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 12/06/2018

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
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 12/04/2018 through 12/06/2018. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 12/4/18 through 12/6/18. Significant corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Three complaints were investigated during the survey. The census in this 180 certified bed facility was 164 at the time of the survey. The survey sample consisted of 57 resident reviews.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review the facility staff failed to ensure 1 resident (Resident #260) of 57 residents in the survey sample was assessed to self administer medications. For Resident #260, a bottle of colace (for constipation) was observed on the over bed table.	F 554	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is 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	1/10/19

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

Electronically Signed | 12/26/2018

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 12/06/2018

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 554	Continued From page 1 The findings included: Resident #260 was admitted to the facility on 11/27/18. Diagnoses included constipation, chronic obstructive pulmonary disease, and dysphagia. As Resident #260 was new to the facility, a minimum data set assessment had not been completed. On 12/4/18 at 11:10 a.m., Resident #260 was interviewed in her room. She was seated in a wheel chair. The over bed table was in front of her. During the interview, a small bottle of colace was observed on the over bed table. On 12/5/18 at 8:20 a.m. Resident #260 was observed in her room eating breakfast. The bottle of colace had been removed from the over bed table. Resident #260's care plan was reviewed. It did not include any information regarding self administration of medications. At the end of day meeting on 12/5/18, the Administrator, Director of Nursing and Corporate Nurse were notified that the bottle of colace was observed on Resident #260's over bed table. The facility staff were asked to provide a physician order or resident assessment determining that Resident #260 was safe to administer her own medications. On 12/6/18 at the end of day meeting, the Corporate Nurse stated that Resident #26's family had brought in the colace.	F 554	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. F554 1. Resident #260 medical record updated with self-administration assessment. Medication removed from patient□s bedside. 2. 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 all new resident who self-administer 3 x a week x 2 weeks, then weekly x 2 then monthly x 2. Results will be reviewed quarterly X2 in QA meeting. 5. Date of compliance 01/10/2018	
F 622	Transfer and Discharge Requirements	F 622		1/10/19

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 12/06/2018

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 622 SS=D	Continued From page 2 CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to	F 622		

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 12/06/2018

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 622	Continued From page 3 discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information	F 622		

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 12/06/2018

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 622	Continued From page 4 (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility staff failed for 1 resident (Resident 358) in the survey sample of 57 residents, to provide the resident's caregiver with written discharge instructions and prescriptions for medications for continuity of care. The facility staff failed to provide Resident #358's caregiver with written discharge instructions and prescriptions for medications for continuity of care. The Findings included: Resident #358 was an 88 year old who was admitted to the facility on 8/17/18 and discharged home on 9/28/18. Resident#358's diagnosis included Cerebral infarction, Generalized Muscle Weakness, Aphasia, Dysphasia, Spinal Stenosis, Glaucoma, Heart Failure, Polyosteoarthritis, and Age-Related Physical Debility. The Minimum Data Set, which was a 30-Day Assessment with an Assessment Reference Date of 9/12/18 was reviewed. Resident #358 was coded as having a Brief Interview of Mental Status Score of 14, indicating intact cognition. In addition, she was coded as being totally dependent on the physical assistance of at least	F 622	F622 1. #358 no longer resides in center 2.Residents discharged to community from center are at risk. An audit of last 14days of resident who discharged home, will be reviewed to ensure that each resident has received discharge instruction form and medication for continuity of care 3. The nurse Educator or designee will educate licensed nurses, therapist and discharge planners on discharge process. 4. The DON or designee will review all residents who discharge to the community to ensure discharge instruction and medication received on discharge . 3x a week x 2 weeks, then weekly x 2 then monthly x 2 . Results will be reviewed quarterly X2 in QA meeting. 5. Date of compliance 01/10/2018	

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 12/06/2018

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 622	Continued From page 5 2 people for transfers. On 12/4/18, a review was conducted of Resident #358's clinical record. She was discharged home on 9/28/18. There was no record of the discharge in the progress notes on 9/28/18. The last nursing progress note prior to discharge was written by the night shift on 9/28/18 at 6:55 A.M. It read, "Resident alert, verbal, able to make needs known. Skilled for therapy and nursing services. Here post CVA (cardiovascular accident - stroke) for strengthening. Slept well this shift, no distress noted, no complaints voiced. No needs at this time. Call bell in reach." The following Discharge Planning note was documented two days prior to discharge: "Met with patient's daughter. Durable Medical Equipment has been ordered including hospital bed. Made transportation arrangements through Anthem for 2:00 P.M. Explained discharge procedures. [Redacted] stated that no family will be at the facility for discharge and to send any information in a folder. Reviewed prescriptions and order for outpatient therapy will be provided along with discharge instructions. Discharge planning will continue to provide support." On 12/4/18 at 10:00 A.M., an interview was conducted with the Director of Nursing (DON - Employee B). The DON was asked to describe the manner in which discharge instructions and prescriptions are handled. She stated, "Prior to discharge we receive handwritten prescriptions and give them to the patients family, or call them in to the pharmacy of their choice on the day of discharge. We also give the Discharge Instructions form to the patient's family." The DON stated that she did not know when the	F 622		

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 12/06/2018

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 622	Continued From page 6 wheelchair was returned to the facility, or who helped Resident # 358 to get into her house. The DON was unable to provide a copy of the prescriptions or Discharge Instructions. The DON submitted a copy of an email she received from a nurse on Friday, September 28, at 10:28 P.M. It read, "(Resident #358) was discharged today, daughter is very upset related to discharge forms or scripts were not sent home with resident. Resident daughter states when she called the facility and spoke with the nurse on duty, the nurse stated that she did not know the resident had left. This writer sent the scripts to CVS pharmacy per daughter's request, they were unable to fill related to no signature from MD. This writer called beforehand to ensure that they would accept, I was told yes. Nurse practitioner was called with no return call back. Received another call from daughter stating she need her discharge paperwork ASAP as she was attempting to set up home care, all paperwork including scripts were faxed to [redacted]. Resident daughter stated she will be contacting state because she have pictures etc../ proof of neglect." The following afternoon, the clinical record contained a progress note dated 9/29/18 at 3:36 P.M. "[redacted] was notified that prescriptions are at CVS and available for pickup." No further information was received.	F 622		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and	F 656		1/10/19

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 12/06/2018

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 656	Continued From page 7 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. (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.	F 656		

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 12/06/2018

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 656	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, clinical record review, and facility documentation, the facility staff failed to develop and implement comprehensive care plans for three residents (Resident #44, #23, #34) in a sample size of 57 residents. 1. For Resident #44, the facility staff failed to develop and implement care associated with contractures in bilateral hands. 2. For Resident #23, the facility staff failed to develop and implement care associated with contractures in bilateral arms and hands. 3. For Resident #34, the facility failed to develop and implement an individualized care plan that addresses contractures The findings include: 1. For Resident #44, the facility staff failed to develop and implement care associated with contractures in bilateral hands. Resident #44, a 90-year old female, was admitted to the facility on 08/28/2018. Diagnoses include paraplegia, idiopathic neuropathy, failure to thrive, age-related debility, and dementia. Resident #44 also had contractures both hands. Resident #44's most recent quarterly Minimum Data Set (MDS) had an Assessment Reference Date (ARD) of 09/11/2018. Resident #44's Brief Interview of Mental Status (BIMS) was coded as "6" out of possible "15" indicative of severe	F 656	F656 1. Resident # #44,#23,#34 care plan has been reviewed and revised to include contractures nursing staff will be re-educated on following resident□s individualized plan of care for contractures 2. All residents with contractures are at risk. All resident with contracture care-plan reviewed and updated to meet resident individualized plan of care. 3. The Nurse Educator or designee will educate licensed nurses on updating and review care-plan related to Contractures. 4. The DON and designee will review resident 100% resident care plans who have contractures 3x a week x 2 weeks, then monthly x 2. Findings will be reviewed quarterly X2 in QA meeting 5. Date of compliance 01/10/2018	

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 12/06/2018

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 656	Continued From page 9	F 656		

cognitive impairment. Functional status for dressing, eating, and personal hygiene was coded as requiring extensive assistance. Physical therapy and restorative nursing programs did not occur.

On 12/04/2018 at 4:00 PM, Resident #44 was observed resting in bed with the head of the bed elevated. The Resident's arms were bent slightly and fingers on both hands were flexed into the palms consistent with contractures. Hand padding was not visualized.

On 12/05/2018 at 08:30 AM, Resident #44 was observed sitting up in geri-chair, fully dressed. The Resident's arms were bent slightly and fingers on both hands were flexed into the palms consistent with contractures. Hand padding was not visualized.

On 12/05/2018, the physician's orders were reviewed. An active entry with a revision date of 07/31/2018 documented, "apply bacitracin to laceration on left palm after cleaning with NS (normal saline). every day and evening shift for skin care if resident allows, place cloth in hand" (sic)

The nurse's notes were reviewed. An entry dated 07/08/2018 at 18:31 documented, "both hands/fingers remain contracted. able to place palm guard in right hand but unable to left hand due to degree of contracture. clean cloth applied. resident will remove cloths and palm guard from hands on her own. noted small lacreaction (sic) in left palm due to fingernails. Dr [redacted] notified. area cleaned and bacitracin ointment applied. RP (responsible party) (name) aware." (sic)

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 12/06/2018

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 656	Continued From page 10 The treatment administration record for December 2018 was reviewed. The treatment "apply bacitracin to laceration on left palm after cleaning with NS. Every day and evening shift for skin care if resident allows, place cloth in hand" is signed off as administered every day and evening shift in December 2018. The care plan was reviewed. Contractures of bilateral hands are not listed as a focus with associated goals, intervention, and measures to include skin integrity, range of motion, and bathing. On 12/05/2018 at approximately 11:07 AM, LPN A and surveyor entered Resident's room and observed the Resident reclined in the geri-chair. There were two rolled washcloths in the Resident's lap and no padding on palms. When LPN A extended the Resident's fingers of the right hand, the LPN and surveyor observed one round indentation on the palm where the Resident's finger had been pressing into the palm. There was no discoloration or open wound on the right palm. When the nurse extended the fingers of the left hand, the LPN and surveyor observed one round indentation on the palm where the Resident's finger had been pressing into the palm. There was no discoloration or open wound on the left palm. LPN A was unable to fully extend fingers on both hands due to the contractures and limited range of motion. When asked about the importance of hand padding, nurse stated it's important to prevent skin breakdown. On 12/05/2018 at approximately 1:05 PM, an interview with CNA A was conducted. When asked about the bathing process for Resident #44, CNA A stated the Resident was scheduled to	F 656		

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 12/06/2018

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 656	Continued From page 11	F 656		

receive a shower twice a week and a daily bed bath. When asked about the bed bath process, CNA A stated she fills a basin with warm water and facility soap, provides Resident privacy, washes Resident head-to-toe, washes 'the front', washes 'the back', and washes the 'private areas.' CNA A didn't mention the hands specifically.

On 12/05/2018 at approximately 3:00 PM, an interview with Employee D was conducted. When asked about the process for evaluating residents, she stated that physical therapy needs a referral from nursing to assess and evaluate residents with contractures. She also stated nursing may not make a referral if they can 'handle it.' When asked about the importance of splints in residents that need them, Employee D stated if splints aren't used, the resident will get contractures.

On 12/05/2018 at approximately 4:00 PM, an interview of the Resident's current nurse, LPN F, was conducted. LPN F stated the open area on Resident's left palm was healed but "we continue to apply bacitracin ointment to protect the skin."

On 12/05/18 at 4:25 PM, the DON was asked about the bed bath process and she stated it is the expectation that hands will be washed during daily bed bath.

On 12/06/2018 at 9:10 AM, an interview of the Resident's current nurse, LPN B, was conducted. When asked about origin of the open area on the Resident's left palm that had since healed, she stated it was due to the Resident's "nail digging into her skin."

On 12/06/2018 at 1:50 PM, an interview with 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 12/06/2018

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 656	Continued From page 12	F 656		

Resident's current CNA, CNA G, was conducted at the Resident's bedside. CNA G stated he has worked at the facility for 13 years and feels very familiar with Resident #44. CNA G states the Resident used to have palm guards for both hands but then she would cry when opening left hand so they switched to using a washcloth for the left hand and a palm guard for the right hand. When asked how a CNA unfamiliar with the Resident would know to place a washcloth in the left hand and a palm guard on the right hand, he stated he didn't know because that information "is not in PCC (Pont-Click-Care electronic health record)."

On 12/06/2018 at approximately 2:00 PM, and interview with the DON was conducted. When asked about the process for obtaining a palm guard for a resident, she stated a physician's order is not necessary, it is a nursing intervention. She stated that nurses can implement the palm guards, they are located in the supply closet, and then typically the nurses would consult physical therapy for treatment and evaluation. The DON agreed there is no evidence physical therapy was consulted and she went on to say it is "a process issue, it's something we need to look at." When asked about the appropriateness of calling the open area on the Resident's left palm a "laceration", she stated, "To me, it would be an indentation, not a laceration, a laceration is a cut." She agreed the open skin wound on the Resident's left palm was caused by the Resident's nail pressing into the palm.

Facility documentation regarding rehabilitation was reviewed. The facility policy entitled, "Rehabilitation Needs Assessment Referral" documented, "A licensed nurse will complete a

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 12/06/2018

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 656	Continued From page 13	F 656		

therapy screening tool to notify therapy personnel of patient's needs." The procedure steps for this policy are documented,
"1. Screen for therapy needs. 2. Document information on the Rehabilitation Services Screen. 3. Notify therapy personnel as appropriate."

On 12/06/2018 at approximately 5:15 PM, the Administrator and DON were notified of findings and they offered no further information.

2. For Resident #23, the facility staff failed to develop and implement care associated with contractures in bilateral arms and hands.

Resident #23, an 80-year old female, was admitted to the facility on 03/31/2012. Diagnoses include osteoarthritis, age-related debility, malaise, and dementia.

Resident #23's most recent quarterly Minimum Data Set had an Assessment Reference Date of 08/28/2018. Resident #23's Brief Interview of Mental Status (BIMS) score was not coded but cognitive skills for daily decision-making was coded as severely impaired. Functional status for eating, toileting, and personal hygiene was coded as total dependence on staff for assistance. Physical therapy and restorative nursing programs were not coded for any occurrence.

On 12/04/2018 at approximately 11:15 AM, Resident #23 was observed in her room, fully dressed and sitting up in her geri-chair. Both arms were fully flexed at the elbow and both hands were on upper chest under the Resident's chin. Wrists and fingers were flexed consistent

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 12/06/2018

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 656	Continued From page 14 with contractures. No splints, palm guards, or hand padding was observed. On 12/04/2018 at approximately 2:37 PM, Resident #23 was observed in her room and sitting up in her geri-chair. Both arms were fully flexed at the elbow and both hands were on upper chest under the Resident's chin. Wrists and fingers were flexed consistent with contractures. No splints, palm guards, or hand padding was observed. On 12/05/2018 at approximately 8:25 AM, Resident #23 was observed in her room and sitting up in her geri-chair. Both arms were fully flexed at the elbow and both hands were on upper chest under the Resident's chin. Wrists and fingers were flexed consistent with contractures. No splints, palm guards, or hand padding was observed. On 12/05/2018, the care plan was reviewed. One focus created on 08/23/2014 documented, "The resident has an ADL self-care performance deficit r/t (related to) Limited Mobility." The goal for this focus dated 08/23/2014 and revised on 09/07/2018 documented, "The resident will maintain current level of function in through the review date." The intervention that focused on contractures documented, "The resident has contractures of the bilateral hands. Provide skin care daily to keep clean and prevent skin breakdown." Another focus on the care plan, created on 08/23/2014, documented, "The resident has limited physical mobility r/t (related to) weakness." The goal associated with this focus dated 08/23/2014 and revised on 09/07/2018	F 656		

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 12/06/2018

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 656	Continued From page 15	F 656		

documented, "The resident will remain free of complications related to immobility, including contractures, thrombus formation, skin-breakdown, fall-related injury through the next review date." Interventions associated with this focus documented, "heelz up (created on 08/08/2017) (sic). Recliner for socialization and comfort-gel cushion for comfort and prevention (created 06/24/2015). The resident is non-weight bearing (created on 08/23/2014)." Interventions, preventative measures, and evaluations associated with contractures of bilateral arms and hands are not listed.

On 12/05/2018 at approximately 11:10 AM, LPN B and surveyor observed Resident #23 in her geri-chair. When LPN B extended the Resident's fingers of the right hand, LPN B and surveyor observed there was no discoloration or open wound on the right palm. When LPN B extended the fingers of the Resident's left hand, the LPN and surveyor observed there was no discoloration or open wound on the left palm but it was malodorous when fingers were extended. LPN B was unable to fully extend fingers on both hands due to the contractures and limited range of motion. When asked if palm guards would be beneficial for this Resident, LPN B stated it would be (beneficial) for the right hand but "left hand is so tight, it might hurt her."

On 12/05/2018 at approximately 1:05 PM, an interview with CNA A was conducted. When asked about the bathing process for Resident #23, CNA A stated the Resident was scheduled to receive a shower twice a week and a daily bed bath. When asked about the bed bath process, CNA A stated she fills a basin with warm water and facility soap, provides Resident privacy,

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 12/06/2018

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 656	Continued From page 16	F 656		

washes Resident head-to-toe, washes 'the front', washes 'the back', and washes the 'private areas.' CNA A didn't mention the hands specifically.

On 12/05/2018 at approximately 3:00 PM, an interview with Employee D was conducted. When asked about the process for evaluating residents, she stated that physical therapy needs a referral from nursing to assess and evaluate residents with contractures. She also stated nursing may not make a referral if they can 'handle it.' When asked about the importance of splints in residents that need them, Employee D stated if splints aren't used, the resident will get contractures.

On 12/05/18 at 4:25 PM, the DON was asked about the bed bath process and she stated it is the expectation that hands will be washed during daily bed bath.

On 12/06/2018 at approximately 2:00 PM, and interview with the DON was conducted. When asked about the process for obtaining a palm guard for a resident, she stated a physician's order is not necessary, it is a nursing intervention. She stated that nurses can implement the palm guards, they are located in the supply closet, and then typically the nurses would consult physical therapy for treatment and evaluation. The DON agreed there is no evidence physical therapy was consulted and she went on to say it is "a process issue, it's something we need to look at."

Facility documentation regarding rehabilitation was reviewed. The facility policy entitled, "Rehabilitation Needs Assessment Referral" documented, "A licensed nurse will complete a therapy screening tool to notify therapy personnel

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 12/06/2018

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 656	Continued From page 17 of patient's needs." The procedure steps for this policy are documented, "1. Screen for therapy needs. 2. Document information on the Rehabilitation Services Screen. 3. Notify therapy personnel as appropriate." On 12/06/2018 at approximately 5:15 PM, the Administrator and DON were notified of findings and they offered no further information. 3. For Resident # 34 the facility failed to develop and implement an individualized care plan that addresses Contractures. Resident #34 is a 95 year old woman admitted to the facility on 09/20/2013 with diagnoses including but not limited to Dementia with behavioral disturbance, muscle weakness, Dysphagia, Anemia, Anxiety disorder, Hypertension, Cataracts (bilateral) and chronic kidney disease. The latest MDS (Minimum Data Set) was a quarterly and it coded Resident #34 as having a (Brief Interview of Mental Status) BIMS score of 99 indicating that the Resident was unable to complete the interview. Resident has Dementia and is unable to follow simple conversation. During initial facility tour on 12/4/2018 at 11:45 AM Resident #34 was observed sitting in wheelchair in room. The Resident was noted to have both arms bent at the elbow hands clenched and resting on chest. The Resident did not respond when spoken to however she did make eye contact and smile. The curtain was open and the Resident's roommate stated "She can't talk,	F 656		

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 12/06/2018

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 656	Continued From page 18 well she sometimes mumbles but doesn't make sense." On 12/4/2018 at 2:45 PM, Resident #34 was observed again in her room in her wheel chair without splints or palm guards. An interview was conducted with LPN A. LPN A stated that Resident # 34 had Contractures to both hands, the elbow joints, the wrist, and hands. She further stated that they don't use any devices, splints, or palm guards for her. On 12/4/2018 during clinical record review it was noted that Resident #34 did not have an order for splints, palm guards or any orthotic devices for Contracture management. On 12/05/2018 during review of clinical record it was found that the care plan did not address contractures or preventing further contractures. Resident #34's care plan addresses: "Limited Physical Mobility r/t Wheel chair use" initiated 08/23/2014 " Dependent on Staff for meeting emotional, intellectual, physical and social needs related to Physical Limitations muscle weakness and Cognitive Impairments." initiated 08/23/2014 The Administrator was made aware of these concerns on 12/5/2016 during end of day meeting no further information was provided.	F 656		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary	F 661		1/10/19

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 12/06/2018

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 661	Continued From page 19 When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility staff failed for 1 resident (Resident 358) in the survey sample of 57 residents, to ensure that a written reconciliation of pre-discharge medications with the residents post discharge medications was done. For Resident #358, the facility staff failed to ensure that a written reconciliation of pre-discharge medications with the residents post	F 661	F661 1. Resident #358 no longer resides in center 2. Residents discharged to community from center are at risk. An audit of last 14 days of residents who discharged to the community, will be reviewed to ensure that each resident has written reconciliation of pre-discharge medications with the resident post	

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 12/06/2018

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 661	Continued From page 20 discharge medications was done. The Findings included: Resident #358 was an 88 year old who was admitted to the facility on 8/17/18 and discharged home on 9/28/18. Resident #358's diagnosis included Cerebral infarction, Generalized Muscle Weakness, Aphasia, Dysphasia, Spinal Stenosis, Glaucoma, Heart Failure, Polyosteoarthritis, and Age-Related Physical Debility. The Minimum Data Set, which was a 30-Day Assessment with an Assessment Reference Date of 9/12/18 was reviewed. Resident #358 was coded as having a Brief Interview of Mental Status Score of 14, indicating intact cognition. In addition, she was coded as being totally dependent on the physical assistance of at least 2 people for transfers. On 12/4/18 a review was conducted of Resident #358's clinical record. She was discharged home on 9/28/18. There was no record of the discharge in the progress notes on 9/28/18. The last nursing progress note prior to discharge was written by the night shift on 9/28/18 at 6:55 A.M. It read, "Resident alert, verbal, able to make needs known. Skilled for therapy and nursing services. Here post CVA (cardiovascular accident - stroke) for strengthening. Slept well this shift, no distress noted, no complaints voiced. No needs at this time. Call bell in reach." The Discharge Summary, written on 10/2/18 was reviewed. It stated that Resident #358's admitting diagnosis was CVA with Left side weakness, and that she received physical and occupational	F 661	discharge medication done. 3. The nurse Educator or designee will educate licensed nurses, therapist and discharge planners on discharge process. 4. The DON or designee will review all residents who discharge community to ensure. A written reconciliation of pre-discharge medications with the resident post discharge medication done. 3x a week x 2 weeks, then weekly x 2 then monthly x 2 . Results will be reviewed quarterly X2 in QA meeting. 5. Date of compliance 01/10/2018	

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 12/06/2018

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 661	Continued From page 21 therapy. Neither pre-discharge medications or post-discharge medications were addressed in the Discharge Summary. The clinical record did not contain a written reconciliation of pre-discharge medications with post discharge medications. There was no list of post-discharge medications. No further information was received.	F 661		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review and facility documentation review the facility staff failed to mitigate an accident hazard during ADL care for 1 resident (Resident #39) of 57 residents in the survey sample resulting in harm. Resident #39 was coded as two person assistance when turning and repositioning in bed. During incontinence care provided by one staff person, the resident fell out of bed and fractured her shoulder. The findings included:	F 689	F689 1. C.N.A H re-educate that resident requires 2-person assistance with incontinence care. 2. Residents that receive incontinence care are at risk. A review of residents who require 1-person assistance with incontinence care will be reviewed to ensure 2-person assistance is not needed. A review of resident who requires 2-person assistance with incontinence care to ensure that each resident is receiving the proper level of assistance with incontinence care and to ensure that bed mobility coding is accurate according	1/10/19

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 12/06/2018

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 689	Continued From page 22 Resident #39, a 55 year old, was admitted to the facility on 12/11/15. Diagnoses included muscle weakness, morbid obesity, chronic pain, cellulitis, diabetes, chronic obstructive pulmonary disease, heart failure, hypertension, asthma, bipolar disorder, depression, migraines, and anxiety. The most recent Minimum Data Set (MDS) assessment was an annual assessment with an assessment reference date of 9/5/18. Resident #39 was coded with a Brief Interview of Mental Status score of 15 indicating no cognitive impairment. She required extensive assistance with her activities of daily living. On 12/4/18 at 2:10 p.m., an interview was conducted with Resident #39. Resident #39 was sitting up in a bariatric bed. During the interview, Resident #39 stated that she fell out of bed while being changed. She stated that she was turned on her right side facing the window while staff changed her. When asked how many staff were in the room, Resident #39 stated there was one male certified nursing assistant (CNA) in the room. When asked for the CNA's name, Resident #39 provided the name. Resident #39 stated that she fell from the bed and broke her arm near the shoulder. She stated that the CNA tried to grab her as she fell. She stated that she rolled out of the bed towards the window. Resident #39 stated she had an abdominal mass that shifted causing her to fall. Resident #39 stated that since the fall, she had pain in her shoulder. When asked if she participated in therapy to help with her arm, Resident #39 stated that the orthopedic doctor recommended therapy but the facility did not comply. When asked if she ever gets up out of bed, Resident #39 stated no.	F 689	to care provided. 3. The nurse Educator or designee will educate licensed nurses, c.n.a. on how to provide proper level of assistance during incontinence care of resident needing great than 1-person assist. 4. The DON or designee will review 3 residents who require 2-person assistance with incontinence care to ensure the proper level assistance is being provide and to ensure accurate coding of bed mobility according to the care provided. 3x a week x 2 weeks, then weekly x 2 then monthly x 2 . Results will be reviewed quarterly X2 in QA meeting. 5. Date of compliance 01/10/2018	

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 12/06/2018

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 689	Continued From page 23 During the interview, CNA D knocked on the door. He stated he was there to provide care, as this was the time he usually did so with Resident #39 in the afternoon. He was asked to return in 10 minutes. The CNA involved in the fall incident was identified. He is referenced as CNA H in this deficiency. The following nursing notes were documented in the clinical record: - 3/27/18 17:03, Incident Note, "Resident rolled out of bed during ADL (activities of daily living) care." "Resident c/o (complained of) right shoulder pain" "resident sent to (hospital) for further evaluation." - 3/27/18 23:04, Order Note, Percocet 10-325 milligram give 1 tablet by mouth every 6 hours as needed for pain - 3/28/18 01:14, Post Fall Note, situation: resident had a fall, background: diabetes, morbid obesity, assessment: resident has a sling on right shoulder fracture - 3/28/18 16:01, Discharge Planning Progress "Meeting held with patient, ___ case worker/ friend, _____ DON (director of nursing), ____ UM (Unit Manager), and ____ DDP (director of discharge planning) to discuss patient's plan of care. Patient had reported to (friend) issues with being changed timely and pain being unaddressed. Patient continues with refusals of care including medications, treatments, showers, supplements. Patient is also receiving occupational therapy for lymphedema treatment. Patient does not tolerate treatment and exercises	F 689		

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 12/06/2018

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 689	Continued From page 24	F 689		

and at times refuses treatment." "Patient states understanding the need to transfer to a different facility if plan of care is not followed." "Patient stated last night's fall was unpreventable and that the CNA assisting her could not have done anything to prevent the fall. Patient will have two staff assisting with care."

A copy of the hospital discharge summary dated 3/27/18 was reviewed. The summary read, "Your exam shows you have a fractured shoulder." The summary also read, "You have been prescribed narcotic. Narcotic medications are used to relieve pain." The x-ray read, "There is a mildly displaced transverse fracture through the surgical neck of the humerus."

On 12/5/18 at 2:25 p.m., it was reviewed with the DON that Resident #39 was coded on the 3/6/18 MDS assessment to need a two person assist for bed mobility. The DON stated that the MDS coding was wrong and that Resident #39 was a one person assist for ADLs before the fall. The DON was asked to provide documentation of the type of assistance Resident #39 needed for her ADLs. She was also asked to provide the CNA care plan (kardex). The DON stated that after the fall, the facility added a concave overlay to the mattress and added a two person assist during ADL care due to the left lower abdominal mass. She stated that the body habitus changed and was larger at this time.

The facility was asked to provide a physician progress note for when the abdominal mass was first assessed. The following physician progress notes were provided:
-2/14/18: large eccentric pannus with infection possible mass effect no evidence for abdomen

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 12/06/2018

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 689	Continued From page 25 hernia. - 2/14/18: Gastrointestinal (Abdomen: soft, nontender, nondistended, no masses or organomegaly. Large pannus with some dependent edema. No sign of panniculitis, No abdominal hernia. -2/26/18: ABDOMEN: Obese with large pannus, particularly protruding from the left side. No masses are felt with palpation. SKIN: slightly pinkend and warm on bilateral lower extremities, which is baseline. She states there is pain with palpation, intermittent weeping. -3/6/18: The patient states that she is having pain in her lower extremity. She is on multiple pain medications: morphine and Fioricet. ABDOMEN: soft, nontender, nondistended. Bowel sounds active. No guarding or masses with palpation. Obese with large pannus that also has some edema. EXTREMITIES: She does have 3 to 4+ bilateral lower extremity edema. Assessment and Plan: 1. Lymphedema. She is working with physical therapy. -3/13/18: Reason for visit: Per patient request to visualize lower extremities. She does continue to have 4+ pitting edema. Also the patient states that the itching has improved but is still present in her lower extremities. She does use a back scratcher down there and itch. She also states that the pain is significant. Examination: Obese with large pannus and edema up to abdomen. Extremities: 4+ pitting edema. Bilateral lower extremity weakness. The MDS assessment completed prior to the fall had an assessment reference date of 3/6/18.	F 689		

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 12/06/2018

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 689	Continued From page 26 Resident #39's assessment was coded as follows: G0110. A. Bed mobility, describes "how resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture." The resident was coded as 3/3, indicating that extensive assistance (resident involved in activity, staff providing weight-bearing support) involving two+ persons physical assist was needed. G0400. Functional Limitation in Range of Motion: coded no impairment to upper or lower extremity J0400. Pain Frequency: coded as a 1 indicating "almost constantly." K0200. Height and Weight: coded as 62 inches and 420 pounds The CNA Activities of Daily Living (ADL) tracking information for March 2018 was reviewed. Coding on the document was defined as follows: Self-Performance section 3= Extensive Assistance: Resident involved in activity, staff provide weight-bearing support 4= Total Dependence: Full staff performance Support Provided section 2= One person physical assist 3= Two+ persons physical assist The March 2018 ADL tracking document was provided. The Bed Mobility section was set up so that documentation could be completed for each shift. According to the March 2018 ADL tracking, Resident #39 was coded as 4/3 (total dependence of 2+ staff physical assist) for bed	F 689		

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 12/06/2018

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 689	Continued From page 27	F 689		

mobility on six occasions prior to the time of the fall. CNA H (staff involved in the fall), documented a 4/3 on four of the six occasions. The fall occurred during the evening shift on 3/27/18. During the day shift on 3/27/18 (prior to the fall), the CNA providing care documented a 4/3.

According to the March 2018 ADL tracking document, Resident #39 was coded as 4/2 (total dependence of 1 staff physical assist) for bed mobility on 39 occasions prior to the time of the fall. Out of 79 documented opportunities for the month, the CNAs coded total dependence for bed mobility on 45 occasions. CNA H coded total dependence for every shift he worked in March, a total of nine occasions. This meant that Resident #39 was not able to assist with moving or turning in the bed on any day that CNA H worked with her.

The CNA kardex was provided. While the document did not include a date, the section titled "Safety" included the concave overlay, an intervention initiated after the 3/27/18 fall. There is no information on the kardex indicating the number of staff that are supposed to assist with Resident #39's ADL care.

On 12/6/18 at 10:10 a.m., CNA C was interviewed regarding how the CNAs had been trained to code ADL tracking information. CNA C stated that the CNAs documented ADLs electronically. She logged into the computer to show this surveyor. CNA C stated that she was supposed to document the level of care provided for each ADL task she provided to the residents she cared for during her shift. She stated that ADL documentation was completed every shift. When

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 12/06/2018

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 689	Continued From page 28	F 689		

asked to explain the coding choice "Total Dependent," CNA C stated that it meant the resident could not do anything for themselves and staff would need to do everything. CNA C stated that when a resident was total dependent, two people were required to provide care and sometimes more than two were needed. When asked how she knew how many people were required to perform ADLs for a resident, CNA C stated she would find out from the meeting at the beginning of the shift. When asked to give examples of a resident who would be coded as total dependent, CNA A stated a resident with a very high weight or a small resident with fragile skin would be considered total dependent and require 2 staff. CNA C stated that the goal when providing care was to maintain safety for the resident and herself.

On 12/6/18 at 10:30 a.m., Registered Nurse A (RN A) stated that she was the Staff Development Coordinator. RN A was asked when she began her role at the facility. She stated June 2018. RN A was asked to review the training provided to the CNAs upon hire. RN A provided a document titled, "ADL Documentation" Teaching/ Learning Module August 2014. When asked if this training was used at the facility prior to her assuming the position, RN A stated yes. When asked if she had changed the training at all, RN A stated no.

The section "ADL Definitions" defined "self performance" as "what the patient actually did; not what he is capable of doing". The "Self Performance" section read "3= Extensive Assist" for bed mobility, "Patient can help turn himself/herself grabbing onto the side rail, the CNA tells her what to do, She needs the CNA to lift her bottom and guide her legs into position.

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 12/06/2018

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 689	Continued From page 29	F 689		

Hint: The CNA provides weight bearing support and use of muscles." The section also read, "4 Dependent," but did not provide instruction for bed mobility. A slide titled "Noteworthy Comment" read, "If a patient participates in the activity, it is NOT a 4."

The training also provided guidance on "Staff Support" and read, "Highest level of support provided by staff". In addition, the Staff Support section read, "On person physical assist- CNA uses muscles with the patient giving little assistance" and "Two person physical assist- May be required to accomplish a specific ADL; Transfer patient with limited or no ability to assist with the transfer." "2-One person physical assist" for bed mobility read, "A CNA turns patient without additional staff assistance." "3-Two person physical assist" for bed mobility read, "CNA needs help in turning and repositioning the patient. Pulling the patient up in the bed would require two person physical assist."

In addition to the CNA training provided upon hire, the facility used a computer based training developed by the facility corporation titled, "Safe Patient Handling: Positioning Patient to a Side-Lying Position." The section titled "Bed Mobility" read, "When patients are not able to independently turn and reposition in bed, CNAs or nurses are needed to assist with bed mobility tasks to meet the patient's turning and repositioning needs." "Turning a patient to a side lying position may be needed in order:" "to perform certain procedures and care measures such as providing perineal care." The slide titled "Planning and Preparation" read, "Determine how much assistance is needed: Staff- You need at least 1 co-worker to help you. Depending on 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 12/06/2018

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 689	Continued From page 30	F 689		

patient's size, 3 or more staff members may be needed." Another slide read, "Decide how to safely turn the patient before starting the procedure- if you need more than one additional staff person to help, ask before beginning the task. Protect the patient from falling when the bed is raised: Remember the opposite side of the bed is open and in a raised position, therefore implement safety measures to prevent a fall from occurring, to the extent possible, i.e... station 1-2 staff members to the opposite side of the bed." The slide titled "Turning Patients" read, "When turning a patient away from a staff member, ask that one or more staff members stand on the opposite side of the bed from you before turning the patient."

According to CNA H's training log, he completed the "Safe Patient Handling: Positioning Patient to a Side-Lying Position" training on 5/30/18.

Resident #39's comprehensive care plan was reviewed. The focus "The resident has limited physical mobility r/t (related to) weakness" was created on 12/14/15. On 12/5/18 at 2:30 p.m., the DON was asked to explain Resident #39's weakness. The DON stated Resident #39 had lower extremity weakness d/t obesity. The care plan did not include the level of care or number of staff that were needed to assist during ADL care.

On 12/6/18 at 8:30 a.m., the DON was asked to provide the fall investigation. The "Post Fall Assessment" form was provided. The fall occurred on 3/27/18 at 4:30 p.m. The form read, "RSD (resident) rolled out of bed while assisting staff during ADL care." The section "Action following fall" read, "Resident sent to ER." It was documented that six staff members assisted 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 12/06/2018

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 689	Continued From page 31	F 689		

resident getting up after the fall. At this time, the DON also stated that the Occupational Therapy lymphedema specialist began working with Resident #39 on 2/28/18 regarding the left abdominal mass that was due to lymphedema.

Physician orders included the order dated 2/28/18 for Occupational Therapy. The order read, "Pt (patient) will benefit from skilled OT/CLT 5-7x/ 12 weeks, for manual lymphatic drainage, measure/fit/mgmt. (management) of bandaging equipment, self care retraining including skin care mgmt., thera ex, and measure/fit/mgmt. of maintenance compression equipment not to exclude pneumatic compression device."

The Occupational Therapy "Evaluation & Plan of Treatment" document dated 2/28/18 was reviewed. The form read, "Reason for Referral: Patient referred to OT/ CLT due to significant lymphedema B Les (bilateral lower extremities) and abdomen with associated wounds and recurrent cellulitis." The "Evaluation Summary" read "Patient presents with impairments in mobility, sensation, strength, self modification and use of coping strategies resulting in limitations and/or participation in the areas of general tasks and demands, self care and mobility." In the section titled "self care", Resident #39 was documented as "dependent" for toilet hygiene. She was documented as "Partial/Moderate Assistance" for washing upper body.

The Occupational Therapy "Discharge Summary" dated 5/24/18 was reviewed. In the section titled "self care", Resident #39 was documented as "dependent" for toilet hygiene.

On 12/6/18 at 9:00 a.m., it was reviewed with 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 12/06/2018

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 689	Continued From page 32	F 689		

DON that the survey team would like to see the full investigation. She stated that it was part of the quality assurance documentation and she could not provide copies to the survey team. She stated that the surveyors could read the investigation on the computer.

On 12/6/18 at 10:30 a.m., the fall investigation was reviewed in the presence of the DON, two corporate nurses and Surveyor B. The DON provided a copy of a form titled "Witnesses Fall" which read, "Resident rolled out of bed while assisting staff during ADL care, rsd (resident) started dangling her feet when she turned to the right side assisting CNA while holding side bars. Resident then released sidebars and landed on her right shoulder. Resident stated the size of her mass pulled her down to the floor while she was holding on to the side bars." The "Mobility" section on the form was documented as "bedridden." CNA H was listed as a witness.

The DON sat with this surveyor and Surveyor B while the printed investigation documents were reviewed. The DON documented in her investigation summary that Resident #39 was on her right side holding on to the bed rail. Resident #39's left leg was over the right leg while CNA H was cleaning the resident's bottom. The summary read that Resident #39's leg slipped and the resident pulled harder on the bed rail. Resident #39's weight shifted and she slid out of bed. The resident continued to hold onto the bed rail as she slid off the bed. It was documented that Resident #39 complained of right shoulder pain. The summary documented that the resident was assisted to the floor by the Unit Manager.

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 12/06/2018

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 689	Continued From page 33	F 689		

The DON was asked how the Unit Manager knew that Resident #39 had fallen out of bed. The DON stated that CNA H called for the Unit Manager to help him

CNA H's statement was reviewed. The statement read, "res rolled over to the other side grab bar, and her mass pulled her down off bed."

The DON was asked what new interventions the facility implemented for Resident #39 as a result of the fall. The DON stated that a concave mattress overlay was applied to the bed. In addition, two person assist with ADLs was implemented.

There was no documentation provided by the facility indicating Resident #39 was a one person assist for ADL care prior to the fall and there was no documentation provided indicating Resident #39 was a two person assist for ADL care after the fall.

The December 2018 ADL tracking was reviewed. Unlike the March 2018 ADL tracking, the December 2018 tracking did not include Bed Mobility documentation for all three shifts. It only included documentation for the 3-11 shift, twice weekly, to coincide with the twice a week shower days. As of 12/6/18, bed mobility was only coded once for the month. On 12/4/18, bed mobility was coded as 3/2 (extensive assist/ 1 person). On 12/4/18, bath/ shower was coded as 4/2 (total dependence/ one person assist). On 12/4/18, 7-3 shift, toileting was coded by CNA D as 4/2 (total dependence/ one person assist). Toileting was coded 12/1/18-12/4/18 and only 1 person assist was coded on these days.

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 12/06/2018

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 689	Continued From page 34 On 12/6/18, the DON was asked why bed mobility was not documented per shift on the December 2018 ADL tracking. She stated that she just realized when she printed the tracking that the bed mobility tracking was not input into the computer system correctly, so tracking was not completed per shift. When asked why staff were coding toileting for the resident when she did not get out of bed to toilet and instead wore an incontinent brief, the DON stated that toileting documentation was not supposed to occur in the toileting section for Resident #39 because she did not toilet. The DON stated during interviews that the corrective action after the fall was two person assist for ADL care. It does not appear from the documentation on the December 2018 ADL tracking that two persons were being used for Resident #39's ADL care. On 12/4/18 at 2:28 p.m., Surveyor A observed Resident #39's incontinence care with CNA D and CNA J. While at the nursing station, Surveyor A announced that she wanted to watch incontinent care and observe for a wound. CNA J told CNA D that she would help him. Licensed Practical Nurse G was also in the room to assist with the wound observation. The two CNAs performed incontinent care during the observation. CNA D is the CNA who had knocked on the door during Resident #39's interview at 2:10 p.m. and stated he was there to provide care. He did not have another staff with him when he initially came to the room to provide care. On 12/5/18, the survey team held an end of day meeting with the Administrator, Director of Nursing, two Corporate nurses, and the	F 689		

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 12/06/2018

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 689	Continued From page 35	F 689		

Administrator in Training. At this time, the facility staff were notified that the survey team was considering Resident #39's fall with fracture a possible harm level deficiency. The facility staff were asked to provide all documentation regarding the incident.

In summary, the facility staff stated that Resident #39 fell out of bed due to the large abdominal mass affecting Resident #39's stability during bed mobility and ADL care. The large abdominal mass was first assessed by the physician on 2/14/18. The facility was aware of the large abdominal mass for more than a month prior to the fall without implementing interventions to ensure safety while turning and repositioning the resident in bed. The 3/6/18 MDS prior to the fall coded Resident #39 to need extensive assistance involving two+ persons physical assist for bed mobility. Only a one person assist was used to perform ADL care when Resident #39 had the fall with fracture. On the March 2018 ADL tracking, total dependence on staff for bed mobility was documented over 50% of the time. CNA H documented that Resident #39 was total dependence for bed mobility for all nine shifts that he worked with her during the month. According to the interview with CNA C, when staff provide support of total dependence, two persons should be use to assist in care. According to the "Safe Patient Handling: Positioning Patient to a Side-Lying Position" training developed by the facility corporation, staff should "Determine how much assistance is needed: Staff- You need at least 1 co-worker to help you." The DON stated that after the fall, two person assist was implemented for Resident #39's ADL care. No documentation was provided showing that staff had been instructed to use two persons when

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 12/06/2018

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 689	Continued From page 36 providing Resident #39's ADL care. The December 2018 ADL tracking form documented that only one person has been involved when providing ADL care for Resident #39.	F 689		
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those	F 791		1/10/19

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 12/06/2018

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 791	Continued From page 37 circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on observations, family interview, staff interview, clinical record review, facility documentation, and facility policy review, the facility staff failed to provide timely dental services for one resident (Resident #115) in a sample of 57 residents. The findings include: Resident #115, an 86-year old female, was admitted to the facility 02/06/2016. Diagnoses include Alzheimer's disease, anxiety, depression, diabetes, gastroesophageal reflux disease, dysphagia, failure to thrive, and age-related debility. Resident #115's most recent quarterly Minimum Data Set (MDS) had an Assessment Reference Date (ARD) of 10/31/2018. Resident #115's Brief Interview of Mental Status (BIMS) was coded as "6" out of possible "15" indicative of severe cognitive impairment. Functional status for eating and toileting was coded as requiring extensive assistance. Dressing and personal hygiene was coded as total dependence on staff for assistance.	F 791	F791 1. Resident #115 dental appointment 12/13/18 2. Any resident needing dental services is at risk. A review of residents needing dental services the last 14 days will be reviewed to ensure dental services received. 3. The nurse Educator or designee will educate licensed nurses, Unit managers, Discharge planner on dental services policy. 4. The DON or designee will review all residents needing dental service to ensure dental services received 3x a week x 2 weeks, then weekly x 2 then monthly x 2. Results will be reviewed quarterly X2 in QA meeting. 5. Date of compliance 01/10/2018	

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 12/06/2018

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 791	Continued From page 38	F 791		

On 12/04/2018 at approximately 12:00 PM, the Resident was observed awake, lying in bed, and head of bed was elevated approximately 45 degrees. The Resident's daughter and son-in-law were visiting. When asked if they had any concerns about the care their mom was receiving, the daughter stated she was concerned about her mom losing weight and thought it was due to her mom's bottom dentures being lost "about 4 months ago." The daughter stated her mom was switched to a pureed diet when her teeth were lost and she does not like to eat pureed food. The daughter stated she told the unit manager and the social worker about the missing dentures but they still haven't been replaced. The Resident was then observed with top dentures in her mouth but no bottom dentures.

On 12/04/2018 at approximately 4:00 PM, the facility staff was asked to present documentation for any service-related concerns. A Service Concern Report dated 10/29/2018 was presented and reported two pairs of jeans and two coats were missing. The concerns were resolved on 11/13/2018. There was no mention of lost bottom dentures.

On 12/05/2018 at 8:20 AM, the Resident was observed sitting up in bed and the head of bed was elevated approximately 45 degrees. The Resident was awake and observed to have her top dentures in but no bottom dentures were visualized.

On 12/05/2018 at approximately 9:00 AM, an interview with the Resident's current CNA, CNA B, was conducted. When asked about when oral care was done, CNA B stated it was done "before

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 12/06/2018

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 791	Continued From page 39	F 791		

and after" meals. When asked if she assisted the Resident with her dentures that morning, CNA B stated that this Resident doesn't wear dentures. CNA B then stated that this Resident may wear dentures and proceeded to look in the bedside table drawer for them but the bottom dentures were not located.

The clinical record was reviewed. An initial nutrition note dated 02/07/2016 documented, "Resident admitted on a therapeutic RCS (reduced concentrated sweets) diet. Resident wears both upper and lower dentures, no issues chewing. Family brings outside snacks. Family reports patient has poor appetite and will do best with smaller portions and snacks during the day. Patient will often sleep during the day." Admission weight documented on 02/06/2016: 104.1 pounds. Weight documented on 11/26/2018: 131 pounds.

A physician's order for "Regular diet Level 6 - soft & bite sized texture" was discontinued on 07/26/2018. A physician's order for "Regular diet Level 4 - pureed texture, regular liquids consistency, Ensure pudding with lunch and dinner trays" was discontinued on 08/06/2018. A physician's order for "Regular diet Level 4 - pureed texture, Level 3 - moderately thick consistency, Ensure pudding with lunch and dinner trays" was discontinued on 10/29/2018. An active physician's order for "Diabetic diet Level 4 - pureed texture, Level 3 - moderately thick consistency, Ensure pudding with lunch and dinner trays" was dated 12/03/2018.

A discharge planning note dated 06/27/2018 documented, "DDP (discharge planner) and UM (unit manager) met with patient's daughter

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 12/06/2018

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 791	Continued From page 40	F 791		

[name]. Patient lost dentures in May. Patient has had no reported issues with eating meals. Facility has a visiting dentist starting soon. (Daughter) is happy to wait for dentist visit in order to get new impression of bottom dentures. Discharge planning will provide support as needed."

A General Consent form signed by the Resident's daughter in July 2018 authorized a specific dental group to deliver treatments as recommended.

A dental examination form dated 10/10/2018 was signed by a dentist and indicated Resident received a "comprehensive oral evaluation" during a "nursing home facility visit." No treatments were selected on the form but in the "Notes" section, the dentist documented, "Has upper denture - lost lower - pt keeps falling asleep. N.V. (next visit) 1. Clean denture 2. 1 year visit.

A Care Plan Meeting note dated 11/06/2018 documented, "Patient participates in speech therapy. At this time therapist recommendation is to continue on current diet and liquid consistency. Dentures would not impact patient's ability to upgrade. Family would like to proceed with procuring dentures for aesthetics."

Facility policy for dental service needs was reviewed. Procedure #6 documented, "In the event a patient's dentures are lost or damaged the nursing will promptly (sic), within three days, refer the patient for dental services. If the referral does not occur within three days nursing will provide documentation of what has been done to ensure that the resident can still eat/drink adequately while awaiting dental services and will describe reasons for the delay."

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 12/06/2018

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 791	Continued From page 41 On 12/06/2018 at approximately 5:15 PM, the Administrator and DON were notified of findings and they presented a Service Concern Report dated 05/23/2018. The details of the report documented, "Glasses missing black rimmed, bottom teeth also missing. She sometimes leaves them in the bed. 3 weeks ago for the glass (sic) and 4 weeks of dentures (sic). (Daughter) [name] feels patient will be fine without dentures, but wants glasses so she can read." Action taken documentation "Optometry re-order glasses on visit 05/29/2018." Concern was marked as resolved on 06/03/2018 and signed by the Administrator. In summary, the facility staff was aware Resident's bottom dentures were lost since May 2018 and failed to refer Resident for dental services promptly. The Resident still does not have bottom dentures.	F 791		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880		1/10/19

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 12/06/2018

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 880	Continued From page 42 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents	F 880		

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 12/06/2018

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 880	Continued From page 43 identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility documentation review, the facility staff failed, for 1 resident (Resident #17) in the survey sample of 57 residents, to administer medications in a manner to prevent the spread of infection. For Resident #17, the nurse (LPN C) failed to perform proper handwashing technique prior to preparing and administering medications. The Findings included: Resident #17 was a 68 year old, who was admitted to the facility on 6/21/12. Resident #17's diagnoses included Generalized Muscle Weakness, Unspecified Kidney Failure, Chronic Obstructive Pulmonary Disease, and Epilepsy. The Minimum Data Set which was an Annual Assessment with an Assessment Reference Date of 1/22/18 was reviewed. Resident #17 was coded with a Brief Mental Status Score of 14, indicating that she was cognitively intact. On 12/5/18 an observation was conducted of the	F 880	F880 1. LPN C reeducated on proper hand washing technique prior to preparing and administering medication 2. Residents who receive medication are at risk. 3. The nurse Educator or designee will educate licensed nurses on handwashing policy 4. The DON or designee will complete 2 med pass observation to ensure proper hand washing technique prior to preparing and administering medication 3x a week x 2 weeks, then weekly x 2 then monthly x 2 . Results will be reviewed quarterly X2 in QA meeting. 5. 1/10/18	

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 12/06/2018

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 880	Continued From page 44	F 880		

medication administration process. Licensed Practical Nurse (LPN C) was present. At 8:25 A.M., LPN C was observed washing her hands. She turned on the water, then put foam soap on her hands. She washed her hands for 6 seconds, then immediately rinsed off the soap. She then used a paper towel to dry her hands, and another paper towel to turn off the water. She then poured and administered the following medications to Resident #17:

1. Prostat 30 Ml in 240 cc of water
2. Gabapentin 200 MG
3. Juven liquid supplement
4. Amlodipine 10 MG
5. NORCO 7.5/325 MG
6. Anastrozole 1 MG

In addition, at 8:40 A.M. LPN C washed her hands in the same manner for only 6 seconds and then immediately rinsed the soap off.

When asked about the proper amount of time to wash her hands prior to rinsing off the soap, LPN C stated, "I was nervous. I should have washed my hands for 30 seconds." When asked about the importance of proper handwashing technique, LPN C stated, "It's important because we shouldn't pass bacteria and germs to the residents." The facility Director of Nursing (Employee B) was present after the handwashing. LPN C informed the DON that she had not washed her hands adequately.

On 12/5/18 a review was conducted of facility documentation, revealing a handwashing policy. It read, "Revised 12/26/17. All staff are trained on proper technique upon hire, annually, and PRN (as needed), and are monitored for proper

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 12/06/2018

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 880	Continued From page 45 handwashing practices. Employees will wash hands at appropriate times to reduce the risk of transmission and acquisition of infections." The policy described the handwashing technique, which included the following, "Work lather over hands and wrists. Scrub for at least 15-20 seconds. Rinse hands and wrists thoroughly under running water." No further information was received.	F 880		