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	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wonder City Rehabilitation and Nursing Center	905 Cousins Avenue Hopewell, VA 23860

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. Based on observation, resident interview, and clinical record review, the facility failed to ensure a resident was treated with respect and dignity for one (1) of seventeen (17) residents, Resident #3.The findings include:For Resident #3 the facility staff failed to maintain the resident's dignity during a meal as evidenced by standing over the resident to feed the resident and failed to remove facial hair that the female resident indicated she did not wantResident #3 was originally admitted to the facility 02/10/2026. Diagnoses include but are not limited to anxiety disorder, adult failure to thrive, hypotension, fracture of unspecified part of neck of right femur, moderate protein calorie malnutrition, essential hypertension, acute respiratory failure with hypoxia, and insomnia.Resident #3's most recent MDS (Minimum Data Set Assessment) with an ARD (Assessment Reference Date 03/31/2026 coded the resident as completing the BIMS (Brief Interview for Mental Status) 14 out of 15. Indicating the resident was cognitively intact for daily decision making.Review of Resident #3's Physician orders revealed, she was on a Regular diet, dysphagia pureed texture, thin liquids consistency which was started on 04/12/2026 at 1:21 PM. In review of Resident #3's care plan, there was a focus that included the statement, Receives an altered diet with thickened liquids and requires feeding from staff. An intervention stated Encourage optimized PO [intake by mouth] and assist with feeding as needed.On 05/05/2026 at 9:58 AM the Executive Director brought Resident # 3's tray to her room. The nurse stated not to take the tray in because she's a feeder.On 05/05/2026 at 10:00 AM, a CNA brought Resident #3's tray into her and began setting her up for breakfast. The CNA remained standing above the resident and began feeding the resident. The CNA continued standing through the feeding of Resident #3.On 05/05/2026 at 9:05 AM, Resident #3 was noted to have facial hair around her mouth and covering her chin. In an interview on 05/07/2026 at 12:05 PM with Resident #3, she was told that she had facial hair around her mouth and on her chin and asked if she wanted the facial hair. She said no, I don't.The Executive Director, Director of Nursing, Regional Director of Operations, and Regional Director of Clinical Services were made aware of the concerns on 5/7/26 at 2:06 PM.No additional information was provided.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Wonder City Rehabilitation and Nursing Center	905 Cousins Avenue Hopewell, VA 23860

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on staff interview, facility document review, and clinical record review, the facility failed to notify a provider of two falls for one (1) of seventeen (17) residents, Resident #2.The findings include:Resident #2 was originally admitted to the facility 01/20/2026 with diagnoses to include but are not limited to diabetes mellitus type 2, muscle wasting and atrophy, muscle weakness, moderate protein calorie malnutrition, difficulty in walking, myocardial infarction type 2, history of falling, essential hypertension, benign prostatic hyperplasia, anemia, urinary tract infection, and Parkinson's Disease without dyskinesia.Resident #2's most recent MDS (Minimum Data Set Assessment) with an ARD (Assessment Reference Date 01/26/2026 coded the resident as completing the BIMS (Brief Interview for Mental Status) 08 out of 15. This indicates the resident is moderately cognitively impaired for daily decision making.On 05/06/2026 during a review of Resident #2's clinical record, there was no evidence that the facility notified the doctor/provider of falls that occurred on 01/21/2026 and 02/20/2026.On 05/06/2026 at 12:35 PM the Unit Manager for the First Floor was interviewed regarding the falls. Related to the fall on 01/21/2026, the unit manager stated that she did not see a progress note about the fall in the clinical record. She also stated that she did not see documentation in the progress notes or risk management about the provider or responsible party being notified. The Unit Manager was also asked about the fall on 2/20/2026 and she could not provide evidence that the provider was notified of the fall.The Executive Director, Director of Nursing, Regional Director of Operations, and Regional Director of Clinical Services were made aware of the concern on 5/7/26 at 2:06 PM. No additional information was provided.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and resident interview, the facility failed to maintain a clean, comfortable and homelike environment for one of two units.The findings include:On 05/04/2026 at 12:15 PM an initial tour of Unit One was conducted and the following was observed. The walls on the A side of room [ROOM NUMBER] were scuffed up and discolored, the tiles in the bathroom had cracks in them which appeared a dark color and the sill around the toilet was stained. In room [ROOM NUMBER] the B side bed had the finish peeling from the footboard. room [ROOM NUMBER] had black footprints across the floor of the entire room. room [ROOM NUMBER] had a heavy amount of dirt on the floor including a plastic plasticware wrapper.On 05/05/2026 at 9:08 AM during a tour of Unit One, room [ROOM NUMBER] was observed with a heavy amount of dirt and debris on the floor to include toilet paper, napkins, and a plastic lid and straw.On 05/05/2026 at 2:50 PM, resident # 10 was met in the hallway and began talking about the cleanliness of the floors. The resident stated, These floors are filthy. They are all scratched up and there's dirt all over them. The resident stated they did not want their feet to touch the ground, that's how dirty the floor is. Observation of room [ROOM NUMBER] revealed a disheveled room that included an unmade bed with food crumbs all over it, heal boots, balled up napkins, a plastic lid, and other dirt on the floor, a quarter full urinal and food item trash on the overbed table. The B side had a patched wall that had a large hole in the drywall by the window. The sink vanity had the finish coming off it, balled up used napkins on it, and the back splash on the left side had come off, revealing damaged drywall. The bathroom tiles were discolored, had large, discolored cracks between them, and the sill around the toilet was dark and discolored.On 05/06/2025 at 2:32 PM, room [ROOM NUMBER] was observed with dirt and egg on the floor and the wall by the door was scraped and discolored including patching that did not match the wall paint color.On 05/06/2026 at 2:42 PM, room [ROOM NUMBER]'s bathroom had floor tiles that were cracked and discolored and the sill around the toilet was dark and discolored. No additional information was provided.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interview, record review, and policy review, the facility failed to implement its abuse prevention policies by ensuring staff identified in an allegation of sexual abuse were prohibited from resident contact pending completion of the investigation for 1 of 3 sampled residents reviewed for abuse allegations (Resident #9).The findings include: Review of the facility policy titled Responding to Abuse/Neglect/Misappropriation/Crime, dated 1/29/24, revealed the facility would immediately protect residents from further potential abuse, including removal of alleged perpetrators pending the outcome of the investigation.Review of an incident summary dated 12/16/25 revealed Resident #9 alleged on 12/16/25 that two identified housekeeping employees attempted revealed themselves and made sexual comments towards her . Documentation showed the allegation was reported to facility administration on 12/16/25. Review of statements from resident and staff all have time of incident redacted or blank.Further review of staffing schedules, payroll records, and assignment sheets revealed identified employees continued to work full shifts on 12/16/25 after the allegation was reported. Interview with the Administrator on 5/7/26 at 3:30pm advised both employees were permitted to continue working the full shift during the initial investigation. The Administrator stated, We did not suspend them initially because we were still trying to determine whether the allegation was credible.The facility's failure to implement protective interventions and restrict alleged perpetrators from resident contact during an active sexual abuse investigation placed residents at risk for ongoing abuse, intimidation, retaliation, and psychosocial harm.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview, record review, and policy review, the facility failed to thoroughly investigate and prevent further potential abuse by ensuring protective measures were implemented after an allegation of sexual abuse was reported for 1 of 3 sampled residents reviewed for abuse investigations (Resident # 9).The findings include: Review of the facility policy titled Abuse Prevention and Investigation, dated 1/29/24, revealed the facility would immediately implement interventions to protect residents from further potential abuse during investigations, including removal of alleged perpetrators from resident contact pending investigative findings.Review of the facility investigation revealed Resident #9 alleged on 12/16/25 that two identified housekeeping employees attempted revealed themselves and made sexual comments towards her. Documentation showed the allegation was reported to administration on 12/16/25. Review of statements from resident and staff all have time of incident redacted or blank.The facility failed to implement interim protective measures after the alleged incident was reported during the initial investigation. Staffing schedules and assignment sheets showed Employee # worked 8.16 hours and Employee # worked 10.04 hours on 12/16/25 after the allegation had been made to the administration. Clinical with records reveal resident was noted after the investigative report guarded and worried about her safety.Review of the incident summary failed to reveal documented rationale supporting continued resident access by the identified employees, evidence of increased supervision, resident separation measures, or other interventions implemented to protect residents pending completion of the investigation.Interview with the Administrator on 5/7/26 at 3:30pm advised both identified employees were permitted to continue working the full shift during the initial investigation. The Administrator stated, We did not suspend them initially because we were still trying to determine whether the allegation was credible.The facility's failure to implement protective interventions and restrict alleged perpetrators from resident contact during an active sexual abuse investigation placed residents at risk for ongoing abuse, intimidation, retaliation, and psychosocial harm.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interview, record review, and policy review, the facility failed to implement its abuse prevention policies by ensuring staff identified in an allegation of sexual abuse were prohibited from resident contact pending completion of the investigation for 1 of 3 sampled residents reviewed for abuse allegations (Resident #9).The findings include:Review of the facility policy titled Abuse Prevention and Investigation, dated 1/29/24, revealed the facility would immediately implement interventions to protect residents from further potential abuse during investigations, including removal of alleged perpetrators from resident contact pending investigative findings.Review of the facility investigation revealed Resident #9 alleged on 12/16/25 that two identified housekeeping employees attempted revealed themselves and made sexual comments towards her. Documentation showed the allegation was reported to administration on 12/16/25. Review of statements from resident and staff all have time of incident redacted or blank.The facility failed to implement interim protective measures after the alleged incident was reported during the initial investigation. Staffing schedules and assignment sheets showed Employee # worked 8.16 hours and Employee # worked 10.04 hours on 12/16/25 after the allegation had been made to the administration. Clinical with records reveal resident was noted after the investigative report guarded and worried about her safety.Review of the incident summary failed to reveal documented rationale supporting continued resident access by the identified employees, evidence of increased supervision, resident separation measures, or other interventions implemented to protect residents pending completion of the investigation.Interview with the Administrator on 5/7/26 at 3:30pm advised both identified employees were permitted to continue working the full shift during the initial investigation. The Administrator stated, We did not suspend them initially because we were still trying to determine whether the allegation was credible.The facility's failure to implement protective interventions and restrict alleged perpetrators from resident contact during an active sexual abuse investigation placed residents at risk for ongoing abuse, intimidation, retaliation, and psychosocial harm.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation and clinical record review, the facility failed to implement the comprehensive person-centered care plan for (4) four of (13) thirteen residents in the survey sample. (Resident #8, #6, #2 and #3).Findings included:1. For Resident #8, the facility staff failed to implement the comprehensive care plan interventions for enhanced barrier precautions and to honor the resident's food preferences. Resident #8 was originally admitted to the facility 11/25/25 and re-admitted after a hospitalization from 4/26/26 to 5/1/26 for a GI bleed (gastro-intestinal, bleeding in the stomach). Other diagnoses included but are not limited to diabetes mellitus type 2, (GERD) gastroesophageal reflux disease, anemia, atrial fibrillation (irregular heart rate), hypertension, asthma, hemiparesis and hemiplegia following a cerebral infarction (reduced strength in extremities following a stroke), and memory deficit following stroke. Resident #8's most recent MDS (Minimum Data Set Assessment) with an ARD (Assessment Reference Date 3/3/26 coded the resident as completing the BIMS (Brief Interview for Mental Status) 15 out of 15. This indicates the resident is cognitively intact for daily decision making. On 5/5/26 at 9:00 AM, Resident #8 was visited as she was finishing her breakfast. Resident #8 expressed displeasure that kitchen staff failed to ensure that her meal preferences were honored. Resident #8 said, Look here, just look here, my oatmeal is smothered in butter, I can't eat this, it messes with my reflux, and I don't eat sausage or bread because it goes against my body. A review of Resident #8's meal ticket revealed: oatmeal, hard-boiled egg, hot cereal, egg patty (alternate-bread, alternate-breakfast meat); Dislikes: Bread, sausage, grits, potatoes, orange juice, scrambled eggs, fried eggs. Resident #8's meal tray revealed hard-boiled eggs, toast, sausage patty, oatmeal with butter. Resident #8 stated she was happy with her hard-boiled eggs but not with the oatmeal smothered in butter and the toast and sausage. On 5/5/26, approximately 12:15 PM, Resident #8 visited during the midday meal where she received meal tray with sliced ham, broccoli and tomato soup, magic cup, lemonade. Meal ticket revealed: Alternate entrée, broccoli, brownie, apple juice and magic cup. As Resident #8 was eating her lunch, a staff member came in with a bowl of chicken noodle soup and removed the tomato soup. Meal ticket showed Dislikes: Bread, potatoes, tomato sauce, fried foods, mayonnaise, orange juice. On 5/5/26 at 2:20 PM during a meeting with the RD (Registered Dietician), Resident #8's food preferences and care plan were discussed. According to the RD, the residents' preferences should be honored, and the staff has been trying to honor her preferences, but it has been a challenge as they change frequently. The RD revealed that a care plan meeting had been conducted with the resident, her granddaughter, dietary, nursing and social services on the morning of 5/4/26 that included discussion of her food preferences, and her meal ticket was being updated as her preferences changed. On 5/6/26, a review of Resident #8's care plan read in part is at nutritional risk related to diagnosis of cerebral infarction (stroke with reduced strength and function of the arms and legs), asthma, adult (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	failure to thrive, type 2 diabetes mellitus, GERD (gastroesophageal reflux disease, a burning sensation in the chest, also referred to as heartburn), hypertension and history of gastric bypass (weight-loss surgery). Receives a therapeutic diet for diabetes management. Double protein entrees ordered as resident refuse high-calorie dairy-based nutritional supplements. Snacks in room and resident consumption of food brought in by family. Amino acid protein supplements started to encourage healing of pressure injury. Created on: 12/01/2025 Revised on: 05/05/2026. Care plan focus included an intervention of Honor diet-compliant food preferences as made known by resident Created on: 12/01/2025 Revision on: 12/01/2025. The review of Resident #8's care plan also revealed a care plan focus The resident has a chronic wound or pressure ulcer to the sacrum. The resident has a risk for worsening wound(s) or the development of additional wounds related to pressure, sacrum. Created on: 05/04/2026. Revised on: 05/05/2026 with an intervention for Enhanced barrier precautions Created on: 05/04/2026. Resident #8 was visited with room rounds on 5/4/26 at 12:55 PM, meal visits 5/5/26 at 9:00 AM and 12:30 PM, and on 5/7/26 at 9:15 AM and no evidence of signage for Enhanced Barrier Precautions or a bin for personal protective equipment. According to Unit 2 Manager, any resident with an open wound or indwelling devices would have enhanced barrier precautions implemented including placing a sign on or near the door frame and a bin for personal protective equipment such as gloves and gowns to wear when providing direct care. 2. For Resident #6, the facility staff failed to implement the comprehensive care plan for the intervention to administer oxygen as ordered. Resident #6 was admitted to the facility 4/1/25 with diagnoses to include but not limited to chronic obstructive pulmonary disease, chronic respiratory failure with hypoxia, diabetes mellitus type 2, chronic kidney disease stage 3, convulsions, hypertensive heart disease, and heart failure. Resident #6's most recent MDS (Minimum Data Set Assessment) with an ARD (Assessment Reference Date) 3/30/26 coded the resident in Section C. Cognitive Patterns for a BIMS (Brief Interview Mental Status) of 09 out of 15 indicating resident has moderate cognitive impairments with memory, attention and orientation. Section 0. Special Treatments C1 was coded yes for use of oxygen. On 5/4/26 at 12:20 PM, during initial rounds Resident #6 was observed in her bed with the head of the bed elevated and the oxygen concentrator set on 6 liters per minute via nasal cannula. On 5/4/26 at 12:30 PM, Unit 2 Nurse Manager confirmed the oxygen concentrator was set at 6 liters, which exceeded the ordered 4 liters per minute. When asked what the danger of exceeding the oxygen flow rate she stated, it could be toxic to the resident. A review of Resident #6's physician orders revealed an order for oxygen continuous at 4 liters per minute via nasal cannula. A review of Resident #6's care plan revealed a care plan focus: Respiratory: the resident is at risk for respiratory complications secondary to chronic obstructive pulmonary disease and chronic respiratory failure with hypoxia Created on: 12/17/2024 Revision on: 05/05/2026 with intervention to administer oxygen as ordered Created on: 12/17/2024. On 5/7/26 at 2:06 PM during a meeting with the Administrator, DON (Director of Nursing), Regional (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Director of Clinical Services and Regional Director of Operations, they were made aware of the findings of facility staff not following the care plan for Resident #8 and Resident #6. A request for the facility's policy on care planning was requested, none was provided. According to the Center for Medicare and Medicaid Resident Assessment Manual October 2023, Version 3.0, Chapter 4: Care Area Assessment (CAA) Process and Care Planning, Chapter 4, page 8, As required at 42 CFR 483.21(b), the comprehensive care plan is an interdisciplinary communication tool. It must include measurable objectives and time frames and must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The care plan must be reviewed and revised periodically, and the services provided or arranged must be consistent with each resident's written plan of care. No further information was provided. 3. For Resident #2, the facility staff failed to implement fall interventions for bilateral fall mats. Resident #2 was originally admitted to the facility 01/20/2026. Diagnoses include but are not limited to diabetes mellitus type 2, muscle wasting and atrophy, muscle weakness, moderate protein calorie malnutrition, difficulty in walking, myocardial infarction type 2, history of falling, essential hypertension, benign prostatic hyperplasia, anemia, urinary tract infection, and Parkinson's Disease without dyskinesia. Resident #2's most recent MDS (Minimum Data Set Assessment) with an ARD (Assessment Reference Date 01/26/2026 coded the resident as completing the BIMS (Brief Interview for Mental Status) 08 out of 15. This indicates the resident is moderately cognitively impaired for daily decision making. Observation on 5/4/2026 at 12:17 PM, 5/5/2026 at 9:05 AM, and 5/5/2026 at 12:50 PM, revealed that a fall mat was only on the right side of Resident #2's bed. A review of Resident #2's care plan revealed a care plan intervention bilateral floor matts. On 5/6/2026 at 12:35 PM the Unit Manager for First Floor was interviewed about a care plan intervention of bilateral fall mats for Resident # 2. She confirmed that fall mats should be on both sides of the beds. She also stated that the housekeeper took them last week and did not bring them back. 4. For Resident #3, the facility staff failed to implement the care plan intervention for bilateral fall mats. Resident #3 was originally admitted to the facility 02/10/2026. Diagnoses include but are not limited to anxiety disorder, adult failure to thrive, hypotension, fracture of unspecified part of neck of right femur, moderate protein calorie malnutrition, essential hypertension, acute respiratory failure with hypoxia, and insomnia. Resident #3's most recent MDS (Minimum Data Set Assessment) with an ARD (Assessment Reference Date 03/31/2026 coded the resident as completing the BIMS (Brief Interview for Mental Status) 14 out of 15. This indicates the resident is cognitively intact for daily decision making. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 5/4/2026 at 12:17 PM, 5/5/2026 at 9:05 AM, and 5/5/2026 at 12:50 PM, revealed that a fall mat was only on the right side of Resident #3's bed. A review of Resident #3's care plan revealed a care plan intervention bilateral fall matts. On 5/6/2026 at 12:35 PM the Unit Manager for First Floor was interviewed about a care plan intervention of bilateral fall mats for Resident # 3. She confirmed that fall mats should be on both sides of the beds. She also stated that the housekeeper took them last week and did not bring them back. No further information was provided.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews and clinical record review, the facility staff failed to revise and update the residents' person-centered care plan for (2) two of (13) thirteen residents in the sample (Resident #5 and Resident #2). Findings included:1.Resident #5 was admitted to the facility on [DATE] with diagnosis including but not limited congestive heart failure, pulmonary embolism (blood clot), hypertension, chronic obstructive pulmonary disease, anxiety, and myocardial infarction (heart attack). Resident #5's most recent MDS (Minimum Data Set) Assessment with an ARD (Assessment Reference Date) of 3/24/26 coded the resident in C0500. BIMS (Brief Interview of Mental Status) Summary Score as a 15 out of 15 indicating resident was cognitively intact and Section GG0130 - Functional Abilities coded her as 06 indicating independent. On 5/7/26 a review of Resident #5's care plan revealed: Care plan focus The resident prefers to smoke (cigarettes, cigar, pipes, electronic delivery systems (electronic cigarettes/e-cigs, vape pen, etc.) Created on: 12/26/2025, with a revision on 05/05/2026 that included conflicting interventions: 1) May smoke independently - Created on: 01/06/2026, Revised on: 01/31/2026 and 2) Supervise with smoking - Created on: 01/13/2026, Revised on: 05/05/2026. Care plan focus Respiratory infection: the resident has developed an infection secondary to pneumonia Created on: 12/17/2025. Resident #5 does not currently have a respiratory infection. Care plan focus Respiratory: the resident is at risk for respiratory complications secondary to asthma, COPD (chronic obstructive pulmonary disease) Created on: 12/17/2025 with an intervention to obtain vitals as needed Created on: 12/17/2025. A review of Resident #5's physician orders revealed an order - No vitals, labs, or weights dated 12/18/25 per hospice provider. An order CPAP/BiPAP Oxygen tubing change weekly every night shift every Sun, dated 04/20/2026 is not reflected on Resident #5's care plan. No order for CPAP, an order only for tubing change of the CPAP. Resident #5 states she makes her roommate's bed because she likes to help her friend; this was confirmed by the roommate Resident #8 and Resident #8's granddaughter and the Unit 2 Nurse Manager as Resident #5's preference to help her friend. Resident #5's care plan does not reflect her desire to make her roommates bed. Care plan does not reveal any care plan focus or intervention that Resident #5 wishes to make her roommate's bed. On 5/7/26 at 2:06 PM during a meeting with the Administrator, (DON) Director of Nursing Services, Regional Director of Clinical Services and Regional Director of Operations, Resident #5's care plan (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wonder City Rehabilitation and Nursing Center	905 Cousins Avenue Hopewell, VA 23860

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	focus on smoking, respiratory infection and order for CPAP (continuous positive airway pressure, a treatment for obstructive sleep apnea), nasal cannula hanging on her rollator, and having intervention to obtain vital signs when order reveals no vital signs was reviewed. According to the DON, Resident #5 does not currently have a respiratory infection, and the care plan should be updated to reflect her preference to store her nasal cannula on her rollator handle and to make her roommates bed, and resident now requiring supervision with smoking and should not have intervention for obtaining vital signs (measuring blood pressure, heart rate, respirations and temperature) and she was not sure if Resident #5 was using a CPAP. The facility's policy for updating care plans was requested. No policy was provided. According to the Center for Medicare and Medicaid Resident Assessment Manual October 2023, Version 3.0, Chapter 4: Care Area Assessment (CAA) Process and Care Planning, Chapter 4, page 8, As required at 42 CFR 483.21(b), the comprehensive care plan is an interdisciplinary communication tool. It must include measurable objectives and time frames and must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The care plan must be reviewed and revised periodically, and the services provided or arranged must be consistent with each resident's written plan of care. Chapter 4, page 12. 6) The resident's care plan must be reviewed after each assessment, as required by 483.20, except discharge assessments, and revised based on changing goals, preferences and needs of the resident and in response to current interventions. No further information was provided. 2. Resident #2 was originally admitted to the facility 01/20/2026. Diagnoses include but are not limited to diabetes mellitus type 2, muscle wasting and atrophy, muscle weakness, moderate protein calorie malnutrition, difficulty in walking, myocardial infarction type 2, history of falling, essential hypertension, benign prostatic hyperplasia, anemia, urinary tract infection, and Parkinson's Disease without dyskinesia. Resident #2's most recent MDS (Minimum Data Set Assessment) with an ARD (Assessment Reference Date 01/26/2026 coded the resident as completing the BIMS (Brief Interview for Mental Status) 08 out of 15. This indicates the resident is moderately cognitively impaired for daily decision making. On 05/06/2026 during a review of Resident #2's clinical record, it was documented in a 72-hour post fall note dated 01/26/2026 1:28 AM that close monitoring was the intervention in place. On 05/06/20206, A review of Resident #2's care plan revealed the care plan had identified Resident # 2 at risk of falls. A care plan focus the resident is at risk for falls related to recent hospitalization, history of falls, Parkinson created on: 01/20/2026, with a revision on 0 1/21/2026. Medical record review revealed resident #2 had falls on 01/20/2026, 01/21/2026. 01/24/2026, and 02/20/2026. The care plan interventions revisions following these falls are as follows bilateral floor matts created on: 01/21/2026, therapy assessment of w/c cushion created on: 01/22/2026, encourage staff to provide chair activities created on: 01/26/2026, scoop mattress created on: 02/17/2026, and offering prefer clothing created on: 02/23/2026. The care plan was not revised after a fall to include intervention of close monitoring. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/6/2026 at 12:35 PM the Unit Manager for First Floor was interviewed and confirmed that the care plan should have been revised to include the intervention close monitoring.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, clinical record review and facility document review, the facility staff failed to follow physician orders for administration of insulin with specific parameters for (1) one of (13) thirteen residents in the survey sample (Resident #8).Findings included:Resident #8 was originally admitted to the facility 11/25/25 and re-admitted after a hospitalization from 4/26/26 to 5/1/26 for a GI bleed (gastro-intestinal, bleeding in the stomach). Other diagnoses included but are not limited to diabetes mellitus type 2, (GERD) gastroesophageal reflux disease, anemia, atrial fibrillation (irregular heart rate), hypertension, asthma, hemiparesis and hemiplegia following a cerebral infarction (reduced strength in extremities following a stroke), and memory deficit following stroke.Resident #8's most recent MDS (Minimum Data Set Assessment) with an ARD (Assessment Reference Date 3/3/26 coded the resident as completing the BIMS (Brief Interview for Mental Status) 15 out of 15. This indicates the resident is cognitively intact for daily decision making. Section I. Active Diagnosis coded I2900 Diabetes Mellitus. Section N0350.A coded insulin injections and Section N. Medications coded N0415 for High-Risk Drug Class for insulin.A review of Resident #8's clinical record revealed:4/6/26 Nurse Practitioner progress notes revealed: Provider interviewed staff and reviewed chart to assess resident status type 2 diabetes mellitus with hyperglycemia. Blood glucose 212 mg/dL today, with recent glucose variability ranging from 173-216 mg/dL over the past 4 days. Hemoglobin A1c (lab test measuring blood sugar levels over several months) improved to 5.7% on 03/25/2026 from 6.0% in December 2025, approaching the lower end of target range. Active medication management decision made today: adding hold parameter to Lantus (1) insulin regimen (hold for blood glucose less than 200 mg/dL) to prevent hypoglycemia given the improved A1c and risk of hypoglycemia with continued full-dose insulin in the setting of improved glycemic control. This represents a clinical decision balancing tight glycemic control against hypoglycemia prevention, particularly given the recent glucose variability and hold threshold of 200 mg/dL. Continue Lantus 12 units subcutaneously at 6 PM with new hold parameter. Continue continuous glucose monitoring. The patient continues to be noncompliant with diabetic diet. Nursing to monitor for hypoglycemia with the new hold parameter and document continuous glucose monitoring trends and alerts.4/6/26 order Insulin Glargine 300 unit/ml inject 12 units subcutaneously in the evening for diabetes mellitus to HOLD for BS (blood glucose) less than 200mg/dl was transcribed to the MAR (Medication Administration Record).The MAR revealed blood sugar results 4/6/26 BS=184, 4/8/26 BS=197, 4/10/26 BS=189, 4/13/26 BS=158, 4/17/26 BS=165 with nurse documenting insulin was administered outside the physician's order to hold insulin if blood sugar less than 2200mg/dl.4/16/26 Attending Physician progress note read in part: Resident (#8) was seen for physician recertification visit. No acute changes from baseline today. Blood glucose is 196 mg/dL. A hold parameter was added 4/6/26 to her Lantus insulin regimen to hold the dose for blood glucose less than 200 mg/dL. Type 2 diabetes mellitus with hyperglycemia. Stable on current insulin regimen. Continue insulin glargine 12 units with hold parameters. Continue continuous glucose monitoring. The resident remains non-compliant with diabetic diet; continue dietary counseling.4/16/26 Nurse Practitioner progress notes read in part - Monthly medication review completed, taking medications as prescribed; adherence reinforced, no side effects reported, medication list reviewed and reconciled, continue current regimen, blood glucose 192 mg/dL today, blood glucose has ranged from 118 to 216 mg/dL over the past week, with a notable spike to 353 mg/dL on 03/28/2026.4/17/26 Nurse Practitioner progress notes read in part - Assessment: Type 2 diabetes mellitus with diabetic polyneuropathy. Continue insulin glargine 12 units subcutaneously at 6 PM with parameter to hold for blood glucose less than 200 mg/dL and continuous glucose monitoring with sensor.4/18/26 an order was changed on the Medication Administration Record to read: Insulin Glargine Solostar Subcutaneous Solution Pen-Injector 300 unit/ml, inject 12 unit subcutaneously in the evening for Diabetes Mellitus, If the blood sugar is less than 60 or greater than 400 call the (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	provider.Review of the MAR (Medication Administration Record) and blood sugar readings from 4/18/26 through 4/25/26 did not reveal any blood sugars less than 60 or greater than 400.4/20/26 Nurse Practitioner progress note reads in part: Assessment of Type 2 diabetes mellitus with diabetic polyneuropathy. Continue insulin glargine 12 units subcutaneously at 6 PM with parameter to hold for blood glucose less than 200 mg/dL and continue continuous glucose monitoring with sensor.The MAR did not contain the instructions to HOLD if blood sugar is less than 200 mg/dl from 4/18/26 through 4/26/26. No blood sugar readings were recorded less than 200 mg/dl.On 4/26/26, Resident #8 blood sugars were 324 mg/dl at 7:53 AM and 314 mg/dl at 10:38 AM. Due to a change in condition and family request, Resident #8 was transferred to the local hospital. Resident #8 presented to the hospital with acute onset of bloody diarrhea and was admitted on [DATE] at 8:05 PM with diagnosis of acute drop in hemoglobin - blood loss anemia, bloody diarrhea and abdominal pain and sepsis secondary to proctitis.On 5/5/26 at 1:15 PM, an interview and review of Resident #8's April 2026 Medication Administration Record was conducted with the DON (Director of Nursing) and Regional Director of Nursing on their expectation of nurses documenting insulin was administered when the physician orders contained specific parameters to hold the insulin if blood sugar was less than 200 mg/dl. According to the DON, the nurses are to read the entire order and follow the physician orders or notify provider for additional instructions. When asked if the provider reviews the MARs, she did not know for sure but would expect them to review the MAR if they were documenting medications reconciled and taking medications as prescribed.A review of the facility policy titled, General Guidelines for Medication Administration Policy #8.2 effective date 9/2018, revised 8/2020. Page 113. Procedures: II. Administration. 2. Medications are administered in accordance with written orders of the prescriber. ReferenceLantus is a long-acting (basal) insulin used to treat high blood sugar and is designed to work steadily for 24 hours without a pronounced peak, providing a consistent, low level of insulin to control blood sugar between meals and overnight. Sanofi, Manufacturer of Lantus/Glargine insulin. https://www.lantus.com.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, resident and staff interviews, clinical record review, and facility document review, the facility failed to store hazardous chemicals in a manner to minimize accidents and hazards on two of two units, which had the potential to affect residents on both units. The deficient practice resulted in the identification if immediate jeopardy (IJ) and substandard quality of care. Following the verification and removal of IJ, the scope and severity was lowered to level two, pattern. The findings included:The facility staff failed to ensure that hazardous chemicals were stored in a manner to prevent resident access where the liklihood of exposure and/or accidental ingestion was present, which would likely result in severe injury, harm, or even death. On 05/04/2026 at 12:57 PM, during a tour of the facility, outside of the activity room and therapy gym, in an area with direct access by residents, four (4) unsecured and unlocked janitor carts were observed on unit 2. Two of the carts had faulty locks where the lock mechanism could be freely pulled up and down to engage and disengage the locking mechanism, without requiring a key. The other two carts had the key in the lock, where anyone could use the key to open the cabiner and access the chemicals contained within. Each of the carts contained multiple chemicals, which included foam cleaner, Clorox urine cleaner, Clorox cleaner with bleach, disinfectant spray, and neutral floor cleaner, that were unsecured and accessible to residents. One of the janitor carts had an unlabeled yellowish green colored liquid that was observed in a miniature transparent water bottle, identified as neutral floor cleaner by the Environmental Services (EVS) Director.On 05/05/26 at 5:00 PM during additional observations within the facility, the housekeeping storage room was observed unlocked with a and the door was ajar and the lock was not engaged. Upon entering the room, six (6) unsecured janitor carts were observed. Four (4) of six (6) of the janitor carts were unlocked. Each of the four carts had an accessible compartment that contained multiple chemicals that were unsecured and accessible to residents. The cleaning items included foam cleaner, Clorox urine cleaner, Clorox cleaner with bleach, disinfectant spray, neutral floor cleaner.On 05/05/2026 at 5:05 PM, a housekeeper, Other Staff #3 was asked if the house keeping storage room should be locked and they said the room should be locked at all times. When asked if the housekeeping carts should be locked, they stated the carts are supposed to be locked.Material Safety Data Sheets provided by the facility revealed that one of the chemicals in the house keeping cart, a cleaning solution that contained bleach, had a classification that This product is considered hazardous by the 2012 OSHA [Occupational Safety and Health Administration] Hazard Communication Standard (29 CFR 1910.1200). It also stated, if ingested, call a poison control center or doctor.Staff were interviewed about the risks of residents having access to unsecure chemicals on 05/05/2026 at 6:30 PM. The Unit Manager Second Floor stated the risks could be chemical exposure, dementia residents getting ahold of them, chemical poisoning, possible death.At 6:34 PM, the MDS Coordinator # 2 stated the risks could be They can get burned, they can ingest it, they can spill it and slip, death.At 6:35 PM, the MDS Coordinator #1 stated the risks could be Depends if it's a dementia resident, may try to swallow it. They may use it as a weapon. Depends on cognition and motive, if someone may be aggressive.At 6:37 PM, the Social Worker stated the risks could be Well they could try to take them back to their room, maybe cleaning something on their own without gloves and injure their hands. They may ingest them in they are cognitively impaired and don't know they should not be consumed. If they spilled it, it could cause a slip.At 6:39 PM, Certified Nursing Assistant (CNA) # 10 stated the risks could be Umm they can get sick! They can stop breathing. Have an allergic reaction. They could die. They could get someone else sick. Person who left the chemicals could lose their license or get fired.At 6:6:42 PM, Licensed Practical Nurse (LPN) # 7 stated the risks could be They could drink them, put them in the wrong places if they aren't in a secure place. They should be locked away. Should be in a cleaning cart that is locked and requires a key or code. Can't just leave a bottle of bleach out. Potential for people with dementia, Alzheimer's drinking them.At 6:45 PM, Licensed (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Practical Nurse (LPN) # 8 stated the risks could be If we have residents who wander or they are not alert and oriented, residents with infections that are confused. They could think it's a drink and it could cause poisoning. If they touch it they may be allergic to it. It might be some materials there that aren't part of the data sheet where we would look for treatment of chemicals.The survey team identified that the facility was in IJ, the Administrator was notified and provided a copy of the IJ template on 05/05/2026 at 6:29 PM.On 05/05/2026 at 6:54 PM, the Administrator submitted an IJ Removal Plan with a completion date of 05/06/26 at 8:00 AM. The plan read as follows.F689 Accidents and Hazards Removal Plan Plan Corrective Action for those residents found to be affected by the deficient practice:The facility immediately removed the chemicals that were found on [NAME] housekeeping storage room and a doorknob with a lock was placed on the housekeeping storage room that locked to ensure the chemicals are secure and inaccessible to the residents. All housekeeping carts were locked and secure.Corrective Actions taken for residents with potential to be affected by deficient practice:All residents have the potential to be affected. The facility did a search of janitor closets to ensure chemicals were secure and inaccessible. The doors to the janitor supply room and the housekeeping office were checked to ensure they were locked and no chemicals were accessible. The shower rooms, common areas, dining rooms, kitchen and service hallways and residents rooms were inspected to ensure no chemicals were unsecured and accessible to residents. Findings were corrected immediatelySystemic Changes put into place to ensure the deficient practice does not recur: The Interdisciplinary Team (Administrator, Director of Nursing, Assistant Director of Nursing, Director of Social Work, Dietary Manager, Business Office Manager, Director of Housekeeping and Laundry, Human Resources, Rehab Director and Unit Managers) will be educated by the Regional Director of Operations on the proper storage of chemicals to ensure that they are stored in a manner that prevents resident access. The Facility Staff will be educated by the Director of Nursing or designee will educate staff on the proper storage of chemicals to ensure that they are stored in a manner that prevents resident access. No employee will be allowed to work until educated.Completion of removal plan at 8:00 am on 5/6/26. On 05/06/2026 at 9:40 AM, interviews were conducted with staff from various departments to include, Director of Maintenance, Rehab Director, Physical Therapy Assistant, Housekeeping Aide, Laundry Aide, Cook, Social Services Director and Social Services Assistant, Human Resources Director, Director of Nursing, Infection Preventionist, Staff Development Coordinator, MDS Nurse, EVS Director, two Unit Managers, Admissions Director, three Nurses, Assistant Director of Nursing, four certified nursing assistants who confirmed they had received education on the proper storage of chemicals to ensure that they are stored in a manner that prevents resident access and were able to articulate if they observed a potentially hazardous chemical what they would to secure and notify appropriate supervisors. Staffing sheets were reviewed to verify staff had received the training in addition to the interviews.On 05/06/2026 at 9:40 AM, the survey team conducted rounds to verify the community's IJ removal plan. During observation of resident rooms at 9:50 AM the observations revealed dermal wound cleanser in Resident # 18's room, spray disinfectant in the bathroom of Resident # 19's room, air freshener aerosol spray in Resident # 11's room, air freshener aerosol spray in Resident # 15's room, Dakins (diluted, antiseptic bleach solution, used to cleanse skin and wounds) wound cleanser solution and extra strength fabric spray in Resident # 20's room, disinfectant spray and rubbing alcohol in Resident # 21's room at 10:11 AM.On 05/06/2026 at 10:20 AM, the Administrator and Regional Director of Clinical Services #2 were notified that the facility's continued failure to ensure all potentially hazardous chemicals were secured and inaccessible to residents. As a result, the likelihood for serious injury, serious impairment, serious harm or death remained present, and the immediate jeopardy removal plan could not be validated. On 05/06/2026 at 10:52 AM, the Administrator submitted a revised IJ Removal Plan with a completion date of 05/06/26 at 2:00 PM. The plan read as follows. F689 Accidents and Hazards Removal Plan Plan Corrective Action for those residents found to be affected by the deficient practice:The facility immediately removed the chemicals that were found on [NAME] housekeeping storage room and a (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	doorknob with a lock was placed on the housekeeping storage room that locked to ensure the chemicals are secure and inaccessible to the residents. All housekeeping carts were locked and secure.Corrective Actions taken for residents with potential to be affected by deficient practice:All residents have the potential to be affected. The facility did a search of janitor closets to ensure chemicals were secure and inaccessible. The doors to the janitor supply room and the housekeeping office were checked to ensure they were locked and no chemicals were accessible. The shower rooms, common areas, dining rooms, kitchen and service hallways and residents rooms were inspected to ensure no chemicals were unsecured and accessible to residents. Findings were corrected immediatelySystemic Changes put into place to ensure the deficient practice does not recur: The Interdisciplinary Team (Administrator, Director of Nursing, Assistant Director of Nursing, Director of Social Work, Dietary Manager, Business Office Manager, Director of Housekeeping and Laundry, Human Resources, Rehab Director and Unit Managers) will be educated by the Regional Director of Operations on the proper storage of chemicals to ensure that they are stored in a manner that prevents resident access. The Facility Staff will be educated by the Director of Nursing or designee will educate staff on the proper storage of chemicals to ensure that they are stored in a manner that prevents resident access. No employee will be allowed to work until educated.Completion of removal plan at 2:00 pm on 5/6/26On 05/06/2026, the facility's policy for the storage of chemicals was requested. The policy states, [Housekeeping] Carts need to be remain locked at all times and no chemicals stored within easy reach. The policy also states, Janitor closets should be identified on the outside of the door and are to remained locked at all times.On 05/06/2026 beginning at 2:15 PM, a second review of resident rooms and activity room was conducted, with verification that all chemicals were secure.On 05/06/26 at 2:50 PM, additional interviews were conducted with various departments 3 LPNs, 4 certified nursing assistants, Director of Maintenance, Social Services Assistant, 2 Housekeeping aides, Dietary aide, Physical Therapy Aide and 2 Unit Managers. All staff interviewed were able to articulate re-training conducted and what type of items could be potentially dangerous if left unsecure in a resident room or common area.The survey team concluded verification of the IJ removal plan on 05/06/2026 and determined that IJ had been removed. Following the removal of IJ, the scope and severity was lowered to a level 2, pattern.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, staff interviews, clinical record review and facility document review, the facility staff failed to deliver the prescribed oxygen flow rate according to the physician's order for (1) one of (13) thirteen residents in the survey sample (Resident #6)Findings include:Resident #6 was admitted to the facility 4/1/25 with diagnoses to include but not limited to chronic obstructive pulmonary disease, chronic respiratory failure with hypoxia, diabetes mellitus type 2, chronic kidney disease stage 3, convulsions, hypertensive heart disease, and heart failure. Resident #6's most recent MDS (Minimum Data Set Assessment) with an ARD (Assessment Reference Date) 3/30/26 coded the resident in Section C. Cognitive Patterns for a BIMS (Brief Interview Mental Status) of 09 out of 15 indicating resident has moderate cognitive impairments with memory, attention and orientation. Section 0. Special Treatments C1 was coded yes for use of oxygen.On 5/4/26 at 12:20 PM, during initial rounds Resident #6 was observed in her bed with the head of the bed elevated and the oxygen concentrator set on 6 liters per minute via nasal cannula. On 5/4/26 at 12:30 PM, Unit 2 Nurse Manager confirmed the oxygen concentrator was set at 6 liters, which exceeded the ordered 4 liters per minute and she adjusted the flow rate. When asked what the danger of exceeding the oxygen flow rate she stated, it could be toxic to the resident. A review of the clinical record revealed nurse practitioner progress notes dated 5/4/26 and 5/5/26 reading in part continue supplemental oxygen at 2 liters per minute via nasal cannula. A review of Resident #6's physician orders revealed an order for oxygen continuous at 4 liters per minute via nasal cannula. A review of Resident #6's care plan revealed a care plan focus: Respiratory: the resident is at risk for respiratory complications secondary to chronic obstructive pulmonary disease and chronic respiratory failure with hypoxia Created on: 12/17/2024 Revision on: 05/05/2026 with intervention to administer oxygen as ordered Created on: 12/17/2024.On 5/7/26 at 2:06 PM during a meeting with the Administrator, DON (Director of Nursing), Regional Director of Clinical Services and Regional Director of Operations, these findings were shared. The DON was asked what outcome of oxygen flowrate exceeding the physician's order be. According to the DON, the gas exchange of multiple concerns may occur and that could be dangerous to residents. When asked what she expected nurses to do to monitor oxygen flow rate she responded, they are to check the oxygen flow rate each shift, when in and out of the room, when providing meds, and all throughout the day. A review of the facility's policy titled, Respiratory Care & Oxygen Equipment, Poly #1901, effective date 1/19/24, reads in part, Procedure, 1b. Follow physician's order for flow rate and/or oxygen concentration. 4. For continuous oxygen therapy, verify and document in the medical record each shift and as needed. No further information was provided.

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	495123	A. Building B. Wing	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wonder City Rehabilitation and Nursing Center	905 Cousins Avenue Hopewell, VA 23860

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on observation, resident and staff interview, facility document review, and resident record review, the facility failed to provide sufficient nurse staffing to meet the needs of residents on two of two units.The findings included:The facility staff failed to ensure that adequate staffing was maintained to meet the needs of residents when nursing staff walked out on 4/6/26, due to chronic staffing issues, which resulted in Resident #1, Reisdent #2, and Resident #5 not receiving medications timely. On 05/04/2026 at 1:35 PM, Unit Manager second Floor was interviewed about an incident of staff walking out of the building. She stated that this was one incident I believe and it was in March or April on dayshift. She also stated, it was normal to be working with two or three CNAs all the time, she also said when all the CNA?s walked out that day, there was an ?all hands-on deck and two of the three CNAs returned. She added that this incident prompted the use of agency and identified the CNAs on shift that day. On 05/04/2026, at 1:45 Unit Manager First Floor was interviewed related to staffing. She stated they had been staff challenged some days, stating there was usually two CNA?s, maybe three, and four on a good day. On the day (04/06/2026) that the staff walked out, she stated there were three CNAs for the entire. She stated that administrative staff assisted the residents when the staff walked out. On 05/04/2026 at 2:09 PM, CNA #1 was interviewed. She was one of the CNAs that walked out of the facility on 04/06/2026. She has been a CNA at the facility for 37 years. Certified Nursing Assistant #3, another one of the CNAs that walked out on 04/06/2026, was also interviewed at the same time. She has been an employee at the facility for 24 years. The CNA's stated that they were tired of only having two CNAs for 60 residents. They stated the weekends were the worst times with staffing. Certified nursing assistant #1 stated that she had worked short all weekend and then to come in on Monday, 04/06/2026, and only have three CNAs really frustrated her. They stated they left a little after 8:00 AM and came back by a little after 9:00 AM and administrative staff were helping residents. The CNAs stated staffing has been better since they walked out. On 05/04/2026 at 2:25 PM, the Scheduler/Staffing Coordinator was interviewed about staffing patterns and challenges. She stated whenever there were staffing challenges, she let the Administrator know. When she was asked what staffing should be, she stated she believes the PPD is budgeted for 3.27. When asked how many CNA should be on each shift, she stated 12 CNAs on dayshift, 10 CNAs on evening shift, and eight CNAs on night shift. She stated during the time of being staff challenged with CNAs she went to the Administrator and agency was requested and corporate said no to agency. The Scheduler/Staffing Coordinator was asked about the time between January and April 2026, she stated that 70% of the time they were short staffed with two to three CNAs per unit per shift and during this time they were using agency for nurses. She stated they had daily staffing meetings with Human Resources, the Scheduler/Staffing Coordinator, and the Administrator. On 05/04/2026 at 2:44 PM, the Director of Nursing was interviewed. When asked about what staffing patterns had been like and if nursing had been short staffed. She stated at times there were three CNA?s on one unit and there could be two on one unit because of callouts. The Director of Nursing was asked if they had ever considered using agency because of being very short staffed. She stated she asked for agency and the Regional Director of Operations would not approve it. The Director of Nursing advised that daily staff meetings were happening, which included Human Resources, the Administrator, the Scheduler/Staffing Coordinator, and the Director of Nursing. On 05/04/2026 at 3:00 PM, MDS Coordinator #2 was interviewed. When asked about staffing, she stated that it was not unusual to have two or three CNA?s on a unit since she started. She stated she started as a unit manager and became an MDS coordinator in March. She stated during her time as a unit manager, she asked for agency or other help with staffing for a while, she notified the Administrator. She said the Administrator said he would talk to corporate. She was asked if she saw an increase in acquired wounds. She said she did see an increase in acquired wounds and that it could've been attributed to (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	staffing. On 05/05/2026, the survey team requested documentation/meeting minutes related to staffing meeting since 01/01/2026. On 05/05/2026 at 3:45, the survey team was provided with a Weekly Retention Focus Meeting Agenda, dated Tuesday February 24, 2026, at 3:00 PM. A facility census provided to the survey team on 05/07/2026 for 04/06/2025 revealed that occupancy for the day the CNA's walked out was 123 of 131 (93.9%). On 05/07/2026, medication administration records for 04/06/2026 were provided to the survey team. Records revealed that Resident #2 was scheduled to receive Insulin Lispro (1 unit Dial) Subcutaneous Solution Pen-injector 100 Unit/ML at 7:30 AM and did not receive the medication until 9:55 AM. On 04/06/2026, Resident #1 was scheduled to receive Ferrous Sulfate Tablet 325(65 Fe) MG at 8:00 AM and eight medications at 9:00, Two medications were administered at 10:26 AM and the other eight were administered at 10:28 AM. On 04/06/2026, Resident #5 was scheduled to receive Metoprolol Tartrate Tablet 25 MG and one other medication at 8:00 Am and Lipitor Oral Tablet 80 MG and five other medications at 9:00 AM, six of the medications were administered at 12:53 PM and the other two were administered at 12:55 PM. No additional information was provided.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on staff interview, facility document review, and review of nursing schedules, the facility failed to ensure the services of a registered nurse were provided for at least 8 consecutive hours a day, 7 days a week, as required by S483.35(b), for a facility census of 123 residents.This deficient practice had the potential to affect all residents residing in the facility requiring ongoing nursing assessment, clinical oversight, care planning, change in condition evaluation, medication management, and supervision of licensed nursing staff.The findings included: Review of the facility nursing schedules, staffing records, and daily assignment sheets revealed the facility failed to schedule or provide coverage by a registered nurse (RN) for at least 8 consecutive hours on the following dates:4/4/26 and 4/5/26: No RN scheduled or documented as working during the required 8 consecutive-hour period and posted staffing records lacked evidence of RN presence for the required duration.Further review of payroll records and staffing documentation failed to demonstrate an RN was present and providing services during the identified periods.During an interview on 4/7/26 at 3:45pm, the Director of Nursing acknowledged the facility did not have RN coverage for the identified dates and stated the facility was experiencing staffing challenges.The facility's failure to ensure RN services were provided for at least 8 consecutive hours per day in a 24 hour period constitutes noncompliance with 483.35 (b).The Director of Nursing confirmed no supplemental staffing documentation or alternate RN coverage records were available.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Based on observation, resident and staff interview and facility document review, the facility failed to provide sufficient dietary support personnel resulting in meals being served late to residents on two of two units.The findings include:On 05/04/2026, during the facility's entrance conference, the facility provided the survey team with a document of mealtimes. The document read as follows:Resident Mealtimes: Breakfast Hours 7:30am, Lunch Hours: 11:45am 2nd & 1st floor, Dining Room - 1:00pm. Dinner Hours: 4:45pm 2nd & 1st floor, Dining Room - 6:00pm. Snack Times - 10am, 2pm, 8pmOn 05/05/2026 at 9:00 AM a tour of unit one was conducted to observe breakfast, breakfast had not been served on the unit.On 05/05/2026 at 9:05 AM. Resident #3 asked me where breakfast was. Nurse #2 , the nurse assigned to Resident #3 said it should be coming soon.On 05/05/2026 at 9:23 AM, The Administrator was asked about breakfast and whether it was a normal occurrence for breakfast to be this late. He stated, Trays should have come around eight-ish.On 05/05/2026 at 9:23 AM the first tray cart came to unit one.On 05/05/2026 at 9:37 AM, Resident #3 called me in her room again to ask about breakfast because she still had not received her food.On 05/05/2026 at 9:41 AM, the second tray cart came to unit one.On 05/05/2026 at 9:42 AM, Nurse #2, assigned to this hall was asked why breakfast had not arrived as it was nearly 10:00 AM. She said that there was only the Dietary Manager and one other person in the kitchen because of callouts.On 05/05/2026 at 9:45 AM, Resident #10 and #15 asked the administrator where breakfast was and he stated it should be coming now.On 05/05/2026 at 9:47 Resident #3 asked again when food is coming.On 05/05/2026 at 9:48 AM, the Regional Director of Clinical Services #2 was rounding on the hall and checked on Resident #16. Resident #16 stated they were hungry and the Regional Director of Clinical Services #2 offered a snack.On 05/05/2026 at 9:51 AM, Resident #3 again asked when food is coming.On 05/05/2026 at 9:55 AM, the third meal tray cart came to unit one.On 05/05/2026 at 10:00 AM, Resident #3 called out again, Where's my food and an aide brought her tray in.On 05/05/2026 at 1:40 PM, the Registered Dietitian was asked why breakfast did not come out until 10:00 AM. She said she believed it was because there were two callouts in the kitchen and there was only two staff to prepare the meals. On 05/05/2026 at 3:02 PM, the Dietary Manager was interviewed about why breakfast did not come out on unit one until 10:00 AM. She said it was because it was only her and the cook in the kitchen that morning. The Dietary Manager was asked what time dinner was served on Monday. She stated It was between 4:45 PM and 5:15 PM, indicating that it was nearly 17 hours between the meals.Resident council meeting minutes from January 2026 reveal that in response to concerns about late meal times, the Dietary Manager's written response states, late meal times could be caused by staff shortages which results in slower meal preparation and try assembly. Complex meals or limited equipment cause prep to take longer than planned.No additional information was provided.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, resident and staff interview, clinical record review, and facility document review, the facility failed to provide food and drink that is palatable, attractive, and at a safe and appetizing temperature affecting residents on two of two units.The findings include:On 05/05/2026 at 9:10 AM, Resident #4 was interviewed and asked about meals at the facility. She said the food is terrible and not good, she also said it is sometimes cold, especially breakfast.On 05/05/2026 at 4:53 PM an interview with the Administrator was conducted and he was asked about why residents are being served meals in Styrofoam, he said it is because the dishwasher is broken. When asked how long the dishwasher had been broken, a definitive timeframe could not be provided, just that it had been months.Resident council meeting minutes from April 2026 reveal that in response to concerns about meal temperatures, the Dietary Manager's written response states, Due to equipment out of service (dishmachine) we are using Styrofoam which makes it a little difficult to keep food hot as it loose temp. due to not being able to use hot plates/pellets. Late trays/carts are sometimes unavoidable due to preparation equipment not in service which mean it takes longer to prepare everything at once.Facility documentation review of resident council minutes revealed concerns with the preparation and appearance of meals during the January resident council meeting. Concern with the temperature of meals was recorded in resident council meetings in February, March, and April. No additional information was provided.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on observation, resident interview, clinical record review and facility document review, the facility staff failed to honor resident's food preferences for (1) one of (13) thirteen residents in the survey sample (Resident #8).Findings included:Resident #8 was originally admitted to the facility 11/25/25 and re-admitted after a hospitalization from 4/26/26 to 5/1/26 for a GI bleed (gastro-intestinal, bleeding in the stomach). Other diagnoses included but are not limited to diabetes mellitus type 2, (GERD) gastroesophageal reflux disease, anemia, atrial fibrillation (irregular heart rate), hypertension, asthma, hemiparesis and hemiplegia following a cerebral infarction (reduced strength in extremities following a stroke), and memory deficit following stroke.Resident #8's most recent MDS (Minimum Data Set Assessment) with an ARD (Assessment Reference Date 3/3/26 coded the resident as completing the BIMS (Brief Interview for Mental Status) 15 out of 15. This indicates the resident is cognitively intact for daily decision making.On 5/5/26 at 9:00 AM, Resident #8 was visited as she was finishing her breakfast. Resident #8 expressed displeasure that kitchen staff failed to ensure that her meal preferences were honored. Resident #8 said, Look here, just look here, my oatmeal is smothered in butter, I can't eat this, it messes with my reflux, and I don't eat sausage or bread because it goes against my body. A review of Resident #8's meal ticket revealed: oatmeal, hard-boiled egg, hot cereal, egg patty (alternate-bread, alternate-breakfast meat); Dislikes: Bread, sausage, grits, potatoes, orange juice, scrambled eggs, fried eggs. Resident #8's meal tray revealed hard-boiled eggs, toast, sausage patty, oatmeal with butter. Resident #8 stated she was happy with her hard-boiled eggs but not with the oatmeal smothered in butter and the toast and sausage.On 5/5/26 at 11:55 AM, Resident #8 was visited during the midday meal where she received meal tray with sliced ham, broccoli and tomato soup, magic cup, lemonade. Meal ticket revealed: Alternate entree, broccoli, brownie, apple juice and magic cup. As Resident #8 was eating her lunch, Unit 2 Nurse Manager came in with a bowl of chicken noodle soup and removed the tomato soup. Meal ticket showed Dislikes: Bread, potatoes, tomato sauce, fried foods, mayonnaise, orange juice. On 5/5/26 at 2:20 PM during a meeting with the RD (Registered Dietician), Resident #8's food preferences and care plan were discussed. According to the RD, the residents' preferences should be honored, and the staff has been trying to honor her preferences, but it has been a challenge as they change frequently. The RD revealed that a care plan meeting had been conducted with the resident, her granddaughter, dietary, nursing and social services on the morning of 5/4/26 that included discussion of her food preferences, and her meal ticket was being updated as her preferences changes.On 5/6/26, a review of Resident #8's care plan focus at nutritional risk revealed an intervention of honor diet-compliant food preferences as made known by resident Created on: 12/01/2025 Revision on: 12/01/2025 On 5/7/26 at 2:06 PM during a meeting with the Administrator, (DON) Director of Nursing Services, Regional Director of Clinical Services, and Regional Director of Operations, they were made aware of Resident #8's food preferences not being honored on 5/5/26 for breakfast and lunch.No further information was provided.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interview, and facility documentation review, the facility staff failed to store, prepare and serve food in accordance with professional standards for food service safety in the main kitchen, which had the potential to affect residents on two of two units. The findings included:The facility staff failed to maintain the main kitchen in a clean and sanitary manner which had the potential to affect residents on two of two units as all food is stored, prepared and served from the main kitchen.On 5/6/26 at 2:45 PM, a tour was conducted of the facility's kitchen, the surveyor was accompanied by the dietary manager. The tour revealed the kitchen and food storage areas were not maintained in a clean and sanitary manner. There were multiple dead bugs noted in the food service area (underneath the three-compartment sink), outside of the walk-in freezer and in the dry storage area.Throughout all areas of the kitchen were food crumbs, debris and a build-up of grime. The food preparation area was not clean and sanitary. Throughout the kitchen and food storage areas were significant damage to the walls, base boards and tile missing, walls pulling away leaving gaps and a disregard for repair and upkeep of the kitchen area. Following the observations/tour of the kitchen, an interview was conducted with the dietary manager. When asked about the kitchen and the identified areas of concern discussed during the tour, the dietary manager reported that the kitchen needed a lot of attention. The dietary manager was asked about the cleaning schedule of the kitchen. The dietary manager reported they have a cleaning schedule and provided the surveyor with two separate logs. One log was titled, Cooks daily cleaning assignments which identified various equipment to include, grill, steam table, steamer, tilt skillet, convection oven, fryer, prep wall, spice cart, all prep tables, and slicer. The second was titled, Monthly Cleaning Assignments. The monthly cleaning assignment noted, Clean plate/tray/mug dollies, walk in freezer, walk-in [cooler], sweep/mop dish room, clean all baseboards, ceiling vents, slicer table/above shelf and below, clean convection ovens, clean conventional. When asked if there was any daily cleaning schedules other than what had been provided, the dietary manager reported while there wasn't a form they do mop the floor daily. On 5/7/26 at 1 PM, an interview was conducted with the facility administrator. When asked if he visits the kitchen, the administrator reported he visits the kitchen a couple of times a week I make rounds. When asked if he had identified any concerns, he reported, no. When asked what he looks for when making rounds in the kitchen, the administrator said, I look at the temperature logs, ensure everything is stored correctly, that's mainly what I am going in there for, checking out the tray line and temperatures. When asked if he had any observations regarding the cleanliness of the kitchen, the administrator said, it is usually pretty clean when I go.According to the Food Code, U.S. Public Health Service 2017 published by the U.S. Department of Health and Human Services, Public Health Service, Food and Drug Administration, it read in part, .This shared responsibility extends to ensuring that consumer expectations are met and that food is unadulterated, prepared in a clean environment, and honestly presented. Section 2-102.11 read in part, Based on the risks inherent to the food operation, during inspections and upon request the person in charge shall demonstrate to the regulatory authority knowledge of foodborne disease prevention, application of the hazards analysis and critical control point principles, and the requirements of this Code. The person in charge shall demonstrate this knowledge by: . (8) Describing the relationship between the prevention of foodborne illness and the management and control of the following: . d) Maintaining the food establishment in a clean condition and in good repair. Section 3-305.111 of the Food Code, titled, Food Storage read, (A) Except as specified in (B) and (C) of this section, food shall be protected from contamination by storing the food: (1) In a clean, dry location. Section 4-602.13 read, Nonfood-Contact Surfaces. Nonfood contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues.No additional information was provided.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility staff failed to have credible evidence of a hospice plan of care, services provided by hospice and documentation of hospice provider visits for (1) one resident in a survey sample of (13) thirteen residents receiving hospice care (Resident #5).Findings included: Resident #5 was admitted to the facility on [DATE] with diagnosis including but not limited congestive heart failure, pulmonary embolism (blood clot), hypertension, chronic obstructive pulmonary disease, anxiety, and myocardial infarction (heart attack). Resident #5 was admitted to hospice services on 12/18/25. Resident #5's most recent MDS (Minimum Data Set) Assessment with an ARD (Assessment Reference Date) of 3/24/26 coded the resident in C0500 BIMS (Brief Interview of Mental Status) Summary as a 15 out of 15 indicating resident was cognitively intact and Section K1. the resident was coded as Yes for receiving hospice services.On 5/7/26 during clinical record review for Resident #5, an order read as admitted to [name redacted] hospice services with admitting diagnosis: Congestive Heart Failure. No 911, Do not transport, continue scheduled/ and (PRN) as needed medications, No vital signs (monitoring of blood pressure, heart rate, respirations or temperature), labs, or weights. Further review of the clinical record did not reveal any visit notes or visit documentation from hospice provider nurses, aides, social services, or clergy and no hospice plan of care or hospice agreement was found. Progress notes written by the facility's attending physician, nurse practitioners and nurses did show that Resident #5 was receiving hospices services for congestive heart failure, that she had orders for medications to manage pain and anxiety as needed, and that hospice providers were being notified of changes in condition such as fall events and nausea by the facility staff. No evidence of documentation or visit notes from the hospice provider. Resident #5 has been receiving comfort care services from [name redated] hospice services since 12/18/25.A review of Resident #5's care plan revealed a care plan focus titled, HOSPICE: The resident is receiving hospice services and is not expected to improve in condition for diagnosis of: CHF (congestive heart failure), NO vital signs, labs, or weights. admitted to (name redacted) Hospice with admitting diagnosis: Congestive Heart Failure. Attending Physician- [name and telephone number redacted] Created on 12/19/2025 and Revised 04/24/2026. The care plan included interventions: admitted to [name redacted] Hospice with admitting diagnosis: congestive heart failure. Do not call 911, do not transport to hospital, continue scheduled medications and medications as needed (PRN), No vitals, labs, or weights, refer to hospice provider as needed, see hospice plan of care.Unable to locate a plan of care developed by Hospice provider.On 5/7/26 at 1:25 PM, during a visit with Resident #5 she confirmed she had been receiving hospice services for a few months due to her diagnosis of heart failure.On 5/7/26 at 2:00 PM during a meeting with the Administrator, (DON) Director of Nursing Services, and Regional Director of Clinical Services, the DON was asked where hospice visit notes and hospice plan of care documentation and agreement could be found for Resident #5. According to the DON, all hospice documentation and paperwork is kept in a designated purple binder located at the nurse's station.On 5/7/26 at 6:00PM, the Administrator was asked if they had presented all the documents requested and he stated Yes, we have given you everything you have requested except we are waiting for a fax from the hospice provider for [name redacted] Resident #5. When asked what they were waiting for from hospice, the DON entered the room and said they were waiting for the hospice provider to fax over the hospice visit notes and other hospice related paperwork as they were unable to locate the purple hospice binder for Resident #5. She stated that they had had a change in Unit Managers and were not able to locate the purple binder for Resident #5 and the documents had not been scanned into the electronic medical record. When asked what her expectation of documentation of visits and the plan of care from the hospice provider was, she said, They should be in the resident's chart or a designated binder.A request for the facility's policy on hospice services policy was requested, none was provided.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	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wonder City Rehabilitation and Nursing Center	905 Cousins Avenue Hopewell, VA 23860

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0850 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Hire a qualified full-time social worker in a facility with more than 120 beds. Based on staff interview and record review, the facility failed provide a full-time, qualified social services worker meeting requirement of S483.70(p). Specifically, the facility employed an individual with a Bachelor of Science degree as the facility social worker; and the facility was unable to provide credible evidence demonstrating the individual had completed at least one year of supervised social work experience under the supervision of a qualified bachelor's degree-level social worker. This deficient practice had the potential to affect residents requiring psychosocial assessment, discharge planning, behavioral support services, and coordination of resident rights and social service needs. The findings included: Personnel file review for SW (Social Worker) 1, identified by the Administrator as the facility's social worker, revealed documentation of a Bachelor of Science degree. The personnel file lacked evidence of:A bachelor's degree in social work.Documentation demonstrating one year of supervised social work experience under the supervision of a qualified social worker.During an interview on 5/7/26, at 2:55pm, the Administrator stated SW#1 had a degree in human services with a major in criminal justice. When asked if SW # 1 degree and training met the required qualifications, the Administrator stated yes, she has been in other buildings. The Administrator did not have additional documentation supporting supervised social work training or experience for SW #1.On 5/7/26 at 3:30pm the Administrator presented a document titled SWDP (Social Workers Department) New Hire Orientation Training dated 3/6 with seven attendees as well as four documents titled Central Weekly SWDCP Meeting dated 3/23/26, 4/13/26 and 4/27/26. Provided documents, did not reveal supervised training. On 5/7/26 at: 4:00p.m., Administrator, Director of Nursing and Regional Nurse were informed of this concern. No additional information was provided prior to exit.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview, staff interview, and facility documentation review, the facility staff failed to maintain essential equipment in a functional manner in the main kitchen, which affected residents on two of two units.The findings included:On 5/4/26, during observations of the meals, it was noted that all residents were being served on Styrofoam/disposable containers with disposable cups and utensils. On 5/5/26 at 9:10 AM, Resident #4 was interviewed and asked about meals at the facility. She said the food is terrible and not good, she also said it is sometimes cold, especially breakfast.On 5/5/26 at 4:53 PM, an interview was conducted with the facility administrator. When asked about residents being served with disposable tableware, the administrator reported the dishwasher was broken. Review of the resident council meeting minutes revealed that during the April 2026 meeting a grievance form was completed and according to the investigative initiatives it noted, 2. Due to equipment out of service (dish machine) we are using Styrofoam which makes it a little difficulty to keep food hot as it loose temperature [sic]. Similar concerns about the food being cold were reported in February and March resident council meetings.On 5/6/26 at 2:45 PM, a tour was conducted of the facility's kitchen with the dietary manager. The tour revealed that the dish room had plastic sheeting hanging from the ceiling to block the room off from the remainder of the kitchen area, the area did not contain a dish machine. In the back storage area of the kitchen, the dietary manager identified two large pieces of equipment that were still packaged and encased in a wooden shipping crate as the two dish machines that had been delivered. The dietary manager went on to explain that the facility has been using disposable dishes for several months due to the dishwasher having to be replaced. The dietary manager reported a dish washer went down the beginning of March, it stopped getting the dishes clean. She reported the service technician came and noted the machine would not reach temperature and indicated the machine needed to be replaced. He then ordered a replacement machine.The dietary manager reported that when the dish machine was delivered, the service technician returned to install it and said it was the wrong machine, so he then ordered another dish machine. The old machine was then removed by the service technician and the dietary manager said, we had to replace tile in the dish room, it was broken and cracked. The dietary manager went on to report that they determined the floor in the dish room also needed to be replaced. The maintenance department reported the floor was completed on Sunday, 5/3/26, but it needed time to cure so they had to postpone the scheduled install of the new dish machine for 5/4/26. The dietary manager reported the new install date is scheduled for 5/19/26.On 5/6/26 at 3 PM, an interview was conducted with the facility's maintenance director. The maintenance director reported that the facility could not use their two-compartment sink, it was turned off last week, so the only means to wash dishes or cooking pans and utensils was the three-compartment sink. The maintenance director reported that the contracted company they lease kitchen equipment from came and did an inspection and determined the floor needed to be replaced before the new machine could be installed. The maintenance director reported that he and his staff did the work and completed the floor on Friday, 5/1/26. On 5/6/26 at 3:27 PM, an interview was conducted with the service technician from the lease company. The service technician explained that they had to postpone installation of the new dishwasher on several occasions, due to the wrong machine, the floor repairs, etc. He went on to explain that they also had to replace the chemical dispensers for the three-compartment sink since the chemicals were no longer available for the dispensers in use. When asked when the dish machine went down and quit working, the service technician referenced from documents and reported in January or February he determined the machine needed to be replaced and in February or March it went out of service. The technician said, they have been on paper for some time. After looking at service records, he reported that on February 5, 2026, the vacuum breaker was leaking very badly, and it could not be repaired so he decided the machine needed to be replaced. On 5/7/26, the facility (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	administrator provided evidence of text messages with the service technician dating back to mid-February where they were awaiting the signature of the lease to order the new dish machine. There were also messages indicating an install date of March 26, 2026, which wasn't completed. Then on May 3, notice that the floor needed three days to dry and the installation had to be postponed again.On 5/7/26 at 1 PM, an interview was conducted with the facility administrator. When asked to explain the timeline of events involving the dish machine, the administrator reported, It was old, had some issues. They would send tech to fix it; they would fix it. In February it completely stopped working, we reached out to [company the dish machine was leased from redacted], they figured out what to do and said it was best to get a new machine. February 13, they sent over a lease, on February 19 it was signed. March 2, 2026, I reached back out and they didn't have any update on the status of the new machine. Sometime in March we received the new machine, they said it was the wrong unit and removed the existing machine. Fast forward a few weeks and we received what they said was the correct machine. Ends up they said the first machine was correct and we didn't need the second one, there was a gap in all this with getting another machine ordered, etc. They gave an install date of this Monday [5/4/26] but they had to reschedule to May 19 because the floor needed to dry.On 5/7/26 at 4:10 PM, another interview was conducted with the facility's maintenance director. When asked for details about how the repairs to the floor in the kitchen dish room came about and what had to be done, the maintenance director said, we had to rebuild the floor back up and replace some pipes, clean up in the area- had some fruit flies, had to wait for it to dry. The maintenance director reported the repairs took about a week and a half. When asked what the delay in getting the floor in the kitchen repaired was, the maintenance director said, We had to finish room [ROOM NUMBER] so we could fill the building up. We had to rebuild the room; they hadn't had it up [available for occupancy] for several years. We redid the floors, put new closets in, new lights, a new p-tac unit [personal heating/air unit], new beds, painted and everything. We had to finish that before we could start on the kitchen floor.On 5/7/26, during an end-of-day meeting, the above concerns and the details of the facility being without a functioning dishwasher for several months, which has resulted in the use of disposable dishes, was discussed. In addition, the use of disposable dishes has been identified as the reason for ongoing resident complaints about cold and unpalatable food. No additional information was provided.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observation, staff interview, and facility documentation review, the facility staff failed to maintain an effective pest control program affecting the main kitchen, which had the potential to affect residents on two of two units, as all food for the facility is stored and prepared in the main kitchen. The findings included:On 5/6/26 at 2:45 PM, a tour was conducted of the facility's kitchen, the surveyor was accompanied by the dietary manager. The tour revealed a dead bug that appeared to be a cockroach underneath the three-compartment sink where a staff member was actively washing meal service pans/dishes. When the dietary aide was asked about pest control, he reported it is better than it used to be and they rarely see pests.As the observations in the kitchen and food storage areas continued, another dead bug, which appeared to be a dead cockroach, was noted in the dry storage room floor. Along the outer wall/doorway of the walk-in freezer was another dead bug. Dietary staff were actively cleaning the door in the hallways where the walk-in freezer was located. There was visible damage to the walls, baseboards missing, cracks and large crevices that appeared to be long-standing were identified throughout the kitchen and food storage areas. Further review revealed that under the three-compartment sink was a large access gap around a drainage pipe that could allow pests entry into the kitchen. At the back door of the kitchen, was a gap between the doors where pests could enter.Following the observations/tour of the kitchen, an interview was conducted with the dietary manager. When asked about pests in the kitchen and the needed repairs to the wall, the dietary manager reported that the kitchen needed a lot of attention. An interview was conducted with the cook, who reported that he feels the pest problem has improved.On 5/6/26-5/7/26, a review of the pest control records revealed that a contracted pest control company had been making routine visits to the facility. In their monthly reports it was noted that the areas identified/observed by the surveyor had been identified in the pest control company's routine reports dating back to January 2025. Many of the items were identified in the report as having a high priority level noting they . allowing pest access. Please repair to prevent pest entry.On 5/7/26 at 4:10 PM, during an interview with the facility's maintenance director, he was asked about pest control within the facility. The maintenance director reported that usually they come one to two times a month, I meet them, give them the pest control book kept at the nursing station and go through what the nurses have written. They go to the location and take care of it. I ask them to call me when they leave, sometimes they leave a report, or I ask them to send it. When asked what the maintenance director does with the reports, he said, I just stick them in the book, I didn't look through the last few reported. I just learned about it in the last three months and how big pest control is here, that's when I took it seriously.On 5/7/26 at 1 PM, an interview was conducted with the facility administrator. When asked if he visits the kitchen, the administrator reported he visits the kitchen a couple of times a week I make rounds. When asked if he had identified any concerns, he reported, no. When asked what he looks for when making rounds in the kitchen, the administrator said, I look at the temperature logs, ensure everything is stored correctly, that's mainly what I am going in there for, checking out the tray line and temperatures. When asked if he had any concerns with pests in the kitchen, the administrator said no.During the above interview with the administrator, he was asked about their pest control contracted company and if he reviewed their reports. The administrator said, sometimes, they go to [the maintenance director's name redacted]. It is his responsibility to make sure they provide services when they come out, we call if we have urgent issues. When asked if he was aware they made recommendation in their report, the administrator said, I was not aware they had recommendations. The pest control reports were reviewed with the administrator, and it was noted that identified issues from over a year ago had yet to be corrected and there was evidence of active pest activity within the kitchen during the survey. Review of the facility's policy titled, Pest Control with an effective date of 5/1/2022 was conducted. The policy read in part, The center environment will be inspected monthly and treated for pests by a corporate-approved contractor.No additional information was provided.