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 ______	R-C 01/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS An unannounced Medicare/Medicaid revisit to the abbreviated standard survey conducted 10/19/22 through 10/21/22, was conducted 1/9/23 through 1/12/23. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. Four complaints were investigated during the survey as follows: VA00057338=Substantiated with deficiency. VA00057322=Substantiated with deficiency. VA00057090=Substantiated with deficiency. VA00057024=Substantiated without deficiency. The census in this 180 certified bed facility was 168 at the time of the survey. The survey sample consisted of 12 resident reviews.	{F 000}		
{F 658} SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, facility documentation review, and in the course of a complaint investigation, the facility staff failed to follow standards of nursing practice for 1 Residents (Resident #102) in a survey sample of 12 Residents. The findings included: For Resident #102, the facility staff failed to obtain lab work/urine sample as ordered by the	{F 658}	The statements made in the following plan of correction are not an admission. The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take actions set forth in the plan of correction. The following plan of correction constitutes the facilities allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated.	2/7/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 02/03/2023

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

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{F 658} Continued From page 1
physician.

On 1/10/23-1/11/23, a clinical record review of Resident #102's chart was conducted. This review revealed the following:

On 7/10/2022 at 2:52 PM, a progress note was entered into the record that read, "Writer spoke with residents RP [responsible party] in regard to resident current condition. Per RP resident is having increased confusion and requiring more cueing with adls [activities of daily living] than usual. VSS [vital signs stable]. RP concerned that resident may have an UTI [urinary tract infection]. On call MD [medical doctor/physician] notified of concerns order obtained to obtain UA/ C&S [urine analysis with culture and sensitivity]. RP updated".

A physician order dated 7/10/22, read, "UA/C&S may straight cath [catheterize] if needed one time only".

Review of the medication administration record, treatment administration record, results tab, and miscellaneous tab of the chart revealed no evidence of this urine sample being obtained.

On 1/11/23 at 3:25 PM, Surveyor C met with the Director of Nursing (DON) and Regional Director of Clinical Services (RDCS) in the DON office. The DON accessed Resident #102's clinical record and confirmed the progress note and MD order for the urine sample/test. She confirmed that the results were not under the results tab. The DON was asked to provide any evidence that this lab was obtained as ordered.

On 1/12/23 at 10:19 AM, an interview was

{F 658}

F658 Services Provided Meet Professional Standards
1. Resident #102 no longer resides in the facility.
2. Current residents in the center have the potential to be affected. Current residents who reside in the facility will have their physician orders reviewed by the DON or designee from 01/13/23 through current to ensure lab work/urine samples were obtained as ordered by the physician.
3. The Staff Development Coordinator or designee will educate all licensed nurses on ensuring lab work/urine samples are obtained as ordered by the physician.
4. The Unit Manager or designee will complete a weekly review for 30 days to ensure resident lab work/urine samples are obtained as ordered by the physician. Results of the review will be presented to the QAPI committee for review and recommendation. Once the committee determines the problem no longer exists, the review will be conducted on a random basis.
5. Date of compliance: 02/07/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 658}	Continued From page 2	{F 658}		

conducted with LPN E. LPN E was asked what the process is when she receives an order from a physician for labs or specimens. LPN E said, "We do the labs, if a urine we collect the urine and call for the lab to pick it up. When the doctor orders it, we will do it as soon as possible, when the results come in the lab faxes them to the doctor, if they send it to us, we print it and put it in the doctor book".

On 1/12/23 at 10:23 AM, an interview was conducted with LPN F. LPN F was asked about labs. LPN F said the lab sends someone to draw blood for labs and the facility staff collect urine samples. LPN F went on to explain the process as, "We would obtain the specimen, label and date the specimen, put it in the fridge, document in the chart that I collected it and call the lab to pick up the sample".

On 1/12/23 at 10:45 AM, Surveyor C called the facility's contracted laboratory. They looked in their system for any labs or specimens and noted that they did not have Resident #102 in their system and had never processed any specimens for this Resident.

Review of the facility policy titled; "Laboratory/Diagnostic Testing" was conducted. This policy read, "1. A licensed nurse will obtain laboratory, radiology, or other diagnostic services to meet the needs of its patients as ordered by the physician or physician extender. 2. A licensed nurse will monitor and track all physician or physician extender ordered laboratory, radiology, and other diagnostic tests; ensure that tests are complete as ordered and communicate results to the physician in a timely manner. 3. Laboratory, radiology, and other diagnostic services will be

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	495097	A. BUILDING ________ B. WING ________	R-C 01/12/2023

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{F 658}	Continued From page 3 provided only when ordered by the physician or physician extender. 4. The physician or extender will be notified of the results as soon as possible by a licensed nurse of any results that fall outside the clinical reference range. 5. Once the physician or extender has been notified, the licensed nurses will document the date of notification, the method of notification as well as any other necessary information related to the lab, radiology, or other diagnostic testing results in the patient's medical record. Copies of the results will be placed in the patient's clinical record. " No further information was provided prior to the conclusion of the survey.	{F 658}		
{F 755} SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-	{F 755}		2/7/23

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	495097	A. BUILDING ______ B. WING ______	R-C 01/12/2023

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{F 755}	Continued From page 4 §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, facility documentation review and in the course of a complaint investigation, the facility's contracted pharmacy failed to provide a physician ordered medication timely for one Resident (Resident #101) a survey sample of 12 Residents. The findings included: For Resident #101, the pharmacy failed to obtain and provide a physician ordered antibiotic resulting in 8 missed doses. Review of the clinical record for Resident #101 revealed that the Resident was admitted to the facility on 12/21/22. The discharge orders/physician orders from the hospital discharging physician revealed an order, "Fidaxomicin 200 mg Tablet, commonly known as: Dificid. Take 1 tablet by mouth two (2) times a day for 17 doses. Last time this was given: 200 mg on December 21, 2022, at 10:18 AM. Your next dose is: 12/21/22 at 9 PM." A progress note written 12/22/2022 at 12:44 PM,	{F 755}	F755 Pharmacy Services 1. Resident #101 no longer resides in the facility. 2. Current residents in the center have the potential to be affected. A review of the medication carts will be completed by the DON or designee to ensure the residents□ medications are available for administration per physician orders. The pharmacy will be contacted for medications that have not been delivered to ensure medications are received on the next delivery. 3. The Staff Development Coordinator will educate all licensed nurses on the process for ensuring physician ordered medications are available for all residents. 4. The Unit Manager or designee will review the medication carts and resident□s administration records weekly for 30 days to ensure physician ordered medications are available and being administered as per physician orders. The pharmacy will be contacted for medications that have not been delivered	

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	495097	A. BUILDING ______ B. WING ______	R-C 01/12/2023

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{F 755}

Continued From page 5

read, "Dificid Tablet 200 MG, give 1 tablet by mouth two times a day for c-diff for 17 Administrations Medication on next med run MD/RP [physician and responsible party] aware".

Review of the Medication Administration Record (MAR) revealed Resident #101 did not receive her scheduled dose of Dificid on 12/21/22, 12/23/22, 12/24/22, and the morning dose on 12/25/22. The MAR was signed off for the evening dose of 12/22/22, however the medication had not been delivered to the facility at this time and the Resident not in the facility during this scheduled dose.

There were multiple progress notes entered into the clinical record of Resident #101 on 12/24/22, that indicated the Dificid was not available to give.

Review of the on-site Omnicell [medication dispensing machine/emergency medication supply] revealed that Dificid was not available on-site for staff to administer.

On the morning of 1/9/23, the facility Administrator reported to the survey team that initially the Resident expressed a desire to leave the facility and therefore they waited until they knew she was going to stay at the facility to have the Dificid delivered. The Administrator went on to say that the pharmacy had notified the facility the Dificid was an expensive medication and needed permission before filling the physician order/script for Dificid. The facility Administrator further explained that as soon as he saw the pharmacy notification, he authorized for the medication to be dispensed. The administrator provided the survey team with a copy of the emails which indicated that on 12/23/22 at 2:39

{F 755}

to ensure medications are received on the next delivery. Results of the review will be presented to the QAPI committee for review and recommendation. Once the committee determines the problem no longer exists, the review will be conducted on a random basis.

5. Date of compliance: 02/07/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 755}	Continued From page 6	{F 755}		

PM, the pharmacy emailed the facility staff indicating the Dificid was a "High-Cost Medication" and would cost $4,622.16. On 12/24/22 at 10:40 AM, the facility Administrator responded to the email with "Please send. Thanks".

On 1/11/23, in the afternoon, the Regional Director of Clinical Services indicated it was the facility's contracted pharmacy's responsibility to call the back-up pharmacy to obtain medications if they were not able to fill a physician order.

The facility policy titled; "unavailable medications" was reviewed. This policy read, "Medications used by residents in the nursing facility may be unavailable for dispensing from the pharmacy on occasion. This may be due to the pharmacy being temporarily out of stock of a particular product, a drug recall, or manufacturer's shortage of an ingredient, or may be a permanent situation due to the medication no longer being produced. The facility must make every effort to ensure that medications are available to meet the needs of each resident".

The above referenced policy continued to read, "Procedure: The pharmacy staff shall: 1. Notify nursing staff that the order product(s) is/are unavailable. 2. Notify nursing staff of when it is anticipated that the drug(s) will become available. 3. Suggest alternative, comparable drug(s) and dosage of drug(s) that is/are available.

The nursing staff shall: 1. Notify the attending physician (or on-call physician when applicable) of the situation and explain the circumstances, expected availability, and alternative therapy(ies) available. If the facility nurse is unable to obtain a

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	495097	A. BUILDING ______ B. WING ______	R-C **01/12/2023**

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{F 755}	Continued From page 7 response from the attending physician or on-call physician, the nurse should notify the nursing supervisor and contact the Facility Medical Director for orders and/or direction. 2. Obtain a new order and cancel/discontinue the order for non-available medication. 3. Notify the pharmacy of the replacement order." The pharmacy contract between the facility and the pharmacy was reviewed. An excerpt from this contract on page 3 read, "...(c) The Pharmacy shall deliver Medications and provide services to the Facility seven (7) days a week, three-hundred sixty-five (365) days a year, with modified schedules on national holidays based on a daily delivery schedule mutually determined by the Facility and the Pharmacy. Emergency delivery of Medications shall be done by the Pharmacy during normal business hours, except for circumstances beyond the Pharmacy's reasonable control, and emergency services shall be available after hours through an answering service with a pharmacist on-call. (i) The Pharmacy shall establish an emergency system for backup and/or interim order dispensing. Any emergency drug supply provided under this Section shall be the property of the Pharmacy as prescribed by Applicable Laws..." The facility Administrator and Director of nursing were made aware of the findings. No further information was provided. Complaint related deficiency.	{F 755}		
{F 760} SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2)	{F 760}		2/7/23

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 ______	R-C 01/12/2023

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{F 760}

Continued From page 8

The facility must ensure that its-
§483.45(f)(2) Residents are free of any significant medication errors.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, clinical record review, facility documentation review and in the course of a complaint investigation, the facility staff failed to provide a significant antibiotic medication resulting in 8 missed doses for one Resident (Resident #101) a survey sample of 12 Residents.

The findings included:

For Resident #101, the facility staff failed to administer 8 doses of a significant antibiotic resulting in 8 consecutive doses being missed .

Review of the clinical record for Resident #101 revealed that the Resident was admitted to the facility on 12/21/22. The discharge orders/physician orders from the hospital discharging physician revealed an order, "Fidaxomicin 200 mg Tablet, commonly known as: Dificid. Take 1 tablet by mouth two (2) times a day for 17 doses. Last time this was given: 200 mg on December 21, 2022, at 10:18 AM. Your next dose is: 12/21/22 at 9 PM."

Another progress note written 12/22/2022 at 12:44 PM, read, "Dificid Tablet 200 MG, give 1 tablet by mouth two times a day for c-diff for 17 Administrations Medication on next med run MD/RP [physician and responsible party] aware".

Review of the Medication Administration Record (MAR) revealed Resident #101 did not receive

{F 760}

F760 Residents are free from significant medication errors

1. Resident #101 no longer resides in the facility.
2. Current residents in the center have the potential to be affected. A review of the residents' medication administration records by the DON or designee will be completed from 01/13/2023 to ensure the residents medications have been administered.
3. The Staff Development Coordinator or designee will educate all licensed nurses on administering resident medications as ordered by the physician.
4. The Unit Manager or designee will review the medication carts and residents administration records weekly for 30 days to ensure residents medications have been administered per physician orders. Results of the review will be presented to the QAPI committee for review and recommendation. Once the committee determines the problem no longer exists, the review will be conducted on a random basis.
5. Date of compliance: 02/07/2023

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 ______	R-C 01/12/2023

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{F 760}		{F 760}		

Continued From page 9

her scheduled dose of Dificid on 12/21/22- 2 doses, morning dose on 12/22/22, 12/23/22- 2 doses, 12/24/22- 2 doses, and the morning dose on 12/25/22. The MAR was signed off for the evening dose of 12/22/22, however the medication had not been delivered to the facility at this time.

Review of the on-site Omnicell [medication dispensing machine/emergency medication supply] revealed that Dificid was not available on-site for staff to administer.

On the morning of 1/9/23, the facility Administrator reported to the survey team that initially the Resident expressed a desire to leave the facility and therefore they waited until they knew she was going to stay at the facility to have the Dificid delivered. The Administrator went on to say that the pharmacy had notified the facility the Dificid was an expensive medication and needed permission before filling the physician order/script for Dificid. The facility Administrator further explained that as soon as he saw the pharmacy notification, he authorized for the medication to be dispensed. The administrator provided the survey team with a copy of the emails which indicated that on 12/23/22 at 2:39 PM, the pharmacy emailed the facility staff indicating the Dificid was a "High-Cost Medication" and would cost $4,622.16. On 12/24/22 at 10:40 AM, the facility Administrator responded to the email with "Please send. Thanks".

On 1/11/23 at 4:53 PM, an interview was conducted with Employee F, the Quality Assurance Pharmacist at the facilities' contracted pharmacy. Employee F stated the pharmacy

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 760}	Continued From page 10 received the order/prescription for Resident #101's Dificid on 12/21/22 at 6:35 PM. The medication was out of stock at the pharmacy and on 12/23/22 at 6:47 AM, a notice was sent to the facility. [the notice being referenced was the "High-Cost Medication". Employee F stated the mediation was delivered to the facility on 12/25/22 at 6:40 PM. Upon further review, Employee F noted that the medication Dificid was filled twice, and a second fill was delivered to the facility on 12/28/22 at 10:54 AM. The facility Administrator and Director of nursing were made aware of the findings. No further information was provided. Complaint related deficiency.	{F 760}		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observation, Resident and staff interviews, clinical record review, facility documentation review and in the course of a complaint investigation, the facility staff failed to provide food that accommodates Resident	F 806	F806 Resident Allergies, Preferences, Substitutes 1. The meal ticket for Resident #106 was updated to reflect their current preferences on 01/11/2023.	2/7/23

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 ______	R-C 01/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 806

Continued From page 11

preferences for one Resident (Resident #106) in a survey sample of 12 Residents.

The findings included:

For Resident #106 the facility failed to provide meals consistent with the Resident's dislike of broccoli.

On 1/9/23 at 3:08 PM, the Ombudsman met with the survey team. The Ombudsman verbalized that "Food has consistently been an issue here with poor quality, not enough food and lack of choices. I know they were renegotiating the food contract last spring".

On 1/10/23 at 5:30 PM, observations were made of the evening meal. Resident #106 was served mixed vegetables that consisted primarily of broccoli. Resident #106 was noted to not eat the meal. The meal ticket on the meal tray at the bedside was noted to read, "Allergies: Broccoli, Brussels Sprouts, Cabbage, Cauliflower, Zucchini Squash, Asparagus". When interviewed Resident #106 stated, "I can't eat that". When asked if he was allergic to broccoli, the Resident said, "no, I don't like it, but they send it all the time".

On 1/10/23 at approximately 5:45 PM, CNA C accompanied Surveyor C to the room of Resident #106. CNA C confirmed the meal ticket indicated an allergy to broccoli and the Resident was served broccoli.

On 1/10/23 at 5:55 PM, an interview was conducted with Employee F, the cook for the evening meal. Employee F was asked about the food items listed as an allergy and Employee F

F 806

2. Current residents in the center have the potential to be affected. A review of current residents diet orders by the Dietary Manager or designee was completed to ensure meal tickets were accurate and reflected their current food preferences.
3. The Staff Development Coordinator or designee will educate all dietary staff on accommodating resident food preferences.
4. The Dietary Manager or designee will observe meal tray service daily as needed for 30 days to ensure residents food preferences are accommodated as required. Results of the review will be presented to the QAPI committee for review and recommendation. Once the committee determines the problem no longer exists, the review will be conducted on a random basis.
5. Date of compliance: 02/07/2023

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 ______	R-C 01/12/2023

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 806	Continued From page 12	F 806		

said the Residents are not to get those items.

On 1/10/23 at 6:02 PM, an interview was conducted with Employee E, the dietary aide. Employee E stated that usually the meal tickets would have information in the middle of the ticket that would tell them what food items to put on the plate. Employee E went on to say, "the ticket is blank in the middle that explains everything so without it we don't know what to put on the plate".

On 1/11/23 at 12:09 PM, an interview was conducted with Employee G, the registered dietician (RD). The RD indicated she is currently at the facility 2 days per week and the facility is currently without a dietary manager. When asked about the meal tickets, the RD said, "They have not been printing out the actual daily menu, [Employee H name redacted] the Regional is also new and hasn't been doing that". Indicating the meal tickets are not being printed where it details what the staff are to put on each meal tray taking preferences and allergies in consideration and making substitutions. The RD went on to say, "As of tomorrow it will start printing the food items".

During the above interview the RD was asked about Resident #106's notation on the meal ticket as an allergy to broccoli. The RD said, "he doesn't like broccoli, preferences don't always print on the ticket if the meal were on the ticket, it would automatically substitute that food item for something else".

The clinical record for Resident #106 was reviewed. The dietary progress notes didn't reference any meal/food preferences or dislikes. The physician orders revealed an active physician

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 ______	R-C 01/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 806	Continued From page 13	F 806		

order that was entered 7/16/22, that read, "Heart Healthy Diabetic diet Level 7 - Regular texture, Regular Liquids consistency". Resident #106's care plan was reviewed without any reference to dietary preferences/dislikes being noted.

Review of the facility policy titled, "Dining and Food Preferences" was reviewed. This policy read, "...4. Food allergies, food intolerances, food dislikes, and food and fluid preferences will be entered into the resident profile in the menu management software program. 5. The Registered Dietician/Nutritionist (RDN) or other clinically qualified nutrition professional will review, and after consultation with the resident, adjust the individual meal plan to insure [sic] adequate fluid volume and appropriate nutritional content for residents that do not consume certain foods or food groups. 6. The Dining Services Director, RDN or other clinically qualified nutrition professional, or designee, will enter information pertinent to the individual meal plan into the plan of care. 7. The individual tray assembly ticket will identify allergies, food and beverage preferences or special requests, and adaptive equipment as appropriate. 8. Upon meal service, any resident/patient with expressed or observed refusal of food and/or beverage will be offered an alternate selection of comparable nutrition value. 9. The alternate meal and/or beverage selection will be provided in a timely manner".

On 1/10/23 during an end of day meeting the facility Administrator was made aware of the above findings.

No additional information was provided prior to the conclusion of the survey.

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 ______	R-C 01/12/2023

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 806	Continued From page 14 Complaint related deficiency.	F 806		
F 808 SS=D	Therapeutic Diet Prescribed by Physician CFR(s): 483.60(e)(1)(2) §483.60(e) Therapeutic Diets §483.60(e)(1) Therapeutic diets must be prescribed by the attending physician. §483.60(e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced by: Based on observation, Resident and staff interviews, clinical record review, facility documentation review and in the course of a complaint investigation, the facility staff failed to provide a therapeutic diet as ordered by the physician for one Resident (Resident #107) in a survey sample of 12 Residents. The findings included: For Resident #107 the facility failed to provide a therapeutic diet of double portions as ordered by the physician. On 1/9/23 at 3:08 PM, the Ombudsman met with the survey team. The Ombudsman verbalized that "Food has consistently been an issue here with poor quality, not enough food and lack of choices. I know they were renegotiating the food contract last spring". On 1/10/23 at approximately 5:35 PM, observations were made of the evening meal.	F 808	F808 Therapeutic Diets prescribed by Physician 1. The meal ticket for Resident #107 was updated to reflect their current therapeutic diet orders on 01/11/2023. 2. Current residents in the center have the potential to be affected. A review of current residents diet orders was completed by the Dietary Manager or designee to ensure they were accurate and being followed per physician orders. 3. The Staff Development Coordinator or designee will educate all dietary staff on ensuring they provide residents with therapeutic diets as ordered by the physician. 4. The Dietary Manager or designee will observe meal tray service daily as needed for 30 days to ensure residents therapeutic diets are provided as ordered by the physician. Results of the review will be presented to the QAPI committee for review and recommendation. Once the	2/7/23

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 ______	R-C 01/12/2023

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 808	Continued From page 15 Resident #107 was served the meal in his room. The Resident was not in the room at the time of the observation and the meal tray was left at the bedside on the over bed table. Observations of the meal ticket on the meal tray revealed the following text in the top left corner, "NPO NPO [nothing by mouth] [sic] Double Portions". Further down on the ticket the following was noted, "...Note: Send Double Portions". The plate was observed and revealed two pieces of meat and a regular serving of creamed potatoes and zucchini. On 1/10/23 at approximately 5:45 PM, CNA C accompanied Surveyor C to the room of Resident #107. CNA C confirmed the meal ticket indicated double portions were to be served. CNA C confirmed that the serving of potatoes and zucchini was the same portion served to all of the other Residents for that meal. CNA C further confirmed that he had distributed multiple trays on the unit and observed multiple plates and portions and knew this was not double servings. Resident #107 was not able to be located on the evening of 1/10/23 for an interview. On 1/10/23 at 5:55 PM, an interview was conducted with Employee F, the cook for the evening meal. Employee F was asked about double portions and what this meant, the cook said, "double protein". On 1/10/23 at 6:02 PM, an interview was conducted with Employee E, the dietary aide. Employee E was asked what double portions meant, he said, "They don't get 2 of everything, it is just double meat or double vegetable". When asked to clarify, Employee E said it is one or the	F 808	committee determines the problem no longer exists, the review will be conducted on a random basis. 5. Date of compliance: 02/07/2023	

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 ______	R-C 01/12/2023

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 808	Continued From page 16	F 808		

other [meat or vegetable serving] that is doubled". Employee E went on to say, "the ticket is blank in the middle that explains everything so without it we don't know what to put on the plate".

On 1/11/23 at 12:09 PM, an interview was conducted with Employee G, the registered dietician (RD). The RD indicated she is currently at the facility 2 days per week and the facility is currently without a dietary manager. When asked about the meal tickets, the RD said, "They have not been printing out the actual daily menu, [Employee H name redacted] the Regional is also new and hasn't been doing that". Indicating the meal tickets are not being printed where it details what the staff are to put on each meal tray taking preferences and allergies in consideration and making substitutions. The RD went on to say, "As of tomorrow it will start printing the food items".

During the above interview the RD was asked about Resident #107's meal ticket and was shown a copy of the meal ticket. The RD looked at the meal ticket and said, "I didn't do that one. I will typically do double entree, but double portions is two of everything, you give them 2 meals".

On 1/12/23 at 10 AM, an interview was conducted with Resident #107. When asked if he is receiving enough to eat, Resident #107 said, "I was getting double portions but I don't get it now".

The clinical record review for Resident #107 was conducted. The dietary progress notes didn't reference a double portion diet. The physician orders revealed an active physician order that was entered 6/6/22, that read, "Regular diet Level 7 - Easy to Chew texture, Regular Liquids

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 ______	R-C 01/12/2023

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 808 Continued From page 17 F 808

consistency, Double portions". Resident #107's care plan was reviewed without any reference to current diet order.

Review of the facility policy titled, "Dining and Food Preferences" was reviewed. This policy didn't address therapeutic diets being provided.

On 1/10/23 during an end of day meeting the facility Administrator was made aware of the above findings.

On the morning of 1/11/23, the facility Administrator provided Surveyor C with a copy of Resident #107's meal ticket which had been edited and now read, "Note: Double Entree".

No additional information was provided prior to the conclusion of the survey.

Complaint related deficiency.

F 842 SS=D Resident Records - Identifiable Information F 842 2/7/23
CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)

§483.20(f)(5) Resident-identifiable information.
(i) A facility may not release information that is resident-identifiable to the public.
(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident

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 ____	R-C 01/12/2023

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 842	Continued From page 18	F 842		

that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-

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 ______	R-C **01/12/2023**

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 842 Continued From page 19
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, staff interview, facility documentation review, outside record review, and in the course of a complaint investigation, the facility staff failed to maintain a complete and accurate clinical record for two residents, Resident #105 and Resident #111, in a survey sample of 12 residents.

The findings include:

1. For Resident #105, the facility staff failed to document events leading up to, and including, the administration of cardiopulmonary resuscitation (CPR) on 11/28/22.

On 1/10/23, a closed record review was conducted of Resident #105's clinical record. A progress note dated 11/28/22 at 09:07 read, "NP [Nurse Practitioner, name redacted] notified of Resident's expiration. Per NP, she will notify [MD, name redacted]" and at 09:09, "Resident's emergency contact/sister [name redacted] notified of Resident's passing...". Both progress notes were written by LPN C.

Review of the physician orders for Resident #105

F 842

F842 Resident Records - Identifiable Information
1. Resident #105 no longer resides in the facility.
2. Current residents in the center have the potential to be affected. A review of current residents by the DON or designee in the facility will be done to ensure there is a complete and accurate clinical record when sentinel events occur (unexpected occurrence involving death or serious physical or psychological injury).
3. The Staff Development Coordinator or designee will educate all licensed nursing staff on ensuring residents have a complete and accurate clinical record when sentinel events occur.
4. The Unit Manager or designee will complete random resident record reviews for 30 days to ensure resident records are complete and accurate. Results of the review will be presented to the QAPI committee for review and recommendation. Once the committee determines the problem no longer exists, the review will be conducted on a random

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 ______	R-C 01/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 842	Continued From page 20 revealed an order dated 9/8/22 that read, "Code Status (FULL CODE)". There were no documented details within the clinical record with regard to the circumstance of Resident #105's death in the facility, to include clinical assessment, clinical response, and/or clinical interventions that may have been provided. On 1/10/23 at approximately 10:30 AM, an interview was conducted with the Director of Nursing (DON), the Regional Director of Clinical Services (RDCS), and the Facility Administrator, all of whom confirmed that CPR is expected to be provided for any resident having a Full Code status and documented in the clinical record. Facility policies for CPR and clinical documentation were requested and received. On 1/10/23 at approximately 2:10 PM, the DON, RDCS, and the Facility Administrator provided 2 written statements from LPN B and LPN C which read, in part, that Resident #105 was assessed, a "Code Blue" was called, LPN B and LPN C initiated CPR, EMS was called and took over CPR for Resident #105. LPN B's statement read, "...if the documentation is not there, the probability is, I did not [document] but I meant too [sic]". LPN B and LPN C were unavailable to interview; phone calls were placed with messages left, however no return call received. On 1/10/23 at approximately 4:30 PM, a copy of the report from Emergency Medical Services (EMS) was obtained directly from the local EMS department and read, "Upon making pt [patient] contact, the pt was found lying supine in his bed with nursing staff doing CPR and their AED	F 842	basis. 5. Date of compliance: 02/07/2023	

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 ______	R-C 01/12/2023

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 842	Continued From page 21	F 842		

[Automatic External Defibrillator device] was attached" and "Skin: Warm, dry, and of normal color".

Review of the facility policy titled, "Cardio-Pulmonary Resuscitation (CPR)", effective date 3/24/20, subtitle "Procedure", item 6 read, "A licensed nurse will document on the Code Blue Documentation form, the condition and circumstance of initiating CPR, the duration and events of the procedure, and outcome of the situation".

Review of the facility policy titled, "Significant Change of Condition, effective date 11/1/19, subtitle "Procedure", item 11 read, "Each change of condition shall be documented in the progress notes...".

On 1/11/23 at approximately 10:40 AM, a meeting was conducted with the DON, RDCS, and Facility Administrator, all of whom were updated on the findings. The DON, RDCS, and Facility Administrator confirmed they had reviewed the clinical record for Resident #105 and were "concerned" about the lack of documentation. No further information was provided.

COMPLAINT RELATED DEFICIENCY

2. For Resident #111, the facility staff failed to maintain a complete and accurate clinical record with regards to the events that occurred on the day the Resident expired.

On 1/10/23, a clinical record review was conducted of Resident #111's chart. This review

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 ______	R-C 01/12/2023

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 842	Continued From page 22	F 842		

revealed the following nursing note entry from LPN D dated 1/7/23 at 4:10 AM, "Resident noted to be unresponsive during rounds, code called, cpr [cardiopulmonary resuscitation] initiated, 911 called. Upon clarification of code status, cpr immediately stopped. EMS [emergency medical services] arrived, resident pronounced at 0309am. MD and RP made aware".

Review of the physician orders revealed that on 1/7/23, the active physician order read, "Code Status full code" which was dated 1/6/23.

Review of the progress notes revealed an entry made by the social worker on 1/6/2023 at 1:04 PM, that read, "SW [social worker] spoke with family during admission assessment. RP/family would like to change code status to DNR [do not resuscitate]. MD [medical doctor] and DON [director of nursing] aware of DNR order to be put in place".

There was a physician order entered into the clinical record on 01/07/2023 at 05:01 AM, which was after the Resident had been pronounced expired, that read, "Code Status DNR".

On the afternoon of 1/10/23, the facility Administrator, Director of Nursing (DON), and Regional Director of Clinical Services (RDCS) were asked to explain the process with regards to Resident's code status, when CPR is initiated, when CPR can be stopped, etc. The DON and RDCS both explained that upon admission code status/CPR status is discussed and a physician order of their code status is entered into the chart. When CPR is initiated, it cannot be stopped unless a physician is onsite and orders for it to be stopped or the rescue squad have responded and

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 ______	R-C 01/12/2023

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 842		F 842		

Continued From page 23

took over CPR, they are able to stop it. They were made aware of the above findings and entries into the clinical record of Resident #111's chart which indicated CPR had been stopped by facility staff prior to the arrival of EMS. They indicated they were not aware of this prior to this conversation with the survey team and would have to look into it.

On 1/10/23 at approximately 2:40 PM, attempts were made by the survey team to reach the facility staff that were involved with Resident #111 on the morning of 1/7/23. All efforts were unsuccessful.

On the afternoon of 1/10/23, the survey team was able to access outside records that indicated that CPR was in progress when the rescue squad personnel arrived on-site on the morning of 1/7/23 at 3:02 AM. The rescue squad personnel/EMS [emergency medical services] staff assessed the Resident and pronounced death at 3:09 AM.

On 1/11/23 at approximately mid-morning, the facility Administrator, Director of Nursing and RDCS met with the survey team and provided a written statement from LPN D who charted on Resident #111 the morning of 1/7/23. LPN D indicated in the written statement, "...CPR continued until EMS arrived". The written statement and explanation provided by the facility management team indicated that when LPN D went to the nursing station following the EMS arrival and assumption of Resident #111's care, LPN D noted in the admission paperwork which was in the medical records bin a DNR was in the paperwork.

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 ______	R-C **01/12/2023**

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 842	Continued From page 24 The facility Administrator, DON and RDCS confirmed that the clinical record was not complete or accurate with regards to the events that had taken place on the morning of 1/7/23. No further information was provided.	F 842		