STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495097	A. BUILDING _____ B. WING _____	C 09/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARHAM HEALTH CARE & REHAB CEN	2400 E PARHAM ROAD RICHMOND, VA 23228

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 9/26/17 through 9/28/17. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. 3 complaints were investigated during the survey. The census in this 180 certified bed facility was 166 at the time of the survey. The survey sample consisted of 22 current Resident reviews (Residents #1 through #22) and 4 closed record reviews (Residents #23 through #26).	F 000		
F 155 SS=D	RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES CFR(s): 483.10(c)(6)(8)(g)(12), 483.24(a)(3) 483.10 (c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. (g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the	F 155		10/19/17

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

Electronically Signed | 10/16/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495097	A. BUILDING _____ B. WING _____	C 09/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARHAM HEALTH CARE & REHAB CEN	2400 E PARHAM ROAD RICHMOND, VA 23228

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 155	Continued From page 1 resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. 483.24 (a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to have a completed DDNR (Durable Do Not Resuscitate) form for 1 of 26 residents in the survey sample. (Resident #1)	F 155	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495097	A. BUILDING _____ B. WING _____	C 09/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARHAM HEALTH CARE & REHAB CEN	2400 E PARHAM ROAD RICHMOND, VA 23228

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 155	Continued From page 2 The findings included: The facility staff failed to have a completed DDNR (Durable Do Not Resuscitate) in the clinical record for Resident #1. Resident #1 was admitted to the facility on 5/31/16 with the following diagnoses of, but not limited to heart failure, high blood pressure, arthritis, anxiety disorder and chronic obstructive pulmonary disease. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 7/14/17, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 13 out of a possible score of 15. Resident #1 was also coded as requiring supervision for eating and personal hygiene and requiring extensive assistance from 1 staff member for bathing. During the clinical record review on 9/27/17 performed by the surveyor it was noted that the resident's DDNR was not completely filled out. Under the section "I further certify (must check 1 or 2): 1. The patient is CAPABLE of making an informed decision, about providing, withholding, or withdrawing a specific medical treatment or course of medical treatment ... 2. The patient is INCAPABLE of making an informed decision about providing, withdrawing, or withholding a specific medical treatment or course of medical treatment because he/she is unable to understand the nature, extent, or probable consequences of the proposed medical decision, or to make a rational evaluation of the risks and benefits of alternatives to that decision." Neither of the above statements was checked by	F 155	completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. F155 1. Resident #1 DDNR was corrected as appropriate MD and RP aware 2. All resident will DDNR are at risk. An audit of resident who have DDNR was review for completion 3. The nurse educator or designee will educate licensed nursing staff on completion DDNR . 4. The DON or designee will audit all residents with DDNR orders 3x a week x 2 weeks, then weekly x 2 then monthly x 2 . Results will be reviewed quarterly x2 in QA Meeting	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495097	A. BUILDING _____ B. WING _____	C 09/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARHAM HEALTH CARE & REHAB CEN	2400 E PARHAM ROAD RICHMOND, VA 23228

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 155	Continued From page 3 the physician. On 9/27/17 at approximately 4 pm, the administrative team was notified of the above documented findings by the surveyor in the conference room. The administrative staff member #3 stated "That form is used for when the resident is transferred outside of the facility for any reason, but it does need to be completed". No further information was provided to the surveyor prior to the exit conference on 9/28/17.	F 155		
F 176 SS=D	RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE CFR(s): 483.10(c)(7) (c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview, facility document review and clinical record review, the facility staff failed to assess and educate the resident's ability to self-administer a medication for 1 of 26 residents in the survey sample. (Resident #1) The findings included: The facility staff failed to assess and educate Resident #1's ability to self-administer Albuterol nebulizer treatments as ordered by the physician. Resident #1 was admitted to the facility on 5/31/16 with the following diagnoses of, but not limited to heart failure, high blood pressure,	F 176	F176 1. Resident #1 medical record was clarified that facility nursing staff will administer patient medication 2. All residents desiring to self-medicate are at risk. An audit of resident who self-administer medication will be reviewed to ensure that each resident has been assessed and educated on self-administration of medication. 3. The Nurse Educator or designee will educate licensed nurses on assessment and education of residents who wish to self-administer medication 4. The DON or designee will review audit all new resident who self-administer	10/19/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495097	A. BUILDING _____ B. WING _____	C 09/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARHAM HEALTH CARE & REHAB CEN	2400 E PARHAM ROAD RICHMOND, VA 23228

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 176	Continued From page 4 arthritis, anxiety disorder and chronic obstructive pulmonary disease. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 7/14/17, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 13 out of a possible score of 15. Resident #1 was also coded as requiring supervision for eating and personal hygiene and requiring extensive assistance from 1 staff member for bathing. On 9/26/17 at 5 pm, the surveyor observed Resident #1 self- administering an Albuterol nebulizer treatment. The surveyor asked the resident if she gave herself this treatment all the time. Resident #1 stated, "oh, yes. I don't have any problems in doing it." At 5:15 pm, Licensed practical nurse (LPN) # 3 was interviewed by the surveyor. The surveyor asked LPN #3 if Resident #1 self- administered the Albuterol nebulizer treatment to herself. LPN #3 stated "Yes she does and does very well with it. I don't have to do anything to help her with this." During the clinical record review by the surveyor on 9/27/17 at 9 am, the surveyor noted the following physician order dated for 4/11/2017 which stated "may self administer meds (medicines) in room." On 9/27/17 at 10:30 am, the surveyor notified administrative staff member #4 was notified of the above documented findings. Administrative staff member #4 stated that he would have to check into this and get back to the surveyor with the information.	F 176	3x a week x 2 weeks, then weekly x 2 then monthly x 2 . Results will be reviewed quarterly X2 in QA meeting .	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495097	A. BUILDING _____ B. WING _____	C 09/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARHAM HEALTH CARE & REHAB CEN	2400 E PARHAM ROAD RICHMOND, VA 23228

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 176	Continued From page 5 At 10:55 am, Administrative staff member #4 came back to the surveyor in the conference room and stated "There was no assessments done prior to today to assess the resident's ability to self-administer the Albuterol nebulizer treatments." The surveyor requested a copy of the facility's policy on self-administration of medications. At 1 pm, administrative staff member #4 provided a copy of the facility's policy titled "Self-Administration of Medication at Bedside". Under the Procedure section of the policy it read in part: " ...3. Complete Self-Medication Request/Evaluation form. 4. The Interdisciplinary Team will review the assessment ad will document during care plan. 5. Complete the Care Plan for approved self-administered drugs. 6. Self-administration of meds (medicines)must be reviewed by the Interdisciplinary Team quarterly and PRN (as needed) if change in status is noted ... 7. Medications that are ordered by the physician to be self- administered will be identified on the MAR (Medication Administration Record) ..." At approximately 4 pm, the administrative team was notified of the above documented findings by the surveyor. No further information was provided to the surveyor prior to the exit conference on 9/28/17.	F 176		
F 279 SS=D	DEVELOP COMPREHENSIVE CARE PLANS CFR(s): 483.20(d);483.21(b)(1) 483.20	F 279		10/19/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495097	A. BUILDING _____ B. WING _____	C 09/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARHAM HEALTH CARE & REHAB CEN	2400 E PARHAM ROAD RICHMOND, VA 23228

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 6	F 279		

(d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan.

483.21
(b) Comprehensive Care Plans

(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -

(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and

(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).

(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495097	A. BUILDING _____ B. WING _____	C 09/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARHAM HEALTH CARE & REHAB CEN	2400 E PARHAM ROAD RICHMOND, VA 23228

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 7 (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on, staff interview and clinical record review, the facility staff failed to develop comprehensive care plan for 2 of 26 residents, Resident #14 and Resident #1. 1. Resident #14 did not have a comprehensive care plan to include anti-depressant medication. 2. The facility staff failed to develop a comprehensive care plan (CCP) regarding the self-administration of a medication for Resident #1. Findings include: Resident #14 was admitted to the facility on 4/1/16 with a readmission on 5/21/17, with diagnoses including insomnia and depression.	F 279	F279 1. Resident #14 care-plan was updated to include care-plan for depression, resident #1 care-plan reviewed and revised 2. All patients with diagnosis of depression and who self-administer medication will be at risk. An audit of care-plans in the last 7 days will be reviewed for accurate and complete care-plans to include care-plans for depression and self-administration. 3. The Nurse Educator or designee will educate licensed nurses on updating and review care-plan per center protocol related to diagnosis of depression 4. The DON and designee will review 3 resident care-plan 3x a week x 2 weeks, then weekly x 2 then monthly x 2to verify	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495097	A. BUILDING _____ B. WING _____	C 09/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARHAM HEALTH CARE & REHAB CEN	2400 E PARHAM ROAD RICHMOND, VA 23228

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 8 The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 8/23/17. Resident #14 was assessed as being cognitively intact with a BIMS (brief interview for mental status) score of 15. Resident #14's electronic record was reviewed on 9/26/17 and evidenced, via comprehensive annual MDS dated 12/5/16, section "V" (Care Area Assessment) that Resident #14 had triggered for a care plan for antipyschotic medications (psych meds). Further review of Resident #14's clinical record (via physician's orders and medication administration record, MAR) indicated that Resident #14 was receiving Trazadone (anti-depressant) since 5/23/16 for insomnia and depression. Review of Resident #14's care plan did not evidence a care plan to include psych medications. On 9/27/17 at 9:20 a.m. the MDS coordinator (identified as registered nurse, RN #3) was interviewed. RN #3 reviewed Resident #14's care plan and verbalized that there should be a care plan for psych medications for Resident #14 and was not sure what may have happened in regards to no care plan. RN #3 also verbalized that sometimes the unit managers would create a care plan and that it could be possible that the care plan may have been deleted due to Resident #14 had been discharged and readmitted. On 9/27/17 at 9:25 a.m. the unit manager (registered nurse, RN #4), where Resident #14	F 279	complete and accurate care-plan. Findings will be reviewed quarterly x2 in QA meeting	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495097	A. BUILDING _____ B. WING _____	C 09/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARHAM HEALTH CARE & REHAB CEN	2400 E PARHAM ROAD RICHMOND, VA 23228

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 9	F 279		

resides was interviewed concerning the above finding. This surveyor asked RN #4 to review Resident #14's care plan and asked what would be included in a care plan for psych medications. RN #4 verbalized that typically a care plan for psych medications would include monitoring for side effects and adverse reactions to the medications. While reviewing the care plan, RN #4 verbalized that a care plan for psych medications was not noted on Resident #14's comprehensive care plan.

On 9/27/17 at 3:30 p.m. the above finding was brought to the attention of the director of nursing and administrator and nurse consultant. The nurse consultant agreed that a care plan should have been in place for psych medications.

No further information was presented prior to exit conference on 9/28/17.

2. The facility staff failed to develop a comprehensive care plan (CCP) regarding the self-administration of a medication for Resident #1.

Resident #1 was admitted to the facility on 5/31/16 with the following diagnoses of, but not limited to heart failure, high blood pressure, arthritis, anxiety disorder and chronic obstructive pulmonary disease. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495097	A. BUILDING _____ B. WING _____	C 09/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARHAM HEALTH CARE & REHAB CEN	2400 E PARHAM ROAD RICHMOND, VA 23228

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 10	F 279		

Reference Date) of 7/14/17, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 13 out of a possible score of 15. Resident #1 was also coded as requiring supervision for eating and personal hygiene and requiring extensive assistance from 1 staff member for bathing.

On 9/26/17 at 5 pm, the surveyor observed Resident #1 self- administering an Albuterol nebulizer treatment. The surveyor asked the resident if she gave herself this treatment all the time. Resident #1 stated, "oh, yes. I don't have any problems in doing it."

At 5:15 pm, Licensed practical nurse (LPN) # 3 was interviewed by the surveyor. The surveyor asked LPN #3 if Resident #1 self- administered the Albuterol nebulizer treatment to herself. LPN #3 stated "Yes she does and does very well with it. I don't have to do anything to help her with this."

During the clinical record review by the surveyor on 9/27/17 at 9 am, the surveyor noted the following physician order dated for 4/11/2017 which stated "may self administer meds (medicines) in room." The surveyor also reviewed the CCP for Resident #1. It was noted that the staff did not implement or develop a CCP for Resident #1 in the area of self-administrating medications.

On 9/27/17 at 10:30 am, the surveyor notified administrative staff member #4 of the above documented findings. Administrative staff member #4 stated that he would have to check into this and get back to the surveyor with the information.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495097	A. BUILDING _____ B. WING _____	C 09/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARHAM HEALTH CARE & REHAB CEN	2400 E PARHAM ROAD RICHMOND, VA 23228

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 11 At 10:55 am, Administrative staff member #4 came back to the surveyor in the conference room and stated "There was no assessments done prior to today to assess the resident's ability to self-administer the Albuterol nebulizer treatments." The surveyor requested a copy of the facility's policy on self-administration of medications. At 1 pm, administrative staff member #4 provided a copy of the facility's policy titled "Self-Administration of Medication at Bedside". Under the Procedure section of the policy it read in part: " ...3. Complete Self-Medication Request/Evaluation form. 4. The Interdisciplinary Team will review the assessment ad will document during care plan. 5. Complete the Care Plan for approved self-administered drugs. 6. Self-administration of meds (medicines)must be reviewed by the Interdisciplinary Team quarterly and PRN (as needed) if change in status is noted ... 7. Medications that are ordered by the physician to be self- administered will be identified on the MAR (Medication Administration Record) ..." At approximately 4 pm, the administrative team was notified of the above documented findings by the surveyor. No further information was provided to the surveyor prior to the exit conference on 9/28/17.	F 279		
F 280 SS=D	RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP CFR(s): 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2)	F 280		10/19/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495097	A. BUILDING _____ B. WING _____	C 09/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARHAM HEALTH CARE & REHAB CEN	2400 E PARHAM ROAD RICHMOND, VA 23228

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 12 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care.	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495097	A. BUILDING _____ B. WING _____	C 09/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARHAM HEALTH CARE & REHAB CEN	2400 E PARHAM ROAD RICHMOND, VA 23228

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 13 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495097	A. BUILDING _____ B. WING _____	C 09/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARHAM HEALTH CARE & REHAB CEN	2400 E PARHAM ROAD RICHMOND, VA 23228

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview and clinical record review, the facility staff failed to review and revise the CCP (comprehensive care plan) for one of 26 residents in the survey sample, Resident # 12. Resident # 12's CCP was not reviewed and revised regarding ECT (electro convulsive therapy). Findings include: Resident # 12 was admitted to the facility on 3/11/15, with the most current readmission on 08/10/16. Diagnoses for Resident # 12 included, but were not limited to: major depressive disorder, anxiety disorder and bipolar disorder. Resident # 12's most current full MDS (minimum data set) assessment dated 2/20/17 documented that the resident had a cognitive score of "14", indicating the resident was cognitively intact for daily decision making skills. The resident triggered in the CAAS (care area assessment summary) section of this MDS for psychotropic drug use. During an interview with the resident on 09/27/17 at approximately 8:00 a.m., the resident stated that she had been having ECT treatments for over 20 years. The resident additionally stated that her (the resident's) daughter took care of taking her to appointments and setting up the appointments and that she went every two weeks. Recently she changed doctors due to her normal doctor retiring and that she is now receiving the treatments at another facility.	F 280	F280 1. Resident # 12 care plan has been reviewed and revised nursing staff will be re-educated on following resident□s individualized plan of care for ECT treatment 2. All residents receiving ECT treatments are at risk. An audit will be completed of resident who receive ECT treatments and their care-plan reviewed for completion. 3. The Nurse Educator or designee will educate licensed nurses on updating and review care-plan related to ECT treatments 4. The DON and designee will review resident 100% resident care plans s with diagnosis requiring ETC treatments 3x a week x 2 weeks, then monthly x 2 . Findings will be reviewed quarterly X2 in QA meeting	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495097	A. BUILDING _____ B. WING _____	C 09/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARHAM HEALTH CARE & REHAB CEN	2400 E PARHAM ROAD RICHMOND, VA 23228

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 15	F 280		

Resident # 12's CCP was reviewed and documented, "...the resident uses psychotropic medications r/t [related to] Severe depression, anxiety and insomnia. Receives ECT every 2 weeks...neuropyschiatric and counseling associates [name of doctor/phone number]; observe for side effects and effectiveness..." The physician listed on the care plan was not the name of the physician the resident named as her doctor during the interview.

This was the only information on the resident's CCP regarding the resident's ECT treatments.

On 09/27/17 at 2:10 p.m., LPN (Licensed Practical Nurse) # 4, also known as Resident # 12's Unit Manager was interviewed regarding the above information. The LPN stated that the resident's daughter handles that and that she (the daughter) communicates with the doctors office regarding anything new or follow up appointments. The LPN was asked if that information should be included in the resident's CCP. The LPN stated, "Yes."

The DON (director of nursing), administrator, and assistant administrator were made aware in meeting with the survey team on 09/27/17 at approximately 2:45 p.m. The DON stated that the daughter is very involved and agreed that all information regarding the daughter making appointments and taking the resident to appointments should be part of the resident's CCP and that the CCP should be updated with the updated changes of the physician and location.

No further information and/or documentation was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495097	A. BUILDING _____ B. WING _____	C 09/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARHAM HEALTH CARE & REHAB CEN	2400 E PARHAM ROAD RICHMOND, VA 23228

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 16 presented prior to the exit conference on 09/28/17.	F 280		
F 281 SS=D	SERVICES PROVIDED MEET PROFESSIONAL STANDARDS CFR(s): 483.21(b)(3)(i) (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, clinical record review, and in the course of a complaint investigation the facility staff failed to follow professional standards of care for medication administration for 1 (Resident #23) of 26 residents in the survey sample. 1. For Resident #23, the facility staff failed to properly transcribe medication orders for Flexeril and Mucinex, and failed to clarify physician orders for pain medication. The findings included: Resident #23, a 68 year old female, was admitted to the facility on 4/1/2017 for rehabilitation following surgery for a left knee replacement. Her diagnoses included osteoarthritis of the left knee, fibromyalgia, reflux, hypertension, and hypothyroidism. Resident #23's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date)	F 281	F281 1.Resident #23 no longer resides in center 2 All residents may be at risk for deficient practice. An audit of new admission and physician orders received in the last 14days will be reviewed to ensure proper transcription of orders 3. The Nurse Educator or designee will educate licensed nurses on how to review discharge summary on admission, clarification of physician orders and data entry of new orders 4. The DON or designee will audit new admission discharge summary 3x a week x 2 weeks, then weekly x 2 then monthly x 2 . Findings will be reviewed quarterly x2 in QA meeting	10/19/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495097	A. BUILDING _____ B. WING _____	C 09/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARHAM HEALTH CARE & REHAB CEN	2400 E PARHAM ROAD RICHMOND, VA 23228

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 17	F 281		

of 4/7/2017 was coded as a 5 day assessment. Resident #23 was coded a BIMS (Brief Interview of Mental Status) score of 15/15, indicating no cognitive impairment. Resident #23 was coded as needing only supervision of one person for her activities of daily living, and as being always continent of bowel and bladder.

In conjunction with a complaint investigation, a clinical record review was conducted at 11:00 AM on 9/27/2017. This review revealed medication discharge orders from the hospital as follows:

"Guaifenesin (Mucinex) 600 mg (milligram) one tab twice a day."

This order was transcribed on the MAR (Medication Administration Record) as "Guaifenesin tablet 600 mg give one tablet every 12 hours AS NEEDED.

"Cyclobenzaprine (Flexeril) 10 mg tab oral twice a day."

This order was transcribed on the MAR as "Flexeril (Cyclobenzaprine) 10 mg by mouth every 24 hours AS NEEDED.

The MAR also revealed two orders for pain medication as follows:

"Tramadol 50 mg give 100 mg by mouth as needed for 4-6 pain scale."

"Roxicet 5-325 mg one tablet every 4 hours as needed for 4-6 pain scale."

On 9/28/2017 at 9:00 AM an interview was conducted with Administration D, Corporate

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495097	A. BUILDING _____ B. WING _____	C 09/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARHAM HEALTH CARE & REHAB CEN	2400 E PARHAM ROAD RICHMOND, VA 23228

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 18 Nurse Consultant. He was asked what dosage should be given at a pain level of 1-3, and 7-10. The MAR showed that Roxicet was administered 8 times during the Resident's stay when pain was 7-10. He stated that this order should have been clarified with the physician. Administration was informed of the findings on 9/28/2017 at 11:00 AM.	F 281		
F 282 SS=D	SERVICES BY QUALIFIED PERSONS/PER CARE PLAN CFR(s): 483.21(b)(3)(ii) (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on, staff interview and clinical record review, the facility staff failed to implement the comprehensive care plan for one of 26 residents, Resident #21. Intake and output was not being implemented as indicated as an intervention for fluid overload on Resident #21's care plan. Findings include: Resident #21 was admitted to the facility on 1/28/16 with a readmission on 9/20/17, with diagnoses including renal insufficiency with dialysis, chronic kidney disease, and fluid	F 282	F282 1. Resident #21 care plan has been reviewed and revised. nursing staff will be re-educated on following resident□s individualized plan of care for observation of intake and output. 2. All residents with orders related to fluid restrictions may be at risk An audit residents with fluid restriction orders will be completed to ensure that nursing staff are following the resident□s individualized plan of care 3. The Nurse Educator or designee will educate Licensed Nurses on assessment and documentation of intake and output	10/19/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495097	A. BUILDING _____ B. WING _____	C 09/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARHAM HEALTH CARE & REHAB CEN	2400 E PARHAM ROAD RICHMOND, VA 23228

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 19	F 282		

overload.

The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 9/5/17. Resident #21 was assessed as being cognitively intact with a BIMS (brief interview for mental status) score of 15.

Resident #21's electronic record was reviewed on 9/27/17 and evidenced via care plan, that Resident #21 had an intervention to monitor and document fluid intake and output due to potential for fluid overload related to kidney failure and congestive heart failure.

Review of Resident #21's medical record, did not evidence that intake and output (I & O) was being monitored or documented.

On 9/27/17 at 4:00 p.m. the unit manager (registered nurse, RN #2) where Resident #21 resides was interviewed concerning documentation of I & O's. RN #2 verbalized that I & O's are supposed to be documented on the medication administration record (MAR) or the treatment administration record (TAR) and that sometimes a nursing note would document the I & O's.

RN #2 was asked to review and show this surveyor where the documentation of the I & O's were. RN #2 reviewed Resident #21's record and could not find evidence of any documentation of the intake and output for Resident #21. RN #2 verbalized that Resident #21 had recently been readmitted back to the facility and maybe the I & O had been missed. RN #2 also verbalized that Resident #21 is noncompliant with the fluid restriction and she (RN #2) would implement an I

according to center protocol and following resident individualized plan care.
4. The DON and designee will review resident with fluid restrictions 3x a week x 2 weeks, then weekly x 2 then monthly x 2, then quarterlyx2 in QA meeting.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495097	A. BUILDING _____ B. WING _____	C 09/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARHAM HEALTH CARE & REHAB CEN	2400 E PARHAM ROAD RICHMOND, VA 23228

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 20 & O right away. On 9/28/17 at 8:30 a.m. the above finding was brought to the attention of the facilities nurse consultant and nurse practitioner. This surveyor explained the concern for not doing I & O on Resident #21 given Resident #21's history of fluid overload, renal failure with dialysis, and congestive heart failure. The nurse consultant verbalized that Resident #21 is very noncompliant in regards to fluid intake and agreed that the care plan should have been followed and documentation of intake and output should have been done. On 9/28/17 at 9:00 a.m. the director of nursing was made aware of the above finding. No further information was presented prior to exit conference on 9/28/17.	F 282		
F 309 SS=E	PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING CFR(s): 483.24, 483.25(k)(l) 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure	F 309		10/19/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495097	A. BUILDING _____ B. WING _____	C 09/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARHAM HEALTH CARE & REHAB CEN	2400 E PARHAM ROAD RICHMOND, VA 23228

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 21 that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, clinical record review and in the course of a complaint investigation, the facility staff failed to provide the highest possible wellbeing for two residents (#23 and #7) of 26 residents in the sample. 1. For Resident #23, the facility staff failed to administer medications on the day of arrival in the facility, failed to assess and monitor pain, and failed to follow physician's order for pain control. 2. The facility staff failed to ensure Resident #7 received physician ordered medication for glaucoma for over 11 months. Findings included:	F 309	F 309 1. Resident #23 is no longer resides in center. Resident #7 physician was notified of physician order medication for glaucoma not being administered. A clarification order received for Latanoprost Solution 0.005 % , No untoward effect noted to resident . 2. A. All residents with orders for latanoprost solution may be at risk. An audit of residents receiving lantoprost solution will be completed to ensure orders are administered per physician order B. All residents admitted with orders for pain medication may be at risk. An audit of new admission admitted to the center in the last 14days will be reviewed to ensure	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495097	A. BUILDING _____ B. WING _____	C 09/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARHAM HEALTH CARE & REHAB CEN	2400 E PARHAM ROAD RICHMOND, VA 23228

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 22 1. For Resident #23, the facility staff failed to administer medications on the day of arrival in the facility, failed to assess and monitor pain, and failed to follow physician's order for pain control. Resident #23, a 68 year old female, was admitted to the facility on 4/1/2017 for rehabilitation following surgery for a left knee replacement. Her diagnoses included osteoarthritis of the left knee, fibromyalgia, reflux, hypertension, and hypothyroidism. Resident #23's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 4/7/2017 was coded as a 5 day assessment. Resident #23 was coded a BIMS (Brief Interview of Mental Status) score of 15/15, indicating no cognitive impairment. Resident #23 was coded as needing only supervision of one person for her activities of daily living, and as being always continent of bowel and bladder. In conjunction with a complaint investigation, a clinical record review was conducted at 11:00 AM on 9/27/2017. This review revealed a MAR (Medication Administration Record) showing that no medications, including physician ordered pain medications, were administered on 4/1/2017, the date of admission. Admission records showed that Resident #23 was admitted to the facility on 4/1/2017 at 12:10 PM. Admission records showed that a pain assessment was conducted upon admission, and this assessment revealed that Resident #23 had no pain upon admission at 12:10 PM. No further pain assessment was conducted until 8:17 AM on	F 309	medication administration is occurring on day of admission per the physicians order. C. All residents admitted to the center are at risk of having pain on admission. An audit of new admissions to the center in the last 14 days will be reviewed to ensure that pain is asses and monitored. 3. The Nurse Educator or designee will educate licensed nurses on how to review physician consultation reports and data entry of new orders. The Nurse Educator or designee will educate UM□s and supervisory staff on Center protocol for reviewing new orders to ensure accurate and complete order entry. The nurse educator or designee will educate licensed nursing staff on center admission policy and procedure related to admission orders 4 The DON or designee will audit new admission charts for pain assessment, medication administration of pain medication, and administration of physician order medication. 3x a week x 2 weeks, then weekly x 2 then monthly x 2 then quarterly 2 in QA meeting. The DON and designee will review of resident with ophthalmic orders 3x a week x 2 weeks, then weekly x 2 then monthly x 2 the quarterly x2 in QA meeting .	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495097	A. BUILDING _____ B. WING _____	C 09/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARHAM HEALTH CARE & REHAB CEN	2400 E PARHAM ROAD RICHMOND, VA 23228

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 23	F 309		

4/2/2017 where pain was recorded as 6/10. Pain medication was given at this time.

The clinical record also revealed hospital discharge orders for pain management as follows:

"Tramadol (a non-narcotic pain reliever) 100 mg (milligram) every 4 hours as needed for 4-6/10 pain scale"

"Oxycodone/APAP 5/325, Roxicet, (a narcotic pain reliever) one tablet every 4 hours as needed for 4-6/10 pain scale IF TRAMADOL WAS INEFFECTIVE."

"If Tramadol was ineffective" was not transcribed to the MAR and, as a result, this order was not followed. Roxicet was given 3 times on 4/2/2017 and Tramadol was not given at all that day. On 4/3/2017 Tramadol was given at 10:00 PM and Roxicet was given 3 times during the day.

The MAR revealed an additional pain control order dated 4/1/2017 as follows:

"Ice to knee four times a day for 20 minutes each time". This intervention was not carried out until 9:00 AM on 4/2/2017.

These issues were brought to the attention of Administration D, Corporate Nurse Consultant on 9/28/2017 at 9:00 AM. He stated that he does not know how these problems happened. He stated that delays in medication administration were not necessary since a supply of all of the medications prescribed for Resident #23 were kept on hand

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495097	A. BUILDING _____ B. WING _____	C 09/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARHAM HEALTH CARE & REHAB CEN	2400 E PARHAM ROAD RICHMOND, VA 23228

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 24	F 309		

Administration was informed of the findings on 9/28/2017 at 11:00 AM.

2. The facility staff failed to ensure Resident # 7 received physician ordered medication for glaucoma for over 11 months.

Resident # 7 was admitted to the facility on 8/1/14, with the most recent readmission on 6/23/17. Diagnoses for Resident # 7 included, but were not limited to: DM (diabetes mellitus), HTN (high blood pressure), bilateral cataracts and glaucoma.

The most current full MDS (minimum data set) assessment was an annual MDS dated 4/24/17. This MDS assessed the resident with a cognitive score of "13", indicating the resident was cognitively intact for daily decision making skills. The resident triggered in the CAAS (care area assessment summary) section of this MDS for vision.

During clinical record review on 09/27/17, Resident # 7's nursing notes were reviewed.

A nursing note dated 8/24/17 and timed 9:14 p.m. documented that the resident was seen by the Optometrist (eye doctor) with a chief complaint of glaucoma and to continue with latanoprost solution 0.005% one drop in both eyes at bedtime and to monitor IOP (intraocular [eye] pressure) every three months.

Resident # 7's physician's orders were reviewed, along with the resident's MARs/TARs (medication administration records/treatment administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495097	A. BUILDING _____ B. WING _____	C 09/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARHAM HEALTH CARE & REHAB CEN	2400 E PARHAM ROAD RICHMOND, VA 23228

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 25	F 309		

records). No evidence was found that the resident had an order for the glaucoma eye drops or that the resident had received the glaucoma eye drops.

A 'Summary of Ocular Progress Note' was found in the consult section dated 08/23/17. The consult documented, "...chief complaint: glaucoma by history; IOP evaluation for management...Medications: latanoprost 0/005% ophthalmic solution 1 gtt [drop] OU [both eyes] QHS [every night bedtime]..." This note was signed by the long term care facility NP (nurse practitioner).

Another 'Summary of Ocular Progress Note' was found in the consult section dated 04/18/17. The consult documented, "...chief complaint: glaucoma by history; IOP evaluation for management...Physician's Orders: 1) latanoprost 0.005% ophthalmic solution 1 gtt [drop] OU [both eyes] QHS [every night bedtime] indefinitely..." This note was signed by the long term care facility NP.

And another, 'Summary of Ocular Progress Note' was found in the consult section dated 10/18/16. The consult documented, "...chief complaint: Blurred Vision: hard to see at distance and near...Physician's Order: 1) latanoprost 0.005% Ophthalmic Solution 1 gtt [drop] OU [both eyes] QHS [every night bedtime] indefinitely...Open angle with borderline finding, low risk bilateral glaucoma by history..." This progress note was signed by the long term care facility's physician.

Resident # 7's CCP (comprehensive care plan) was then reviewed and documented, "...The resident has impaired visual function r/t [related

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495097	A. BUILDING _____ B. WING _____	C 09/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARHAM HEALTH CARE & REHAB CEN	2400 E PARHAM ROAD RICHMOND, VA 23228

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 26	F 309		

to] glaucoma...will show no signs of decline in visual function...Provide accommodations, such as large print magazines, preferred seating near front/speaker, etc..." No other information/interventions were listed on the resident's CCP regarding vision care and/or treatment.

On 09/27/17 at 2:10 p.m., LPN (Licensed Practical Nurse) # 4, also known as Resident # 7's Unit Manager was interviewed regarding the above information. The LPN stated that she did not think the resident was receiving any type of eye drops. The LPN reviewed the above information on the resident's electronic clinical record with this surveyor. The LPN was asked what is the process when a resident goes to an eye appointment and orders are attached. The LPN stated that the resident will come back with 'one of these' progress notes or order sheets, the physician or NP will review it and either accept or not accept, and then sign if they accept, it then goes to the nurse who will enter the order and note it as being done.

On 09/27/17 at approximately 2:40 p.m., the DON (director of nursing), administrator, and assistant administrator were made aware of concerns regarding Resident # 7 not receiving the physician ordered glaucoma medication in meeting with the survey team. The facility staff were asked for assistance in locating information to clarify this order for Resident # 7.

On 09/28/17 at approximately 8:40 a.m., the DON stated that there was no documentation that the order for Resident # 7's latanoprost 0.005% Ophthalmic solution was ever entered into the system and further stated, "It got missed." The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495097	A. BUILDING _____ B. WING _____	C 09/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARHAM HEALTH CARE & REHAB CEN	2400 E PARHAM ROAD RICHMOND, VA 23228

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 27 DON stated that the expectation would be, once the order is verified (by physician signature) it then goes back to the nurse to transcribe and document it, as noted. No further information and/or documentation was presented prior to the exit conference on 09/28/17.	F 309		
F 371 SS=E	FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY CFR(s): 483.60(i)(1)-(3) (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by:	F 371		10/19/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495097	A. BUILDING _____ B. WING _____	C 09/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARHAM HEALTH CARE & REHAB CEN	2400 E PARHAM ROAD RICHMOND, VA 23228

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 28 Based on observation, staff interview and facility document review, the facility staff failed to ensure an air gap was maintained on the ice machine in the main kitchen. Findings include: During the initial tour of the kitchen on 09/26/17 at approximately 3:40 p.m., the ice machine area in the main kitchen was observed. The ice machine and the emergency eye station were side by side. The ice machine had a drain pipe that exited the back of the machine and was routed to the left side of the machine, and stopped near the front leg/stand of the machine. The drain pipe was resting on the metal grate of the floor drain cover. The emergency eye station had a drain pipe that exited the sink underneath; it was routed right beside the drain pipe of the ice machine. Both drainage pipes were resting on the metal grate covering of the floor drain. The drainage pipes were held together with a plastic zip tie that was attached to the front left leg/stand of the machine, which had slipped-resulting in the drainage pipes (both) laying flush with the grate covering on the floor. The DSM (dietary services manager) stated that she did not know how long that had been like that, but could get the MM (maintenance manager) to take a look at it and fix it. The corporate RD (Registered Dietitian) was present during the tour and stated that the pipes should not be resting on the grate. On 09/27/17 at approximately 1:25 p.m., the MM was interviewed regarding the above information.	F 371	F371 1. The air gap to the ice machine drainage pipe located in the main kitchen has been corrected to ensure compliance with the center policy. 2. All areas related to Air Gap drainage pipes are at risk for deficiency and all residents may be at risk for this deficient practice. 3. Education was provided to dietary staff by the Dining Services Directed or designee. Education was provided to the Maintenance director by the administrator. 4. The maintenance director or designee will audit the gap clearance to ice machine drainage pipes for all center ice machines 3 times per week for 2 weeks, Weekly for 2 weeks and then monthly for 2 months. Review quarterly in QA meeting X2 .	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495097	A. BUILDING _____ B. WING _____	C 09/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARHAM HEALTH CARE & REHAB CEN	2400 E PARHAM ROAD RICHMOND, VA 23228

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 29 The MM was asked if there is a policy on the air gap clearance regarding the ice machine. The MM stated that he was not sure and would check, but went on to say that the air gap should be at least "2 inches." A copy of the policy was requested at that time. At approximately 1:45 p.m., the MM presented a policy titled, "Ice Machines." The policy documented, "...all ice machine will be inspected regularly as scheduled and preventative maintenance service will be performed to verify proper and safe operation...check water valves and connectors...Verify a 1 (one) inch air gap at drain..." The MM was asked if the ice machine had an anti-back flow valve to prevent backup drainage from entering the ice machine drainage pipe. The MM stated, "No, we have some-but not for the ice machine." On 09/27/17 at approximately 2:45 p.m., the administrator, assistant administrator and DON (director of nursing) were made aware in a meeting with the survey team. No further information and/or documentation was presented prior to the exit conference on 09/28/17.	F 371		
F 502 SS=D	ADMINISTRATION CFR(s): 483.50(a)(1) (a) Laboratory Services (1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced	F 502		10/19/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495097	A. BUILDING _____ B. WING _____	C 09/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARHAM HEALTH CARE & REHAB CEN	2400 E PARHAM ROAD RICHMOND, VA 23228

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 502	Continued From page 30 by: Based on staff interview and clinical record review the facility staff failed to ensure labwork was obtained for 1 of 26 residents (Resident #13). A Complete Blood Count (CBC) ordered on 7/25/17 was not obtained. The findings included: Resident #13, a 74 year old, was admitted to the facility on 3/28/15. Her diagnoses included dementia, dysphagia, depression and chronic kidney disease. Her most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 7/10/17. She was coded with moderate cognitive impairment and required assistance with her activities of daily living. Resident #13's clinical record included an order for a Complete Blood Count (CBC) dated 7/25/17. The results of the labwork were not in the clinical record. On 9/27/17 at 1:40 p.m. the Corporate Nurse stated that the nurse practitioner had entered the order and it was overlooked by the nursing staff and never completed. The issue was reviewed at the end of day meeting on 9/27/17 with the Administrator and Director of Nursing.	F 502	F502 1. Resident #13 physician was notified that cbc was not obtained per physician order dated 7/25/17. Clarification order received to discontinue order for cbc. 2. All resident requiring laboratory evaluation may be at risk. An audit of current resident charts for new labs ordered in the last 14 days will be completed to verify physician ordered labs have been obtained according to order, and in medical record. 3. The Nurse Educator or designee will educate licensed staff on the Centers process of verifying lab orders and results, related to CBC . 4. The DON or designee will audit lab results related to CBC 3x a week x 2 weeks, then weekly x 2 then monthly x 2 , the quarterly x2 in QA meeting .	
F 504 SS=D	LAB SVCS ONLY WHEN ORDERED BY PHYSICIAN CFR(s): 483.50(a)(2)(i) (a) Laboratory Services	F 504		10/19/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495097	A. BUILDING _____ B. WING _____	C 09/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARHAM HEALTH CARE & REHAB CEN	2400 E PARHAM ROAD RICHMOND, VA 23228

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 504	Continued From page 31 (2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to obtain a physician order prior to obtaining laboratory tests for 1 of 26 residents in the survey sample. (Resident #2) The findings included: The facility staff failed to obtain a physician order prior to obtaining laboratory testing for Resident #2. Resident #2 was readmitted to the facility on 6/29/17 with the following diagnoses of, but not limited to atrial fibrillation, high blood pressure, end stage renal disease, diabetes, arthritis, stroke and chronic obstructive pulmonary disease. On the significant change MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 7/15/17, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 7 out of a possible score of 15. Resident #2 was also coded as requiring extensive assistance of 1 staff member for dressing, eating and personal hygiene. The surveyor performed a clinical record review of Resident #2's chart on 9/27/17. The surveyor noted the following laboratory test results in the clinical record: 8/17/17 Hemoglobin A1C, 5/16/17 Basic Metabolic Panel and 2/3/17 Hemoglobin	F 504	F504 1. Resident #2 physician was notified that a BMP had been obtained without a physician□s order and an order was obtained to correlate with the BMP results. 2. All residents requiring laboratory evaluation may be at risk . An audit of current resident charts who have received labs in the last 14 days will be completed to verify lab results correlate with a physician□s order. 3. The Nurse Educator or designee will educate licensed staff on the Centers process of verifying lab orders and results. 4. The DON or designee will audit lab results 3x a week x 2 weeks, then weekly x 2 then monthly x 2 the quarterly in QA meeting .	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495097	A. BUILDING _____ B. WING _____	C 09/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARHAM HEALTH CARE & REHAB CEN	2400 E PARHAM ROAD RICHMOND, VA 23228

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 504	Continued From page 32 A1C. The surveyor could not locate any physician orders to obtain the above documented laboratory results that were in the resident's clinical record. At approximately 4 pm, the surveyor notified the administrative team of the above documented findings. On 9/28/17 at approximately 3:30 pm, administrative staff member #3 came to the surveyor and stated, "I cannot find any physician orders for the labs that you told us yesterday that you did not have orders for." No further information was provided to the surveyor prior to the exit conference on 9/28/17.	F 504		