QA meeting on a monthly basis times 2. 5. Completion date: August 17, 2023	

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 814	Continued From page 96 Further observation of the facility's outside dumpster area on 07/10/23 at 6:00 AM and 6:00 PM, on 07/11/23 at 8:00 AM and 6:00 PM, and on 07/12/23 at 6:45 AM and 7:45 PM revealed this dumpster did not have a lid and the trash inside was uncovered.	F 814		
F 843 SS=F	Transfer Agreement CFR(s): 483.70(j)(1)(2) §483.70(j) Transfer agreement. §483.70(j)(1) In accordance with section 1861(l) of the Act, the facility (other than a nursing facility which is located in a State on an Indian reservation) must have in effect a written transfer agreement with one or more hospitals approved for participation under the Medicare and Medicaid programs that reasonably assures that- (i) Residents will be transferred from the facility to the hospital, and ensured of timely admission to the hospital when transfer is medically appropriate as determined by the attending physician or, in an emergency situation, by another practitioner in accordance with facility policy and consistent with state law; and (ii) Medical and other information needed for care and treatment of residents and, when the transferring facility deems it appropriate, for determining whether such residents can receive appropriate services or receive services in a less restrictive setting than either the facility or the hospital, or reintegrated into the community will be exchanged between the providers, including but not limited to the information required under §483.15(c)(2)(iii). §483.70(j)(2) The facility is considered to have a transfer agreement in effect if the facility has	F 843		8/17/23

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 843	Continued From page 97 attempted in good faith to enter into an agreement with a hospital sufficiently close to the facility to make transfer feasible. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility record review, the facility staff failed to maintain a written transfer agreement with a hospital, which has the potential to affect all 123 Residents residing in the facility. The findings included: On 7/13/23, during the extended survey, Surveyor C asked the facility staff to submit for review the hospital transfer agreement. On 7/13/23, the facility submitted a policy titled, "Extended Power Outages". An excerpt from this policy was pointed out, which read, "... 5. The center will maintain current transfer agreement(s) with local hospital(s) and transportation agencies and will implement transferring procedures to move the patient if the medication condition necessitate or the patient's safety and/or comfort cannot be maintained appropriately within the building...". On 7/13/23, Surveyor C let the facility Administration know the survey team was looking for a written/executed transfer agreement with a hospital, not a policy. On 7/14/23, the facility staff submitted a contract with the Veterans Administration. It was discussed by the survey team that this was a contract for the facility to provide services to Veterans in a manner to bill the Veterans Administration for services. The discussion	F 843	F843 1. The facility now has a transfer agreement with Tri Cities Hospital system. 2. All residents have the potential to be affected. 3. The Administrator will keep a copy of the transfer agreement filed in Administrator□s office. 4. The Regional Director of Clinical Services will audit presence of the transfer agreement monthly times 2. 5. Completion date: August 17, 2023	

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 843	Continued From page 98 included that this was not a hospital transfer agreement, as all Residents are not veterans and are therefore not able to receive services or be transferred to the Veterans hospital for services. On 7/14/23, the facility Administrator stated they had a staff member "at the hospital now, working on that [referring to the transfer agreement]". They further confirmed that at the time of survey they did not have credible evidence of an active and current transfer agreement with a hospital. No further information was provided.	F 843		
F 880 SS=D	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 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;	F 880		8/17/23

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 880	Continued From page 99 §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 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.	F 880		

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 880	Continued From page 100 §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 and staff interview, the facility staff failed to implement infection control standards to prevent the spread of infections within the facility on 1 of 2 nursing units. The findings included: On the first-floor nursing unit the facility staff failed to don (put on) an isolation gown, gloves, and mask prior to entering the room identified as being on droplet precautions. On 7/9/23 at 2:17 PM, Employee S was observed to enter the room to deliver personal laundry. Employee S failed to don (put on) any PPE (personal protective equipment/gloves, gown, and mask). Upon Employee S' exit from the room an interview was conducted. Employee S said, "I didn't know" when asked why she had failed to put on the gloves, gown, and mask. When the droplet precaution sign beside the room door was pointed out, Employee S said, "I don't know nothing about that". The sign outside the room read, "STOP: Droplet Precautions: Perform hand hygiene using soap and water and/or alcohol-based hand rub before entering and before exiting room. Wear mask when entering room, remove before exiting room. Wear gown when entering room, remove before exiting room. Bag linen and discard trash to prevent contamination of self, environment, or outside bag".	F 880	F880 1. Staff are currently donning appropriate PPE when entering a room with precautions for both Units of the facility. 2. All Residents have the potential to be affected. 3. The SDC/designee will educate all staff on checking for the precaution sign before entering the room and donning appropriate PPE when entering a room with special precautions. 4. The UM/designee will complete weekly audits times 4 to monitor use of PPE in rooms with special precautions. Results of the audits will be reviewed at the QA meeting on a monthly basis times 2. 5. Completion date: August 17, 2023	

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 880	Continued From page 101 On 7/10/23 at 8:42 AM, CNA J was observed to enter a room on droplet precautions without donning any PPE. Upon exit CNA J was asked and stated, "I didn't know". A review of the facility policy titled, "Transmission Based Precautions- General Practice", was reviewed. Excerpts from this policy read, "... 2. Transmission based precautions may be used for patients known or suspected to be infected or colonized with highly transmissible or epidemiologically important pathogens. Transmission based precautions are used in addition to standard precautions...". On 7/10/23, during the end of day meeting, the facility's Director of Nursing (DON) stated that all staff entering a room on droplet precautions is to don an isolation gown, mask, and gloves, prior to entering the room. The DON was asked to clarify if this was dependent upon the task the staff person was going to perform once inside the room. The DON stated, "No" and elaborated that regardless of the purpose or duration in the room, all staff were to put on PPE prior to entering the room. No additional information was provided.	F 880		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and	F 883		8/17/23

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 883	Continued From page 102 potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative	F 883		

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 883	Continued From page 103 was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to 1) provide influenza vaccines for 2 residents, Residents #13 and #98, out of 5 residents reviewed for influenza immunization and facility staff failed to 2) provide a pneumococcal vaccine for 1 resident, Resident #12, out of 5 residents reviewed for pneumococcal immunization. The findings included: 1. The facility staff failed to provide influenza immunization, to include education of risks/benefits about influenza immunization, for Residents #13 and #98. On 7/11/23 at approximately 2:30 PM, clinical record reviews were performed and revealed the following: 1A. Resident #13, who was admitted to the facility on 8/18/22, had no documentation with regard to influenza immunization, to include the resident's current influenza vaccination status, offer to provide immunization against influenza infection, or documentation of resident refusal or medical contraindication. 1B. For Resident #98, the clinical record review	F 883	F883 1. Residents #13 and 98 responsible parties declined administration of the influenza vaccine after being educate on the vaccine as documented in the Resident□s medical record. Resident #12 received the pneumococcal vaccine on May 31, 2023, as currently documented in the medical record. 2. Residents who have not received the influenza or pneumococcal vaccine will be educated and offered the vaccine as indicated. 3. The DON/designee will educate nurses on review and documentation of vaccines at time of admission. The DON/designee will educate the Infection Preventionist on monitoring the documentation of vaccines, educating Residents as needed, and provision of the vaccines as indicated. 4. The UM/designee will audit documentation of administration of the influenza and pneumococcal vaccines on a weekly basis times 4. Results of the audits will be reviewed at the QA meeting on a monthly basis. 5. Completion date: August 17, 2023	

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 883	Continued From page 104	F 883		

revealed Resident #98, who was admitted to the facility on 1/25/22, had received influenza immunization on 10/18/21. There was no documentation of the flu vaccine being offered, refused, contraindicated, or administered for the current year, 2022.

On 7/11/23 at approximately 2:45 PM, an interview was conducted with the Director of Nursing (DON) who accessed the clinical records for the residents sampled and verified the findings. The DON confirmed there was no additional information. A facility policy was requested and received.

On 7/11/23 at approximately 3:00 PM, a review of the facility policy entitled, "Influenza Vaccination", effective date 5/01/23, was conducted. It stated under the subtitle, "Procedure", item 1a, "Influenza vaccine should be offered annually...optimal time to administer influenza vaccine is in late September or early October of each year. The vaccine can be given after the flu season begins...Those who have not had a flu vaccine will be offered one upon admission" and item 1, e, 1 read, "Educate the patient and or RP [Responsible Party]...document education in the electronic medical record".

On 7/11/23 at approximately 5:15 PM, the Facility Administrator and Director of Nursing were made aware of the findings. No further information was provided.

2. The facility staff failed to provide education of risks/benefits about pneumococcal immunization, for Resident #12.

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 883	Continued From page 105 On 7/11/23 at approximately 2:30 PM, a clinical record review was performed for Resident #12 and revealed Resident #12 refused to have a pneumococcal vaccine on 6/1/23, however there was no evidence of education regarding the risks/benefits for pneumococcal immunization. On 7/11/23 at approximately 2:45 PM, an interview was conducted with the Director of Nursing (DON) who accessed the clinical record for Resident #12 and verified the findings. The DON confirmed there was no additional information and acknowledged that providing immunization education to residents who may be unsure, or refuse the initial offer to vaccinate, may be beneficial for them to be able to make a fully informed decision. A facility policy was requested and received. On 7/11/23 at approximately 3:00 PM, a review of the facility policy entitled, "Pneumococcal Vaccinations", effective date 5/01/23, was conducted. It stated under the subtitle, "Procedure", item 1, e, 1 read, "Educate the patient and or RP [Responsible Party]...document education in the electronic medical record". On 7/11/23 at approximately 5:15 PM, the Facility Administrator and Director of Nursing were made aware of the findings. No further information was provided.	F 883		
F 887 SS=D	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following:	F 887		8/17/23

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 887	Continued From page 106 (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical	F 887		

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 887	Continued From page 107 contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to provide COVID-19 bivalent vaccines for 1 resident, Resident #98, out of 5 residents reviewed for COVID-19 bivalent immunization. The findings included: 1. The facility staff failed to provide COVID-19 bivalent immunization, to include education of risks/benefits about COVID-19 immunization, for Resident #98. On 7/11/23 at approximately 2:30 PM, a clinical record review was performed and revealed Resident #98, who was admitted to the facility on 1/25/22, had received a monovalent booster on 6/17/22, however there was no evidence that Resident #98 had been offered or received a COVID-19 bivalent booster dose. On 7/11/23 at approximately 2:45 PM, an interview was conducted with the Director of Nursing (DON) who accessed the clinical records	F 887	F887 1. Resident #98 received the Covid bivalent booster on May 17, 2023. Receipt of the administration of the vaccine is now documented in the Resident□s medical record. 2. Residents who have not received the Covid bivalent booster will be educated and offered the vaccine. 3. The DON/designee will educate the Infection Preventionist on documenting administration of the Covid bivalent booster, offering and administering the Covid bivalent booster as indicated, providing education on the Covid bivalent booster as indicated. 4. The UM/designee will monitor documentation of the Covid bivalent booster for all newly admitted Residents on a weekly basis times 4. Results of the audits will be reviewed at the QA meeting on a monthly basis times 2. 5. Completion date: August 17, 2023	

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 887	Continued From page 108 for Resident #98 and verified the findings. The DON confirmed there was no additional information. A facility policy was requested and received. On 7/11/23 at approximately 3:00 PM, a review of the facility policy entitled, "COVID-19 Vaccinations", effective date 5/01/23, was conducted. It stated under the subtitle, "Procedure", item 1, "CDC [Centers for Disease Control and Prevention] recommends that everyone stay up to date with COVID-19 vaccination" and item 2c read, "If contraindicated or refused, document in the patient's immunization record, including that the patient and/or RP [Responsible Party] was provided education regarding the benefits and potential risks associated with the COVID-19 vaccine". The CDC (Centers for Disease Control and Prevention) document titled, "Interim Clinical Considerations for Use of COVID-19 Vaccines in the United States", updated May 12, 2023, page 2, "Recommendations for the use of COVID-19 vaccines", read, "COVID-19 vaccination is recommended for everyone ages 6 months and older in the United States for the prevention of COVID-19" and "CDC recommends that people ages 6 months and older receive at least 1 bivalent mRNA COVID-19 vaccine". On 7/11/23 at approximately 5:15 PM, the Facility Administrator and Director of Nursing were made aware of the findings. No further information was provided.	F 887		
F 908 SS=D	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2)	F 908		8/17/23

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 908	Continued From page 109 §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on Resident interview, staff interview, clinical record review and facility documentation review, the facility staff failed to ensure that Resident beds were maintained in a safe operating condition for 2 Residents (Resident #21 and #330) in a survey sample of 61 Residents. The findings included: 1. For Resident #21, the facility staff failed to ensure an air mattress was properly maintained to prevent the Resident from laying directly on the metal bed frame. On 07/09/23 at 01:58 PM, an interview was conducted with Resident #21. During this interview, Resident #21 reported that she had a sacral wound. It was observed that Resident #21 was not on an air mattress. When asked about this, Resident #21 reported that on several occasions she did have an air mattress and they would "blow out" leaving her laying directly on the metal bed frame, so she isn't interested in being on an air mattress anymore. Review of the clinical record of Resident #21, revealed notes that indicated the Resident refused an air mattress. On 7/11/23 at 10:10 AM, an interview was conducted with RN C, the treatment nurse. When asked about Resident #31 and why she isn't on an air mattress, RN C said, "She said it kept going down flat so she doesn't want it."	F 908	F908 1. Resident #21 was provided a new mattress on July 12, 2023, and states that she is satisfied with the mattress. Resident #330 no longer resides at the facility. 2. All Residents have the potential to be affected. 3. The Maintenance Director will educate all staff on completing a work order for any bed or mattress that is malfunctioning. 4. The UM/designee will complete a weekly audit times 4 of mattresses and functionality of beds. Results of the audit will be reviewed at the QA meeting on a monthly basis times 2. 5. Completion date: August 17, 2023	

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 908	Continued From page 110	F 908		

On 7/12/23, the maintenance work orders for Resident #21's bed were reviewed. It revealed a maintenance request being entered on 2/23/23, to change the air mattress to a regular mattress.

During the end of day meeting held on 7/11/23, the facility Administrator, Director of Nursing and Regional Clinical Director were made aware of the above findings. They were made aware that Resident #21 only refuses the air mattress because she has had several in the past that were not maintained properly.

On the morning of 7/12/23, the facility Administrator let the survey team know he had traveled to a sister-facility and obtained an air mattress the night before and Resident #21 was put on the air mattress. The administrator reported the mattress was a different kind and was demonstrated for the Resident, to show it would not go flat if air pressure was lost. The Resident agreed and is now on the air mattress.

On the morning of 7/12/23, Resident #21 was visited in her room and was observed to be on an air mattress. Resident #21 reported it was very comfortable and very pleased with it.

No further information was provided.

2. For Resident #330, the facility staff failed to maintain the bed in a safe operating condition.

During a closed clinical record review, it was noted that on 4/25/22, Resident #330's bed was not operating properly. The nursing noted read,

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 908	Continued From page 111 "Residents HOB [head of bed] does not go down & the remote control to bed doesn't work, maintenance work order was completed by previous nurse". Review of the facility's investigation file revealed that staff interviews were conducted. The interviews revealed that on 4/22/22, Resident #330's air mattress was "deflating and that the mattress would have to be changed to a regular mattress until it can be fixed". There was an additional statement dated 4/22/22, that read, "the nurse told me his bed was flat, I changed his mattress". On 4/23/22, 4/24/22, and 4/25/22, Resident #330 was transferred in and out of bed, by facility staff, using a draw sheet/bed sheet because the bed was not operating properly. On 4/23/22 and 4/24/22, the head of the bed would not go up or down. On 4/25/23, the bed that had been placed in the room on 4/24/23, did not have a remote control to operate the bed. On the afternoon of 7/12/23, the facility Administrator, Director of Nursing and Corporate Nurse Consultant were made aware of the above findings. No further information was provided.	F 908		
F 925 SS=E	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by:	F 925		8/17/23

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 925	Continued From page 112 Based on observation, interview, review of Resident Council Meeting minutes, and facility policy review, the facility failed to maintain an effective pest control program so the facility was free of pests. This deficient practice had the potential for residents of the facility to be at risk for diseases caused by pest infestations. Findings include: Review of the policy titled, "Pest Control," dated 05/01/22, revealed, " The Center environment will be inspected monthly and treated for pests by a corporate-approved contractor. 1. Observe and document sightings of pests in the contractor/pest sighting logbook maintained at each nursing station." Review of the policy titled, "Sanitation," dated October 2008, revealed, "All kitchens, kitchen areas and dining areas shall be kept clean, free from litter and rubbish and protected from rodents, roaches, flies and other insects." Review of the Resident Council Meeting minutes dated 06/26/23, revealed (Residents (R)42 and R9) voiced concerns about seeing insects in their rooms. Observation during the initial kitchen sanitation inspection on 07/09/23 from 12:00 PM to 12:45 PM, revealed numerous flies in the kitchen's tray line/food preparation area, and dish machine area. Additionally, three dead roaches were observed under shelving units in the kitchen's dry storage area. Observations of the facility's back door revealed it was not completely closed. The door's handle was loose and bent downward and the base of the door was bent inward which	F 925	F925 1. The facility is currently maintaining an effective pest control program. 2. All Residents have the potential to be affected. 3. The Maintenance Director/designee will educate all staff on use of the pest control log to communicate pest sightings. The Administrator/designee will educate maintenance staff on notifying and obtaining additional pest control services as needed. 4. The Administrator/designee will audit effectiveness of pest control measures on a weekly basis times 4. Results of the audits will be reviewed at the QA meeting monthly times 2. 5. Completion date: August 17, 2023	

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 925	Continued From page 113	F 925		

provided holes and opened gaps that would be entry points for flies, roaches, and other insects to enter the kitchen.

During an interview on 07/09/23 at 12:15 PM, Cook1 stated a maintenance request was submitted about two weeks ago to repair the kitchen's back door.

During an interview on 07/09/23 at 3:00 PM, the Dietary Manager (DM) confirmed the kitchen's back door had a broken handle and the bottom of the door was bent which provided holes and gaps for flies, roaches, and other insects to enter the kitchen.

Observation on 07/09/23 at 6:45 PM of the kitchen's back loading dock, with the Administrator present, revealed the kitchen's back door was not completely closed. Additionally, there were two open bags of garbage with numerous flies in and around these opened bags that were placed near the kitchen's partially opened back door, and numerous empty card board boxes were stacked and scattered on the loading dock.

During an interview on 07/09/23 at 6:45 PM, the Administrator stated he saw the issue that the opened bags of garbage and numerous empty boxes placed on the facility's back loading dock would attack flies and insects to the kitchen, and staff should keep the kitchen's back door closed. The Administrator also confirmed the kitchen's back door had a loose and bent handle and a bent base that would provide entry points for insects to enter the kitchen. The Administrator stated the plan was for the kitchen's broken back door to be replaced.

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 947 SS=D	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. §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 staff interview and facility documentation review, the facility staff failed to ensure that the required 12 hours annual in-service training was completed for 2 certified nursing aides (CNAs), CNA C and CNA D, in a survey sample of 3 CNAs. The findings included: The facility staff failed to ensure 12 hours of required annual training for CNA C and CNA D were completed. On 7/13/23 at approximately 11:00 AM, a request was made to the Facility Administrator to provide	F 947	F947 1. CNA C and CNA D have now received 12 hours of inservice education. 2. All CNAs have the potential to be affected. CNAs were audited to ensure that 12 hours of education have been provided. 3. The DON/designee will educate the SDC on provision of 12 hours of education annually for CNAs and monitoring of completion of the education on a monthly basis. 4. The SDC/designee will monitor completion of required inservice education for CNAs on a monthly basis times 2.	8/17/23

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 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WONDER CITY REHABILITATION AND NURSING CENTER	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) COMPLETION DATE
F 947	Continued From page 115 evidence that CNA C, hired on 4/29/2004, and CNA D, hired on 12/3/2020, had completed 12 hours of required annual in-service training and a facility policy regarding annual in-service training for CNAs. On 7/13/23 at approximately 7:00 PM, during the end of day debriefing with the Facility Administrator, Director of Nursing, and Regional Clinical Consultant, a second request was made to provide evidence of required annual in-service training for CNA C and CNA D, along with a facility policy that addressed annual in-service training for CNAs. The Facility Administrator stated, "Okay". On 7/14/23 at approximately 12:30 PM, a third request was made for the previously requested required annual training for CNA C and CNA D and facility policy. The Facility Administrator stated, "Okay". There were no training documents provided to show that CNA C and CNA D had a minimum 12 hours of mandatory in-service training or a facility policy, as previously requested, upon the conclusion of the survey on 7/14/23 at 4:00 PM.	F 947	Results of the monitoring will be reviewed at the QA meeting on a monthly basis times 2. 5. Completion date: August 17, 2023	