STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495423	A. BUILDING _____ B. WING _____	C 07/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHAMPTON REHABILITATION AND HEALTHCARE CENTER	7246 FOREST HILL AVE RICHMOND, VA 23225

(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 abbreviated survey was conducted 7-11-23 through 7-17-23. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Four Complaints were investigated during the survey. VA00059165 - Substantiated with deficiency VA00058897 - Substantiated with deficiency VA00058185 - Substantiated with deficiency VA00057092 - Substantiated with deficiency The census in this 196 certified bed facility was 167 at the time of the survey. The survey sample consisted of 5 resident reviews (Residents #1 through #5).	F 000	The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan constitutes the facility's allegation of compliance. All cited deficiencies have been or will be corrected by the date or dates indicated.	
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on Resident interview, staff interview, clinical record review, facility document review, the facility staff failed to accommodate the needs of one resident (Resident #4) in a survey sample of 5 residents. Resident #4 was 1) not provided an evening meal on the day of admission (4-12-23), 2) not provided any meal on 4-16-23 (Sunday) after another move the evening of 4-15-23 (Saturday	F 558	F558: Reasonable Accommodations Needs/Preferences Resident #4 no longer resides in the facility. The facility completed a review of current residents' diet orders and shower schedules. Preferences were addressed and updated in the resident's record. The Director of Nursing / Designee re-educated nursing and dietary staff on the policy regarding accommodating resident preferences for delivery of meals with a focus on new admissions and room change notification to dietary. The Director of Nursing/Designee re-educates nursing assistants and Licensed nurses on the policy for resident preferences for bathing and showers and providing ADL care as outlined in the resident's care plan. The Director of Nursing/Designee will complete 10 random residents' meal service per day, 5 times per week for 2 weeks, then 5 residents per day 3 times per week for 3 weeks, then 5 residents per week for 2 weeks. The Director of Nursing/Designee will complete 10 random resident shower preference and ADL Care Completion per day 5 times per week for 2 weeks, then 5 residents per day 3 times per week for 3 weeks, then 5 residents per week for 3 weeks. Results of audits will be submitted to the Quality Assurance Committee monthly for further review and recommendations as needed. Further audit frequency will be determined based on the outcome of the previously completed audit findings. Date of Compliance: 8/11/23	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kathrell | TITLE: Administrator | (X6) DATE: 8/7/2023

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 558	Continued From page 1 night), and 3) not provided with a shower or tub bath during her stay. The findings included: Resident #4, was admitted to the facility on 4-12-23. Diagnoses included; Gall bladder stones and cholecyctectomy. Resident #4's Admission MDS (minimum data set) coded Resident #4 as having no memory deficits and oriented to person, place, time and situation, with no cognitive deficits. The Resident required assistance of one staff member to perform some activities of daily living, such as bathing, and the Resident was ambulatory with a walker. On 7-11-23 at 2:00 p.m., Resident #4 was interviewed via phone conversation and found to be a good historian, oriented to person, place, time, and situation. The discharged Resident complained that the day of admission on 4-12-23 the staff did not provide her with a meal, as she entered the facility at 6:00 PM and staff stated they had finished meal delivery. She further stated that after her evening room change on 4-15-23 from the first floor to the second floor there was a mix up and she did not receive meals again on 4-16-23. She stated she had eaten some snacks she had on that day. The Resident went on to state that she did not receive a single tub bath or shower during the entire 10 day stay, and that was "completely unacceptable" to her. On 7-11-23 the clinical record and facility ADL (activities of daily living) records were reviewed. The review revealed no meals were served to Resident #4 on 4-12-23, and 4-16-23. Bathing	F 558		

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F 558	Continued From page 2 records indicated that Resident #4 did not receive tub baths nor showers during her 10 day stay, and she was documented as having had bed baths provided by herself, indicating, no staff assistance. Resident #4's care plan was reviewed and revealed that the Resident was to receive ADL care assistance and meals as part of her skilled nursing admission. On 7-12-23 at 12:00 PM the DON (director of nursing), and Administrator were notified of above findings. No further information was provided.	F 558		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly,	F 584	F584: Safe/Clean/Comfortable/Homelike Environment Resident #2 no longer resides in the facility. LPN A was re-educated on the policy for incontinence care. Deep cleaning was completed for this resident's room. Deep cleaning schedule initiated. The facility completed an audit of resident rooms. Variances were addressed and recorded on the facility audit tool. The Director of Environmental Services/Designee re-educated environmental service staff on the policy for room cleanliness. The Director of Nursing/Designee re-educated Nursing Assistants and Licensed nurses on incontinence care management. The Director of Nursing/Designee will complete random incontinence care management audits of 10 residents daily for 5 days a week for 3 weeks, then 3 times per week for 2 weeks, then 1 time per week for 2 weeks. The Administrator/Director of Environmental Services will complete an audit of the facility environment 5 days a week for 3 weeks, then 3 times per week for 2 weeks, then 1 time per week for 2 weeks. Results of audits will be submitted to the Quality Assurance Committee monthly for further review and recommendations as needed. Further audit frequency will be determined based on the outcome of the previously completed audit findings. Date of Compliance: 8/11/23	

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F 584	Continued From page 3 and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and the facility staff failed to ensure one Resident's environment (Resident #2) was free from strong foul urine odors in a survey sample of 5 Residents. The findings included: Resident #2's environment smelled very strongly of urine odor. Resident #2, was admitted to the facility on 11-30-22. The Resident voluntarily discharged the same day due to complaints of strong urine odors in the building and an inoperable elevator. Progress notes were reviewed and revealed not a single entry in the clinical record.	F 584		

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F 584	Continued From page 4 Resident #2 did have two MDS (minimum data set) assessments with an ARD (assessment reference date) of 11-30-22 which were coded as admit and discharge assessments, as the Resident did not stay a single night. Resident #2 was discharged, so her particular room could not be examined, however, during initial tour of the building and specifically the second floor area where the Resident had been admitted, had a pervasive odor of foul urine on the entire hall. The first floor also smelled of urine near the elevator entrance. During the initial tour of the second floor on 7-11-23 at 1:00 PM, two Residents in different rooms were noted to have wet pants and the Licensed Practical Nurse for the unit (LPN A) was in one of those rooms administering medications. She was alerted to the foul odor and the wet pants of a Resident who was standing in the hallway. She stated that he was very hard to redirect and that he would often refuse to be cleaned. She also stated that in the room where this interview took place was a Resident that had suffered a urinary tract infection recently for which he had finished a course of antibiotics, however, he still continued to have strong urine. That room smelled of urine had wet droplets of a creamy substance on the floor, and the floor was sticky. Lunch carts were in the hallway and meal trays had just begun to be served. These Residents had not yet received their trays, and any spilled food or liquids would have been there since breakfast, as the LPN stated floors had been mopped before breakfast. The Administrator, and DON were made aware of the findings and agreed with LPN A's statement	F 584		

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F 584	Continued From page 5 that the Residents observed on the second floor had the issues observed that day. The Administrator, and DON were advised of the strong urine odor evident on the first and second floors. No further information was provided by the facility.	F 584		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 609	F609: Reporting of Alleged Violations Resident #3- Continues to reside in the facility. The Administrator completed and submitted a Facility Reported Incident to the State Agency. The facility completed a review of incidents in the last 30 days who met the requirement for facility reported incident completion and submission. No additional were identified. The Regional Director of Operations/Designee re-educated the facility Administrator and Director of Nursing on the policy for completion and submission of a facility reported incident. The Administrator/designee re-educated facility staff on the policy for reporting allegations of abuse and neglect. The Administrator/Designee will complete an audit of incident reports 1 time per week for 8 weeks. Results of audits will be submitted to the Quality Assurance Committee monthly for further review and recommendations as needed. Further audit frequency will be determined based on the outcome of the previously completed audit findings. Date of Compliance: 8/11/23	

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F 609	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, facility document review, the staff failed to notify the state agency timely for an injury of unknown origin resulting in serious injury for one Resident (Resident #3) in a survey sample of 5 Residents. The findings included: For Resident #3, the facility staff failed to notify the state agency within the required timeframe of a serious injury involving an injury of unknown origin culminating in several rib fractures. Resident #3 was initially admitted to the facility on 2-3-23, and readmitted on 2-26-23. Diagnoses included osteomyelitis, hemiparesis & hemiplegia status post stroke, Diabetes, history of falls, malnutrition, and pulmonary hypertension. Resident #3's most recent MDS (minimum data set) coded the Resident with a (BIMS) brief interview for mental status score of 10, indicating moderate cognitive impairment. Resident #3 was also coded as requiring assistance of one or two staff members for all activities of daily living. The Resident was incontinent of bowel and bladder, and at risk of falls. On 2-7-23 the Resident fell with no injuries assessed. On 2-16-23 the Resident was sent out for a planned vascular surgery appointment with a staff member from the facility who indicated in a statement that no injury occurred from the facility to the appointment. Upon arrival at the doctor's	F 609		

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F 609	Continued From page 7 office for the appointment, the Resident was found to be "lethargic, pale, unable to answer questions, and unable for a blood pressure to be obtained". All according to the vascular surgeon, who then sent the Resident to the hospital via 911 for evaluation. On 2-16-23 Resident #3 was admitted to the hospital with "Acute Right 9th and 10th rib fractures, and age indeterminate right 3rd and 4th lateral rib fractures." according to hospital emergency room diagnostic records. The Resident was treated in the hospital and discharged back to the facility on 2-26-23, 10 days later. The facility completed an investigation including interviews of staff, transport personnel to the vascular appointment, vascular appointment notes, and hospital records. A facility Reported Incident (FRI) document was sent to the state agency notifying of the injury of unknown origin on 3-10-23 (3 weeks after the fractures were known), and a follow up on 3-13-23. On 7-12-23 at 11:00 AM The Administrator and Director of Nursing (DON) were advised of the failure to report timely. No further information was provided.	F 609		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in	F 684		

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F 684	Continued From page 8 accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, Resident interview, staff interview, facility document review, clinical record review, and during a complaint investigation, the facility staff failed to provide sufficient wound dressing care for one Resident (Resident #1) in a survey sample of 5 residents. The Findings included: For Resident #1, the facility staff failed to maintain clean dressings on the diabetic ulcered legs and hands of the Resident. Resident #1 was originally admitted to the facility on 1-17-23, and readmitted on 7-6-23 after partial amputation of his remaining hand and amputation of his remaining leg. His diagnosis included; Dialysis with kidney failure, diabetes, Hypertension, and peripheral vascular disease. The most recent Minimum Data Set (MDS) assessment was a quarterly Assessment with an Assessment Reference Date of 6-15-23. The MDS document coded Resident #1 as having a Brief Interview of Mental Status score of 11, indicating mildly impaired cognition. In addition, Resident #1 was coded as being able to understand and be understood by others. The Resident required extensive to total dependence on 1 to 2 staff members for all ADL's (activities of daily living). On 7-17-23 the Resident was not in the facility, and was at his regular dialysis appointment for	F 684	F684: Quality of Care Resident # 1 continues to reside in the facility. The resident's physician was made aware of findings. No new orders were noted. The facility changed their Pest Control Company to a new provider. Pest Control assessed and treated the resident area. The facility completed a review of all residents with wounds. Variances were addressed and recorded on the facility audit tool. An environmental review was completed. Variances were addressed and recorded on the facility audit tool. The Director of Nursing/Designee re-educated licensed nursing staff on the policy for wound care administration. The Administrator/Designee re-educated facility staff on policy for pest control with a focus on reporting of findings. The Director of Nursing/Designee will complete wound care audits 1 time per week for 7 weeks. The Environmental Services Director/Designee will complete 10 random room audits per week for 7 weeks. Results of audits will be submitted to the Quality Assurance Committee monthly for further review and recommendations as needed. Further audit frequency will be determined based on the outcome of the previously completed audit findings. Date of Compliance: 8/11/23	

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F 684	Continued From page 9 the day. The Director of Maintenance was interviewed and related that ants had been a problem in the facility and copies of the maintenance log were provided to the surveyor. The logs revealed ants had been noted and complained about in the resident's room as "Room full of ants" on 6-20-23. On 7-17-23 at 3:00 PM Resident #1, and RN A (Registered Nursing) staff at his dialysis center were interviewed. The Resident agreed he had ants in his wound at the facility prior to going for the amputation in the hospital. The Dialysis nursing staff also stated that he had arrived on numerous occasions for dialysis, prior to this recent amputation, "with days old stained, soiled, and weeping dressings to his legs and hand, which had to be cleaned and wrapped there at dialysis to prevent them from contaminating surfaces in the dialysis center." On 7-17-23 at 2:30 PM. the Administrator, and the Director of Nursing were informed of the findings. No further information was provided.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) Type text here §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, staff interview, clinical	F 689	F689: Free of Accident Hazards/Supervision/Devices Resident #3 continues to reside in the facility. Fall mats were placed on the floor next to the resident's bed. LPN A was re-educated on the residents care plan interventions. The facility completed an audit of residents ordered to have fall mats in place. No additional variances were noted. The Director of Nursing/Designee re-educated staff on the policy for resident care plan interventions with a focus on fall management interventions. The Director of Nursing/Designee will completed an audit of fall mats 3 times per week for 3 weeks, then 2 times per week for 2 weeks then 1 time per week for 1 week. Results of audits will be submitted to the Quality Assurance Committee monthly for further review and recommendations as needed. Further audit frequency will be determined based on the outcome of the previously completed audit findings. Date of Compliance: 8/11/23	

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F 689	Continued From page 10	F 689		

record review, facility document review, the staff failed to prevent a known accident hazard for one Resident (Resident #3) in a survey sample of 5 Residents.

The findings included:

For Resident #3, the facility staff failed to ensure fall mats were provided.

Resident #3 was initially admitted to the facility on 2-3-23, and readmitted on 2-26-23. Diagnoses included osteomyelitis, hemiparesis & hemiplegia status post stroke, Diabetes, history of falls, malnutrition, and pulmonary hypertension.

Resident #3's most recent MDS (minimum data set) coded the Resident with a (BIMS) brief interview for mental status score of 10, indicating moderate cognitive impairment. Resident #3 was also coded as requiring assistance of one or two staff members for all activities of daily living. The Resident was incontinent of bowel and bladder, and at risk of falls.

Observation of Resident #3 occurred on 7-11-23 at approximately 1:00 PM. The Resident was lying in bed fully clothed, and seemed comfortable. LPN A was in the room administering medications to this Resident's room mate, and was asked by the surveyor why the only fall mat in the room for Resident #3 was against the opposite wall from the Resident's bed in a chair folded up. LPN A stated "they had cleaned the floor before breakfast that morning and had not replaced the fall mat."

The Resident's care plan was reviewed and revealed an intervention instituted on 2-7-23 after

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SOUTHAMPTON REHABILITATION AND HEALTHCARE CENTER	7246 FOREST HILL AVE RICHMOND, VA 23225

(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 11 a fall, for "fall mat to the left side of the bed at all times when resident in bed". After copies of all clinical and facility records from facility staff were received the DON was asked if this was a complete record, and her answer was "Yes.". On 7-12-23 at 11:00 AM The Administrator and Director of Nursing (DON) were advised of the failure of the staff to provide the necessary fall mat for safety for Resident #3, and late reporting to the state agency. No further information was provided.	F 689		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, facility document review, the facility staff failed to ensure one resident (Resident #4) was free from pain, in a survey sample of 5 residents. The findings included: For Resident #4, facility staff failed to administer Tylenol when requested by the Resident, and as ordered by the physician. Resident #4, was admitted to the facility on 4-12-23. Diagnoses included; Gall bladder	F 697	F697: Pain management Resident # 4 no longer resides in the facility. The facility completed an audit of residents with pain and their pain management. No additional variances were noted. The Director of Nursing/Designee re-educated licensed nursing staff on the policy for pain management and medication administration. The Director of Nursing/Designee will complete an audit of residents pain management daily for 5 days for 2 weeks, then daily for 3 days for 3 weeks, then weekly for 2 weeks. Results of audits will be submitted to the Quality Assurance Committee monthly for further review and recommendations as needed. Further audit frequency will be determined based on the outcome of the previously completed audit findings. Compliance Date: 8/11/23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495423	A. BUILDING _____ B. WING _____	C 07/17/2023

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F 697	Continued From page 12 stones and cholecyctectomy. Resident #4's Admission MDS (minimum data set) coded Resident #4 as having no memory deficits and oriented to person, place, time and situation, with no cognitive deficits. The Resident required assistance of one staff member to perform some activities of daily living, such as bathing, and the Resident was ambulatory with a walker. On 7-11-23 at 2:00 p.m., Resident #4 was interviewed via phone conversation and found to be a good historian, oriented to person, place, time, and situation. The discharged Resident complained that on the day of her discharge (4-21-23) that the staff did not provide her with pain medication (Tylenol) for right abdominal pain as requested by her. She further stated that the nurse came into her room and spoke to her "angrily and argued with me" stating that the "nurse didn't have time to get her Tylenol for a headache." The discharged Resident stated she became "scared, nauseated and upset and vomited blood". At this point the Resident stated she called 911, gathered what belongings she could and waited for the ambulance to arrive while "the nurse continued to argue with me out near the nursing station while I waited for the ambulance." She stated she never received the Tylenol, and when the ambulance arrived they delivered her to the hospital where she stayed until she could be later transferred to another facility for care after her gastric bleeding event. On 7-11-23 the Medication Administration Record (MAR) was reviewed. The review revealed no Tylenol had been administered during the Resident's entire 10 day stay.	F 697		

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 697	Continued From page 13 Review of the progress notes indicated that the Resident did request Tylenol, however, the medication was not administered as ordered. No reason was given as to why it was withheld. Resident #4's care plan was reviewed and revealed that the Resident was to receive pain relief medications per physician orders as part of her skilled nursing admission. The nurse involved in the alleged incident was suspended for an allegation of abuse investigation regarding this Resident and not available for interview. Her written statement of the encounter was reviewed, and revealed that the Tylenol had not been given as requested. On 7-12-23 at 12:00 PM the DON (director of nursing), and Administrator were notified of above findings. No further information was provided.	F 697		