	-	ID HUMAN SERVICES			FORM	APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NC	<u>). 0938-0391</u>
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			LETED
		495097	B. WING			C 14/2023
NAME OF PI	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CODE		
PARHAM	HEALTH CARE & REHAI	3 CEN		2400 E PARHAM ROAD RICHMOND, VA 23228		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F 00	D		
	survey was conducte	fe Safety Code				
	Six complaints were i survey. All six were s VA00059683-7 Allega VA00059457- 5 Allega VA00059436-9 Allega VA00059396- 11 Allega VA00058937- 2 Allega VA00058144- 2 Allega	ations- S w/ def ations- S w/def ations- S w/ def gations-S w/ def ations= S w/ def				
F 584	172 at the time of the consisted of 8 resider	0 certified bed facility was survey. The survey sample nt reviews. ble/Homelike Environment	F 58	4		10/23/23
SS=E	CFR(s): 483.10(i)(1)- §483.10(i) Safe Envir The resident has a rig comfortable and hom but not limited to rece supports for daily livir The facility must prov §483.10(i)(1) A safe, homelike environment use his or her person possible. (i) This includes ensur receive care and serv physical layout of the	(7) onment. ght to a safe, clean, elike environment, including eiving treatment and ng safely.				
LABORATORY	 DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	E	TITLE		(X6) DATE
Electroni	cally Signed					10/19/2023

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.

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF	- CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	ING _			PLETED
		495097	B. WING				C 14/2023
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
	HEALTH CARE & REHAE	CEN		2	2400 E PARHAM ROAD		
FANNAW	HEALTH CARE & REHAL	5 CEN		F	RICHMOND, VA 23228		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 584	<ul> <li>(ii) The facility shall exit the protection of the ror or theft.</li> <li>§483.10(i)(2) Housekes services necessary to and comfortable interions (services necessary to and comfortable interions).</li> <li>§483.10(i)(3) Clean booms in good condition;</li> <li>§483.10(i)(4) Private resident room, as specified to room, as specified to compose the service of the service of</li></ul>	xercise reasonable care for resident's property from loss eeping and maintenance o maintain a sanitary, orderly, ior; ed and bath linens that are closet space in each ecified in §483.90 (e)(2)(iv); te and comfortable lighting table and safe temperature ly certified after October 1, a temperature range of 71 to maintenance of comfortable ' is not met as evidenced n, interview, clinical record ocumentation, the facility the residents right to a nd homelike environment, (Residents #4, #2,# 7, and le of eight (8) residents. : , #7, and #8, the facility staff	F	584	The facility sets forth the following pla correction to remain in compliance wit federal and state regulations. The fac has taken or will take the actions set fi in the plan of correction. The following plan of correction constitutes the facili allegation of compliance. All deficience cited have been or will be corrected by date or dates indicated.	h all ility orth ty⊡s ies ⁄ the	

Facility ID: VA0184

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	F DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) D	NO. 0938-03		
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		Ć	OMPLETED		
						С		
		495097	B. WING			09/14/2023		
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	E, ZIP CODE			
PARHAM	HEALTH CARE & REHA	B CEN		2400 E PARHAM ROAD RICHMOND, VA 23228				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		AN OF CORRECTION	(X5)		
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIN CROSS-REFERENCE	/E ACTION SHOULD BE D TO THE APPROPRIATE ICIENCY)	COMPLETIO		
F 584	Continued From pag	e 2	F 58	4				
				Environment				
	The following observ	ations were made regarding		1. Residents #1, #2	, #7, and #8 still			
	-	s Brief Interview of Mental		reside in the facility. F				
		of 9 indicating moderate		temperature in his roc				
	cognitive impairment	t.		adjusted by ensuring				
	0 00/40/0000 1			switched to the coolin				
	•	proximately 9:50 a.m., bed with his eyes closed,		temperature of this ro 72 to 74 degrees. For				
		ep, dressed in a hospital		temperature in her roo				
		odor of urine in the room,		No adjustments were	-			
	-	ded by the warm humid air in		For Resident #7, the p				
	the room.	2		been vented and the				
				drained to ensure it is	operating efficiently.			
		proximately 2:30 p.m.,		The temperature of th				
		served in bed, awake, and		from 72 to 74 degrees				
		as noted to have beads of Id and was covered in a		The temperature in he				
		et. When asked if he was		liking. No adjustments this time.	s were needed at			
		he was. He stated, "It is a bit		2. All residents in th	e facility have the			
		" When asked if he would		potential to be affecte				
		cooler he said, "Yes ma'am a		practice. Portable unit	•			
	lot cooler."			checked to ensure the	ey were vented, and			
				condensation was dra				
				ensure they operated				
	•	rations were made for		thermostat switches o				
		s a BIMS score of 15,		switched on to ensure				
	indicating no cognitiv			operating properly to other findings requirin				
	On 09/12/2023 at 3.0	00 p.m., an interview was		thermometers.	g adjustment of			
		dent #2, and she was asked		3. The Administrato	r or designee will			
		oning in the building. She		educate the Maintena	-			
		oning has been broke for		ensuring the portable				
		aid, "They use these little		drained as needed to				
	-	s one my family brought me.		operation. Education				
		one in each room, it isn't no		ensuring the thermost				
		hits can cool off one room but		east unit were switche				
	-	full of rooms." When asked		chiller was operating	property to cool off			
	what she did before	getting the unit from her		the unit.				

Facility ID: VA0184

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	· · · ·	DATE SURVEY COMPLETED
	CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING			C
		495097	B. WING			09/14/2023
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	IP CODE	
PARHAM I	HEALTH CARE & REHA	B CEN		2400 E PARHAM ROAD RICHMOND, VA 23228		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 584	Continued From page	e 3	F 58	4		
		e she has "respiratory family gave her was a small		complete weekly inspect	•	
		er that was vented through		then monthly x 2 to ensu temperature is comfortal		
	•	ng out cold air. The room		residents and within the		
	was a comfortable te	mperature and not humid.		guidelines. Any discrepa		
	The following cheen	ationa wara mada far		immediately corrected. T be reported to the QA Co		
	The following observation Resident #7, who has	a BIMS score of 15,		review and revise the ac		
	indicating no cognitiv			needed. This plan of act	•	
				until the QA Committee		
		5 p.m., Resident #7 was		substantial compliance h	nas been	
	and no sheet or blan	sed in only a hospital gown,		achieved. 5. Date of Compliance	10/23/2023	
		a PTAK unit air conditioner			. 10/20/2020	
		portable air conditioner not				
		how she was feeling she				
	said, "Hot as Hell." W	g, she stated that it has not				
		ived in May. Employee C				
		ed if the PTAK units work				
	•	ere operational. When asked				
		ture of the PTAK unit, he out air at 77.8 degrees on its				
		When asked to check the				
		ortable air conditioning unit				
		ghest cool setting, it was				
		degrees. When asked if ling, he stated that it was				
		conditioner stopped running				
		ployee C was asked how the				
		densation from the units, he				
	-	n to the shower room. When matically shuts off and does				
		hen it needs draining and he				
	stated that it does. W	hen asked if the unit runs				
		iently when it is vented, he				
	stated that it did.					1

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 01/05/2024 APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY LETED
		495097	B. WING		_		C 14/2023
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STA	ATE, ZIP CODE	•••	
			2	400 E PARHAM ROAD			
PARHAM	HEALTH CARE & REHAE	3 CEN	F	RICHMOND, VA 23228			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE ICED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
TAG F 584	Continued From page The following observa Resident #8: On 09/13/2023 at app interview was conduc stated the problem wi been brought up in re- that residents are tired to wait for corporate to She further stated, "T hallways are not helpi the one who picks wh room and who can't. A can open your mouth but what about those speak for themselves sweat." Resident #8 h room vented in the wi cool and comfortable. before she got the po complained a lot and On 09/12/2023 at 2:30 conducted with Emplo long the cooling syste effectively, and he sta working there over a y about the portable air in the hallways, he sta	e 4 ations were made for proximately 12:30 p.m., an ted with Resident #8 who th the air conditioner has sident council meetings and d of the response, "We have o get the money to fix it." he portable units in the ing and the Administrator is o can have one in their Well that's just not fair. If you and fuss you can get one poor folks who cannot , they just lay there and had a portable unit in her ndow, and the room was When asked what she did rtable unit she stated, "I	F 584			TE	DATE
	When asked why som vented to the ceiling of they did not have the He stated the tubing t units is very expensiv want to buy it. When a safely without the tubi Employee C went aro	ne of the units are properly or a window, he stated that tubing to vent all the units. o vent the air conditioning e and corporate does not asked if the units could run ing, he stated they could.					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		(X3) DATE COMF	SURVEY PLETED
		495097	B. WING _				C 14/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY	, STATE, ZIP CODE		
PARHAM	HEALTH CARE & REHA	3 CEN		2400 E PARHAM ROAD RICHMOND, VA 2322			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH COR	ER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BI RENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 584 F 657 SS=D	ranged from 64 degree degrees on the East M On 09/13/2023 at app interview was conduct who stated that she s behalf of residents be and humid and smells residents that have fa portable air conditionin have no family will just temperatures. The resi for themselves will no room either. On 09/14/2023 during Administrator was ma No further information Care Plan Timing and CFR(s): 483.21(b)(2)0 §483.21(b) Comprehe §483.21(b)(2) A comp be- (i) Developed within 7 the comprehensive as (ii) Prepared by an inti- includes but is not lim (A) The attending phy (B) A registered nurse resident. (C) A nurse aide with resident. (D) A member of food (E) To the extent prac-	ees on the West wing to 78.8 Wing. proximately 11:00 a.m., an ted with the Ombudsman ubmitted complaints on ecause the building is too hot is of urine. There are a few umily bring in fans or ing units but the ones who at suffer with the sidents who cannot speak at get a portable unit in their g the end of day meeting, the ade aware of the concerns. In was provided. I Revision (i)-(iii) ensive Care Plans prehensive care plan must or days after completion of ssessment. terdisciplinary team, that ited to vsician. e with responsibility for the	F				10/23/23

Facility ID: VA0184

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OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	495097	B. WING				C 09/14/2023
ROVIDER OR SUPPLIER			S	IREET ADDRESS, CITY, STATE, ZIP CODE		
			24	400 E PARHAM ROAD		
HEALTH CARE & REHA	BCEN		R	ICHMOND, VA 23228		
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFI TAG	x	(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE
medical record if the and their resident rep	participation of the resident resentative is determined	F	657			
resident's care plan. (F) Other appropriate disciplines as determ	staff or professionals in ined by the resident's needs					
(iii)Reviewed and rev team after each asse comprehensive and c assessments.	ised by the interdisciplinary ssment, including both the quarterly review					
by: Based on staff interv review, and clinical re failed to review and r	iew, facility documentation ecord review, the facility staff evise the care plan for one			<ol> <li>Resident #6 no longer resides in facility.</li> <li>All residents in the facility have the potential to be affected by this deficient</li> </ol>	the he nt	
and revise the care p	lan after a significant weight			was completed on all current resident ensure residents with significant weig loss had care plan revised. No other	ts to	
The findings included	:			3. The Director of Nursing or design		
Resident #6's clinical Resident # 6 was ede	record. Review revealed entulous, had difficulty			<ul><li>weight loss requires care plan review and revised.</li><li>4. Unit Managers or designee will complete weekly audits x 4 and mont</li></ul>	ed hly x	
Resident #6 had a 20 between July 2022 a were no monthly weig 2022 and August 202	0.0093% decrease in weight nd October 2022. There ghts documented in July 22. The weights from June			reviewed and revised for documented significant weight loss. Any discrepar will be immediately addressed. The findings will be reported to the QA Committee who will review and revise	d ncies e the	
, ,	SUMMARY ST (EACH DEFICIENC REGULATORY OR I REGULATORY OR I Continued From page medical record if the and their resident rep not practicable for the resident's care plan. (F) Other appropriate disciplines as determ or as requested by th (iii)Reviewed and rev team after each asse comprehensive and o assessments. This REQUIREMENT by: Based on staff interv review, and clinical re failed to review and r resident (Resident #6 survey sample. For Resident #6, the and revise the care p loss from July 2022 to The findings included On 09/12/2023, a rev Resident #6 was ede swallowing, and was altered diet. According to the Mon Resident #6 had a 20 between July 2022 an were no monthly weig 2022 and August 202	ROVIDER OR SUPPLIER HEALTH CARE & REHAB CEN SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 6 medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, and clinical record review, the facility staff failed to review and revise the care plan for one resident (Resident #6) of eight (8) residents in the survey sample. For Resident #6, the facility staff failed to review and revise the care plan after a significant weight loss from July 2022 to October 2022. The findings included: On 09/12/2023, a review was conducted of Resident #6 was edentulous, had difficulty swallowing, and was prescribed a mechanically	A BUILDI         495097         B. WING_         ROVIDER OR SUPPLIER         MEALTH CARE & REHAB CEN         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         Continued From page 6         medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.         (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.         (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.         This REQUIREMENT is not met as evidenced by:         Based on staff interview, facility documentation review, and clinical record review, the facility staff failed to review and revise the care plan for one resident (Resident #6) of eight (8) residents in the survey sample.         For Resident #6, the facility staff failed to review and revise the care plan after a significant weight loss from July 2022 to October 2022.         The findings included:         On 09/12/2023, a review was conducted of Resident #6's clinical record. Review revealed Resident #6's a edentulous, had difficulty swallowing, and was prescribed a mechanically attered diet.          According to t	A BULDING       Identical interview       ROWDER OR SUPPLIER       Identical interview       IDENTIFY ING INFORMATION)       IDENTIFY ING INFORMATION)       IDENTIFY ING INFORMATION)       Continued From page 6       REGULATORY OR LSC IDENTIFY ING INFORMATION)       F 657       medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.       (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident's needs or as requested by the resident.       (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.       This REQUIREMENT is not met as evidenced by:       Based on staff interview, facility documentation review, and clinical record review, the facility staff failed to review and revise the care plan for one resident (Resident #6) of eight (8) residents in the survey sample.       For Resident #6, the facility staff failed to review and revise the care plan after a significant weight loss from July 2022 to October 2022.       The findings included:       On 09/12/2023, a review was conducted of Resident #6 was edentulous, had difficulty swallowing, and was prescribed a mechanically altered diet.       According to the Mon	495097         B WING           STREET ADDRESS, CITY, STATE, ZP CODE           ADDRESS, CITY, STATE, ZP CODE           STREET ADDRESS, CITY, STATE, ZP CODE           SUMMARY STATEMENT OF DEFICIENCIES (RACH DEFICIENT WIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)           Continued From page 6 medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.         F 657           Continued From page 6 medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.         F 657           (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the interdisciplinary team after each assessment. This REQUIREMENT is not met as evidenced by:         F657 Care Plan Timing and Revision 1. Resident #6 no longer resides in facility.           For Resident #6, the facility staff failed to review and revise the care plan after a significant weight loss from July 2022 to October 2022.         F657 Care Plan Timing and Revision 1. Resident #6 no longer resides in facility.           Con 09/12/2023, a review was conducted of Resident #6 was edentulues, had difficulty swallowing, and was prescribed a mechanically altered diet.         The findings included:           M correling the Monthy Weight Report, Resident #6 thad a 20.00393% decrease in weight between July 2022 and October 2022. There were no monthy weights documenter in July 2022 and Adugust 2022. The weights ff	A BOULDING       A BOULDING       A BOULDING       REVIDER OR SUPPLIER       MEALTH CARE & REHAB CEN       SUMMARY STINEENT OF DEFICIENCIES (EXAN DEFICIENCY INEL INFORMATION)       SUMMARY STINEENT OF DEFICIENCIES (EXAN DEFICIENCY OR LSG DENTIFYING INFORMATION)       SUMMARY STINEENT OF DEFICIENCIES (EXAN DEFICIENCY OR LSG DENTIFYING INFORMATION)       Continued From page 6 medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident from page 6 medical record if the participation of the resident and their resident gene to the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by:     F657 Care Plan Timing and Revision 1. Resident #6 no longer resides in the facility.       F67 Resident #6, the facility staff failed to review and revise the care plan after a significant weight loss from July 2022 to October 2022.       The findings included:       The findings included:       NUMY 2022 and August 2022. The weights from July 2022 and August 2022. The we

Facility ID: VA0184

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 01/05/202 M APPROVE D. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION	COM	E SURVEY PLETED C
		495097	B. WING			/14/2023
NAME OF P	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE		
PARHAM	HEALTH CARE & REHAI	B CEN		2400 E PARHAM ROAD RICHMOND, VA 23228		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 657	Continued From page	e 7	F 657			
	01/03/2023 - 95.2 lbs	Wheelchair		has been achieved. 5. Date of Compliance: 10/2	3/2023.	
	11/21/2022 - 95.2 lbs					
	10/11/2022 - 100.0 lb	S.				
	10/06/2022 - 96.7 lbs					
	07/07/2022 - 118.2 lb	S.				
	06/28/2022 -116.0 lbs	s Mechanical Lift				
	05/11/2022 - 117.0 lb	S.				
	03/10/2022 - 110.8 lb					
	monthly from January November 2021 of 12	ghts taken monthly to twice / 2021 of 125.5 lbs. to 24 lbs. showed weights that t fluctuations in weight.				
		2022. It was 110 lbs., which erence from the November				
	#6 was seen on 07/18 continue the mechan	ian's notes stated Resident 8/2022 and the plan was to ically altered diet due to nue with staff assisting with ight gain" was noted.				
	has dementia and we Decreased oral intake	n Weight Change ht loss noted and resident eight loss is expected.				

Facility ID: VA0184

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	-	D HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		495097	B. WING				C / <b>14/2023</b>
NAME OF PF	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
PARHAM	HEALTH CARE & REHA	3 CEN			2400 E PARHAM ROAD RICHMOND, VA 23228		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 657	conducted with Licens stated the Certified N expected to report for C stated the nurses re- residents, follow the p physician's orders reg- nutritional supplement physician should be re- residents. On 09/14/2023 at 2:4 conducted with the Di- Resident # 6 had den The Director of Nursin was for the staff to as significant weight loss stated she did not see 2022 and September nursing staff would be resident closely for we diagnoses, history, de prognosis, the Director The Director of Nursin with a weight of 117 v pounds. There would a change in weight. Resident #6's care pla "Nutrition Risk R/t (re-	navoidable." 0 p.m., an interview was sed Practical Nurse C who ursing Assistants were od intake to the nurses. LPN eview the care plans of all olan of care, follow the garding diets, weights and ts. LPN C stated the notified to assess the 5 p.m., an interview was rector of Nursing who stated nentia and failure to thrive. In g stated the expectation sess and monitor for 5. The Director of Nursing e any weights for August 2022. When asked if the e expected to monitor this eight loss due to the medical ecreased food intake, and or of Nursing stated, "Yes." In g agreed that a resident vould look different at 96 be an obvious indication of an was reviewed. It read: lated to) advanced age, mechanically altered e of chewing/swallowing. Il maintain adequate (as evidenced by) no	F	657			
	Date Initiated: 01/06/2						

Facility ID: VA0184

If continuation sheet Page 9 of 34

S FOR MEDICARE & I				(		APPROVED . 0938-0391
DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
	495097	B. WING _				C 14/2023
ROVIDER OR SUPPLIER		· [	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
HEALTH CARE & REHAE	3 CEN					
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	x			(X5) COMPLETION DATE
06/12/2018		F	657			
symptoms) of dyspha Coughing, Drooling, H Several attempts at sy Appears concerned d 07/18/2022 • Monthly Weights Da • Provide adaptive eq plate. Date Initiated: 0 • Provide and serve sy Date Initiated: 01/06/2 • Provide staff supervi feeding at meal times	gia: Pocketing, Choking, lolding food in mouth, wallowing, Refusing to eat, uring meals. Date Initiated: te Initiated: 01/06/2022 uipment for feeding; divided 01/06/2022 upplements as ordered. 2022 ision/assistance with					
Significant weight loss On 09/14/2023 at 3:00 Director of Nursing, a	identified in October 2022. D p.m., the Administrator, nd Assistant Director of					
Services Provided Me	et Professional Standards	F6	658			10/23/23
The services provided as outlined by the cor must- (i) Meet professional s This REQUIREMENT by:	l or arranged by the facility, nprehensive care plan, standards of quality. is not met as evidenced			F658 Services Provided Meet		
	CORRECTION ROVIDER OR SUPPLIER HEALTH CARE & REHAE SUMMARY ST/ (EACH DEFICIENCY REGULATORY OR L Continued From page 06/12/2018 Revision on: 10/25/20 Interventions: · Monitor/document/re symptoms) of dyspha Coughing, Drooling, F Several attempts at sy Appears concerned d 07/18/2022 · Monthly Weights Da · Provide adaptive equiplate. Date Initiated: 0 · Provide adaptive equiplate. Date Initiated: 0 · Provide adaptive equiplate. Date Initiated: 0 · Provide staff supervificed ing at meal times The care plan did not significant weight loss On 09/14/2023 at 3:00 Director of Nursing, a Nursing were notified No further information Services Provided Me CFR(s): 483.21(b)(3)( §483.21(b)(3) Compre- The services provided as This REQUIREMENT by:	CORRECTION       IDENTIFICATION NUMBER:         IDENTIFICATION NUMBER: <td< td=""><td>CORRECTION       IDENTIFICATION NUMBER:       A. BUILDI         495097       B. WING         ROVIDER OR SUPPLIER       HEALTH CARE &amp; REHAB CEN       ID         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID         Continued From page 9       06/12/2018       PREFI         Revision on: 10/25/2022       Interventions:       F         Monitor/document/report PRN any s/sx (signs or symptoms) of dysphagia: Pocketing, Choking, Coughing, Drooling, Holding food in mouth, Several attempts at swallowing, Refusing to eat, Appears concerned during meals. Date Initiated: 07/18/2022       Ontohy Weights Date Initiated: 01/06/2022         • Provide adaptive equipment for feeding; divided plate. Date Initiated: 01/06/2022       • Provide adaptive equipments as ordered. Date Initiated: 01/06/2022         • Provide at serve supplements as ordered. Date Initiated: 01/06/2022       • Provide staff supervision/assistance with feeding at meal times."         The care plan did not address the actual significant weight loss identified in October 2022.       On 09/14/2023 at 3:00 p.m., the Administrator, Director of Nursing, and Assistant Director of Nursing were notified of the findings.         No further information was provided. Services Provided Meet Professional Standards CFR(s): 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:</td><td>CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING_         495097       B. WING</td><td>CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING         495097       B. WING         ROWDER OR SUPPLIER       STREET ADDRESS, OTTY, STATE, ZIP CODE         HEALTH CARE &amp; REHAB CEN       STREET ADDRESS, OTTY, STATE, ZIP CODE         IMPORT DEFICIENCY AND TO PERFORMATION       PREMIX         RECLARDRY OR USE DENTIFYING INFORMATION       PREMIX         Continued From page 9       PROVIDER'S PLAN OF OR USE DENTIFYING INFORMATION         Continued From page 9       F 657         Of/J222018       F 657         Revision on: 10/255/2022       Interventions:         · Monitor/foccument/report PRN any s/sx (signs or symptoms) of dysphagia: Pocketing, Choking, Cooling, Holding food in mouth, Several attempts at swallowing, Refusing to eat, Appears concerned during meals, Date Initiated: 01/06/2022         · Provide adarbive equipments as ordered. Date Initiated: 01/06/2022       · Provide staff supervision/assistance with feeding at meal times."         The care plan did not address the actual significant weight loss identified in October 2022.       F 658         On 09/14/2023 at 3:00 p.m., the Administrator, Director of Nursing, and Assistant Director of Nursing were notified of the findings.         No further information was provided.       F 658         Services Provide date the oprehensive Care Plans       F 658         Netwine weig</td><td>CORRECTION       IDENTIFICATION NUMBER:       A BUILDING       Common         495097       B. WING       B. WING       09         ROWDER OR SUPPLER       STREET ADDRESS, CITY, STATE, ZIP CODE       2000 E PARHAM ROAD       RCHMOND, VA 32228         SUMMARY STATEMENT OF DEFICIENCES       ID       PROVIDER'S FLAN OF CORRECTION       ID         (EACH ORRECTIVE AUTONIN, VA 32228       FARMA ROAD       RCHMOND, VA 32228       ID         Continued From page 9       00/12/2018       F657       F657       F657         OCID/12/2018       Revision on: 10/25/2022       Interventions:       F657       F657         OVIDER: OR Supplicit Data Initiated: 01/06/2022       F657       F657       F657         Value daptive equipment for feeding: divided plate, Date Initiated: 01/06/2022       Frovide adaptive equipment for feeding: divided plate, Date Initiated: 01/06/2022       Frovide adaptive equipment for feeding: divided plate, Date Initiated: 01/06/2022       Frovide adaptive equipment for feeding: divided plate, Date Initiated: 01/06/2022       Frovide adaptive equipment for feeding: divided plate, Date Initiated: 01/06/2022       Frovide adaptive equipment for feeding: divided plate, Date Initiated: 01/06/2022       Frovide adaptive equipment for feeding: divided plate, Date Initiated: 01/06/2022       Frovide adaptive equipment for feeding: divided plate, Date Initiated: 01/06/2022       Frovide adaptive equipment for feeding: divided plate, Date Initiated: 01/06/2022       F658</td></td<>	CORRECTION       IDENTIFICATION NUMBER:       A. BUILDI         495097       B. WING         ROVIDER OR SUPPLIER       HEALTH CARE & REHAB CEN       ID         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID         Continued From page 9       06/12/2018       PREFI         Revision on: 10/25/2022       Interventions:       F         Monitor/document/report PRN any s/sx (signs or symptoms) of dysphagia: Pocketing, Choking, Coughing, Drooling, Holding food in mouth, Several attempts at swallowing, Refusing to eat, Appears concerned during meals. Date Initiated: 07/18/2022       Ontohy Weights Date Initiated: 01/06/2022         • Provide adaptive equipment for feeding; divided plate. Date Initiated: 01/06/2022       • Provide adaptive equipments as ordered. Date Initiated: 01/06/2022         • Provide at serve supplements as ordered. Date Initiated: 01/06/2022       • Provide staff supervision/assistance with feeding at meal times."         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WING         ROWDER OR SUPPLIER       STREET ADDRESS, OTTY, STATE, ZIP CODE         HEALTH CARE & REHAB CEN       STREET ADDRESS, OTTY, STATE, ZIP CODE         IMPORT DEFICIENCY AND TO PERFORMATION       PREMIX         RECLARDRY OR USE DENTIFYING INFORMATION       PREMIX         Continued From page 9       PROVIDER'S PLAN OF OR USE DENTIFYING INFORMATION         Continued From page 9       F 657         Of/J222018       F 657         Revision on: 10/255/2022       Interventions:         · Monitor/foccument/report PRN any s/sx (signs or symptoms) of dysphagia: Pocketing, Choking, Cooling, Holding food in mouth, Several attempts at swallowing, Refusing to eat, Appears concerned during meals, Date Initiated: 01/06/2022         · Provide adarbive equipments as ordered. Date Initiated: 01/06/2022       · Provide staff supervision/assistance with feeding at meal times."         The care plan did not address the actual significant weight loss identified in October 2022.       F 658         On 09/14/2023 at 3:00 p.m., the Administrator, Director of Nursing, and Assistant Director of Nursing were notified of the findings.         No further information was provided.       F 658         Services Provide date the oprehensive Care Plans       F 658         Netwine weig	CORRECTION       IDENTIFICATION NUMBER:       A BUILDING       Common         495097       B. WING       B. WING       09         ROWDER OR SUPPLER       STREET ADDRESS, CITY, STATE, ZIP CODE       2000 E PARHAM ROAD       RCHMOND, VA 32228         SUMMARY STATEMENT OF DEFICIENCES       ID       PROVIDER'S FLAN OF CORRECTION       ID         (EACH ORRECTIVE AUTONIN, VA 32228       FARMA ROAD       RCHMOND, VA 32228       ID         Continued From page 9       00/12/2018       F657       F657       F657         OCID/12/2018       Revision on: 10/25/2022       Interventions:       F657       F657         OVIDER: OR Supplicit Data Initiated: 01/06/2022       F657       F657       F657         Value daptive equipment for feeding: divided plate, Date Initiated: 01/06/2022       Frovide adaptive equipment for feeding: divided plate, Date Initiated: 01/06/2022       Frovide adaptive equipment for feeding: divided plate, Date Initiated: 01/06/2022       Frovide adaptive equipment for feeding: divided plate, Date Initiated: 01/06/2022       Frovide adaptive equipment for feeding: divided plate, Date Initiated: 01/06/2022       Frovide adaptive equipment for feeding: divided plate, Date Initiated: 01/06/2022       Frovide adaptive equipment for feeding: divided plate, Date Initiated: 01/06/2022       Frovide adaptive equipment for feeding: divided plate, Date Initiated: 01/06/2022       Frovide adaptive equipment for feeding: divided plate, Date Initiated: 01/06/2022       F658

Event ID: 05LE11

Facility ID: VA0184

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		MEDICAID SERVICES					NO. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´				ATE SURVEY
		495097	B. WING				C 09/14/2023
NAME OF PI	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
				2	2400 E PARHAM ROAD		
PARHAM	HEALTH CARE & REHAI	BGEN		F	RICHMOND, VA 23228		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 658	Continued From page	<u>-</u> 10	Í F	658			
			1	000	Professional Standards		
		ocumentation, the facility care and services met			1. Resident #2 chart was reviewed	d and	
		ds of quality for 1 resident			weights were obtained with	a, and	
		irvey sample of eight (8)			documentation in the clinical record	to	
	residents.				re-establish a base line weight rema		
					stable.		
		facility staff failed to follow			2. All residents in the facility have		
		weigh Resident #2 three			potential to be affected by this defic		
	-	o a diagnosis of congestive			practice. An audit by the DON or de	signee	
	heart failure (CHF).				was completed to verify all current		
	On 00/12/2022 at any	proximately 12:00 p.m., an			residents with physician orders for w were obtained. No other residents w	•	
		ted with Resident #2 who			identified.		
		diagnosis of CHF. She			3. The Director of Nursing or design	nee	
		losed when she was in her			will educate current licensed nurses	-	
	-	vatch her diet and weight			following physician □s orders to obta	ain	
	frequently and watch	for swelling of her legs and			weights with documentation in the c	linical	
		w many times per week she			record.		
		ighed she stated 3 times per			4. Unit Managers or designee will		
		ow she gets weighed, she			complete weekly audits x 4 and more		
		posed to use the lift scale,			audits x 2 to ensure physician order	s are	
	-	/ don't do it because they lift out and weighing me."			followed for obtaining weights and documented in the clinical record. A	ny	
	A review of the clinics	al record revealed that			discrepancies will be immediately addressed. The findings will be repo	orted	
		was not documented from			to the QA Committee who will review		
	0	7/2023. From 07/07/2023			revise the action plan as needed. The		
		ollowing weights are not			plan of action will continue until the		
	documented as havin				Committee determines that substan		
	July: 07/14, 07/17, 07	7/28 and			compliance has been achieved.	2	
	Aug.: 08/4, 08/14, 08				5. Date of Compliance: 10/23/202	J.	
	Sept.: 09/04, 09/11, a						
	On 09/12/2023 at apr	proximately 1:00 p.m., an					
		ector of Nursing (DON) and					
		of Nursing (ADON) was					
		e both asked if it is the					
	expectation of the fac	cility that nurses will follow					

Facility ID: VA0184

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495097	B. WING		C 09/14/2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	05/14/2023
	HEALTH CARE & REHAI	3 CEN	:	2400 E PARHAM ROAD RICHMOND, VA 23228	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	D 4 T
F 658	the physician's orders	s and/or clarify any orders nd. They both indicated that ctation of all nurses.	F 658	3	
F 677 SS=D	CFR(s): 483.24(a)(2) §483.24(a)(2) A resid out activities of daily I services to maintain of personal and oral hyo This REQUIREMENT by: Based on observatio review, and facility do staff failed to ensure necessary services to and personal hygiene in a survey sample of The findings included On 09/12/2023 at app observation was mad eyes closed, appeare respond to the knock	ent who is unable to carry iving receives the necessary good nutrition, grooming, and giene; is not met as evidenced n, interview, clinical record ocumentation, the facility residents received the o maintain good grooming, e for 1 resident (Resident #1) f eight (8) Residents. : proximately 2:15 p.m., an le of Resident #1 in bed with ed to be resting, and did not on door. The room smelled hich was compounded by	F 677	<ul> <li>F677 ADL Care for Dependent Reside</li> <li>Resident #2 received personal</li> <li>hygiene to include a bed bath on</li> <li>9/13/2023 with documentation. Reside</li> <li>#2 received a shower on his scheduled</li> <li>shower day of 9/14/2023 with</li> <li>documentation.</li> <li>All residents in the facility have the</li> <li>potential to be affected by this deficien</li> <li>practice. An audit by the DON or designed</li> <li>was completed on all dependent resided</li> <li>to ensure no other residents were affected</li> <li>with hygiene, grooming and showers. In</li> <li>other residents were identified.</li> <li>The Director of Nursing or designed</li> <li>will educate certified nursing assistants</li> </ul>	ent d nee t nee ents cted No ee s in
	Resident #1 was in b appeared to be aslee gown. As surveyor m there was a smell of b	proximately 9:50 a.m., ed with his eyes closed, p, and dressed in a hospital oved closer to the resident, body odor, and the room had e, which was compounded ir in the room.		<ul> <li>ensuring all dependent residents recein necessary services to maintain good hygiene, personal grooming and show as scheduled or as needed and/or bed baths as required.</li> <li>4. Unit Managers or designee will complete audits weekly x 4 to ensure a dependent residents receive services for the services of th</li></ul>	ers I

Facility ID: VA0184

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						NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION		ATE SURVEY OMPLETED
			A. DOILDING	·		С
		495097	B. WING			09/14/2023
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		
	HEALTH CARE & REHA	R CEN		2400 E PARHAM ROAD		
	TEALTH CARE & REHA	B CEN		RICHMOND, VA 23228		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLETIOI DATE
F 677	Continued From pag	e 12	F 67	77		
		proximately 2:30 p.m.,	107	maintain hygiene, personal	aroomina bed	
		erved in bed, awake, and		bath and/or showers as sch		
		as noted to have beads of		discrepancies will be immed	•	
		d and was covered in a		addressed. The findings will	be reported	
		et. When asked if he had		to the QA Committee who w		
	0	ay, he stated that he had not. al records revealed that		revise the action plan as ne		
	Resident #1's last re			plan of action will continue u Committee determines that		
	08/10/2023.			compliance has been achiev		
	00/10/2020.			5. Date of Compliance: 10		
	On 09/13/2023, an ir	terview with Employee C				
		55 a.m. Employee C was				
		dents were bathed, she				
	•	showers twice a week or bed he stated sometimes they				
	• •	what the Certified Nursing				
		upposed to do if a resident				
		d they are supposed to notify				
	the nurse so she can	document it in the nurses'				
		an try again later to get them				
	to shower.					
	On 00/13/2023 at an	proximately 11:00 a.m., an				
	-	cted with the Ombudsman				
		es to the facility many times				
	and finds the facility	smells of urine and feces.				
		dent #1's wife complains that				
		larly, and it is evident by the				
		smell. She stated the lack of				
	body odor and incon	ning is not helping with the tinent smells either.				
	A review of the policy	contitled "Shift				
	Responsibilities for C					
		signments at the beginning of				
		ensed nurse. Examples of				
	report information inc	cludes but is not limited to				

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TATEMENT (	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
		495097	B. WING		C 09/14/2023
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•
	HEALTH CARE & REHA	B CEN		2400 E PARHAM ROAD	
		5 5211		RICHMOND, VA 23228	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETIO
F 677	Continued From page	e 13	F 67	7	
		g needs, special care needs			
		nformation to the oncoming ot completed."			
		g the end of day meeting, the ade aware of the concerns.			
	No further information	n was provided.			
F 684 SS=D	Quality of Care CFR(s): 483.25		F 68	4	10/23/23
	applies to all treatment facility residents. Base assessment of a resident that residents received accordance with profi	ndamental principle that nt and care provided to ed on the comprehensive dent, the facility must ensure e treatment and care in essional standards of nensive person-centered			
	by: Based on resident in facility documentatior	is not met as evidenced terview, staff interview, n review, and clinical record		F684 Quality of Care 1. Resident #5 reports having no	
		iff failed to arrange lial appointments for 1 i) in the survey sample of		upcoming appointments. Education provided to resident #5 to inform nurs or unit secretary for self-scheduled appointments to ensure arrangement	
	The findings included	:		transportation. 2. All residents in the facility have t	
	For Resident # 5, the transportation was ar appointments.	facility staff failed to ensure ranged for medical		potential to be affected by this deficie practice. An audit by the DON or des was completed on all current residen the facility to ensure no other residen had missed appointments due to	ignee ts in
		nitted to the facility in July diagnoses included but were		had missed appointments due to transportation not being arranged. No other residents were identified.	<b>b</b>

Facility ID: VA0184

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HUMAN SERVICES			FOR	D: 01/05/2024 MAPPROVED D. 0938-0391
X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		(X3) DATE COMF	E SURVEY PLETED
495097	B. WING			C / <b>14/2023</b>
		STREET ADDRESS, CITY, STATE, ZIP CODE		
CEN		2400 E PARHAM ROAD		
<b>CEN</b>		RICHMOND, VA 23228		
EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SH	IOULD BE	(X5) COMPLETION DATE
14 ure, respiratory failure with ertension, and chronic ecord was conducted on 2023. a.m., an interview was nt #5. He stated it was tation to appointments was ident #5 stated he has tments in the past and did to return to the facility at ted he needed to keep the when they were gn-out sheet was reviewed. sheet revealed that on 45 had an appointment at ted up at 1:00 p.m. There of the time of return. ns for Transportation e, and Scheduler, were not entries on the sheet. oximately 4:00 p.m., an ed with the Administrator 5 often would secure his ippointments. The ere was a scheduler on the transportation. g (DON) stated the facility en Resident #5 had of the facility. The DON the transportation services Madicaid. The DON stated	F 6	<ul> <li>3. The Director of Nursing or d will educate the unit secretary ar licensed nurses in ensuring trans- is arranged for all residents who upcoming appointments. Transp arranged through the residents□ insurance company or the family transporting the resident to their appointment(s).</li> <li>4. Unit Managers or designee complete audits weekly x 4 to er residents have arrangement of transportation for their scheduler appointments. Any discrepancie immediately addressed. The find be reported to the QA Committee review and revise the action plan needed. The plan of action will o until the QA Committee determin substantial compliance has beer achieved.</li> </ul>	nd sportation have ortation is will nsure d s will be lings will e who will n as continue nes that	
	IDENTIFICATION NUMBER:         495097         CEN         EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)         14         14         are, respiratory failure with extension, and chronic         ecord was conducted on 2023.         a.m., an interview was nt #5. He stated it was ation to appointments was ident #5 stated he has ments in the past and did to return to the facility at ed he needed to keep the when they were         In-out sheet was reviewed.         sheet revealed that on 45 had an appointment at ed up at 1:00 p.m. There of the time of return.         not sheet was reviewed.         sheet revealed that on 45 had an appointment at ed up at 1:00 p.m. There of the time of return.         spointments. The entries on the sheet.         oximately 4:00 p.m., an ed with the Administrator 5 often would secure his ppointments. The ere was a scheduler on the transportation.         (DON) stated the facility en Resident #5 had of the facility. The DON	x1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTII A. BUILDIN         495097       B. WING	x1) PROVIDER/SUPPLIER/CLIA IDENTIF/CATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A. BUILDING         495097       B. WING         CEN       STREET ADDRESS, CITY, STATE, ZIP CODE 2400 E PARHAM ROAD RICHMOND, VA 23228         EMENT OF DEFICIENCIES WINT BE PRECEDED BY FULL CIDENTIFYING INFORMATION)       ID PREFIX TAG         14       F 684         14       F 684         a.m., an interview was ation to appointments was ident 45 Stated it was ation to appointment swas ident 45 Stated he has ments in the past and did to return to the facility at ed up a 1:00 p.m. There of the time of return. ns for Transportation e, and Scheduler, were not entries on the sheet.       4. Unit Managers or designee immediately addressed. The find be reported to the QA Committer review and revise the action plain needed. The plan of action will cuntil the QA Committer review and revise the action plain needed. The plan of action will cuntil the QA Committer review and revise the action plain needed. The plan of action will cuntil the QA Committer review and revise the action plain needed. The plan of action will cuntil the QA Committer review and revise the action plain needed. The plan of action will cuntil the QA Committer review and revise the action plain needed. The plan of action will cuntil the QA Committer review and revise the action plain needed. The plan of action will cuntil the QA Committer review and revise the action plain needed. The plan of action will cuntil the QA Committer review and revise the action plain needed. The plan of action will cuntil the QA Committer review and revise the action plain needed. The plan of action will cuntil the QA Committer review and revise the action plain needed. The plan of action will cuntil the QA Committer review and revise the action	EDICAID SERVICES       OMB NK         K1) PROVIDERSUPPLERCUA IDENTIFICATION NUMBER:       (22) MULTIFILE CONSTRUCTION A BUILDING       (23) DATE COM         495097       B       WING       09         495097       B       STREET ADDRESS, CITY, STATE, ZIP CODE       00         200 E PARHAM ROAD RICHMOND, VA 23228       STREET ADDRESS, CITY, STATE, ZIP CODE       00         200 E PARHAM ROAD RICHMOND, VA 23228       PROVIDERS PLANOF CORRECTION (EACH CORRECTIVE ACTION SHOULD DE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY)       00         14       F 684       .       .       The Director of Nursing or designee will educate the unit secretary and licensed nurses in ensuring transportation is arranged for all residents who have upcoming appointments. Transportation is arranged through the residents□ insurance company or the family transporting the residents□ insurance company or the family transportation for their scheduled appointments. Any discrepancies will be immediately addressed. The findings will be reported to the QA Committee determines that substantial compliance in 23/2023.         n-out sheet was reviewed. the transportation a, and Scheduler, were not entries on the sheet.       5. Date of Compliance: 10/23/2023.         s. Date of Compliance: 10/23/2023.       5. Date of Compliance: 10/23/2023.         s. Date of Compliance: 10/23/2023. </td

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 01/05/2024 MAPPROVED
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	CONSTRUCTION		(X3) DATE	0. 0938-0391 SURVEY LETED
		495097	B. WING				C 14/2023
NAME OF PI	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STAT	E. ZIP CODE	00/	14/2020
_				00 E PARHAM ROAD	,		
PARHAM	HEALTH CARE & REHA	B CEN		CHMOND, VA 23228			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD B ED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page		F 684				
	show up as schedule	d.					
	Review of the progres following:	ss notes revealed the					
	"Effective Date: 05/22 Care Note	2/2023 17:38 Type: Plan of					
		eturned from dentist. No e. Stated "I had some teeth					
	Note Text : pt has app	/2023 11:51 Type: Alert Note ot (appointment) 5-22-23 at lress redacted) with pick up					
	Note Text : transporta today 5-19-23 with ca	/2023 11:38 Type: Alert Note ition did not show for pt appt irdiologist was told they der to accommodate his ay trip #71509					
	Note Text: pt has app	/2023 10:31 Type: Alert Note t 5-19-23 at 745am with ss redacted) with pick up at					
	dental appointment of appointment on 05/22 of the facility's transpo- Resident # 5 was pick Nursing progress note 17:36 (5:36 p.m.) stat the facility from the de from the facility for ov after his dental appoint	Resident #5 did not have a n 05/2/2023. There was an 2/2023 at 2:00 p.m. Review ortation records revealed ked up at 1:00 p.m. The es dated 05/22/2023 at ted the resident returned to entist. Resident #5 was gone ver 4 hours and over 3 hours ntment time. There was no ne dental office called the					

Facility ID: VA0184

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		D HUMAN SERVICES MEDICAID SERVICES					FORM	M APPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTR				SURVEY PLETED
		495097	B. WING					
NAME OF PF	ROVIDER OR SUPPLIER		•	STREET AD	DRESS, CITY, STATE, ZIP CO	DE.		
PARHAM I	HEALTH CARE & REHAE	3 CEN			RHAM ROAD ND, VA 23228			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE		(X5) COMPLETION DATE
F 684 F 692 SS=D	appointment with the The transportation co Further review reveals show up for a schedu 04/17/2023 for Reside On 09/14/2023 during the Administrator, Dire Assistant Director of N the findings. No further information Nutrition/Hydration St CFR(s): 483.25(g)(1)- §483.25(g) Assisted r (Includes naso-gastric both percutaneous en percutaneous endosc enteral fluids). Based comprehensive asses ensure that a resident §483.25(g)(1) Maintai of nutritional status, s desirable body weight balance, unless the re demonstrates that this preferences indicate o §483.25(g)(2) Is offerent maintain proper hydra §483.25(g)(3) Is offerent	ave transportation for the cardiologist on 05/19/2023. mpany did not show up. ed that transportation did not led dental appointment on ent #5. g the end of day debriefing, ector of Nursing, and Nursing were informed of a was provided. atus Maintenance -(3) nutrition and hydration. c and gastrostomy tubes, adoscopic gastrostomy and copic jejunostomy, and d on a resident's asment, the facility must t- ins acceptable parameters uch as usual body weight or t range and electrolyte esident's clinical condition is is not possible or resident otherwise; ed sufficient fluid intake to	F 6					10/23/23

Facility ID: VA0184

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	-	D HUMAN SERVICES MEDICAID SERVICES			F	NTED: 01/05/2024 ORM APPROVED NO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		DATE SURVEY COMPLETED C
		495097	B. WING			09/14/2023
NAME OF PF	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP	CODE	
PARHAM I	HEALTH CARE & REHAE	3 CEN		400 E PARHAM ROAD ICHMOND, VA 23228		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 692	by: Based on staff intervi and facility documenta failed to prevent a sig resident (Resident #6 (8) residents. The findings included: For Resident #6, the f a significant weight lo days. In addition, the recognize, evaluate, a nutritional needs in a Resident #6 was adm 2022. Resident # 6's of not limited to: failure t On 09/12/2023, a revi Resident #6's clinical Resident #6 was eder swallowing, and was p altered diet. According to the Mont Resident #6 had a 20 between July 2022 ar were no monthly weig	apeutic diet. is not met as evidenced ew, clinical record review, ation review, the facility staff nificant weight loss for one ) of a survey sample of eight acility staff failed to prevent ss of 20.0093% within 90 facility staff failed to and address Resident #6's timely manner. itted to the facility in June diagnoses included but were o thrive, and dementia. iew was conducted of record. Review revealed hulous, had difficulty prescribed a mechanically thly Weight Report, .0093% decrease in weight ad October 2022. There phts documented in July 2. The weights from June is were:	F 692	<ul> <li>F692 Nutrition/Hydration i Maintenance</li> <li>Resident #6 no longe facility.</li> <li>All residents have the affected by this deficient p was conducted on all resid to ensure no other resider a significant weight loss of needs were not recognize and addressed in a timely other residents were ident</li> <li>The Director of Nursir will educate current licens dietitian to ensure residen significant weight loss or in nutrition are recognized, e addressed with intervention manner.</li> <li>Unit Managers or des complete audits weekly x is 2 to ensure residents who weight loss and nutritional recognized, evaluated, an with interventions in a time discrepancies will be imme addressed. The findings w to the QA Committee who revise the action plan as n plan of action will continue Committee determines that compliance has been achi 5. Date of Compliance:</li> </ul>	r resides in the potential to be ractice. An audit dent □s records its experienced r nutritional d, evaluated, manner. No ified. ng or designee ed nurses and ts who have a nadequate evaluated, and ons in a timely ignee will 4 and monthly x have significant needs are d addressed ely manner. Any ediately vill be reported will review and needed. The a until the QA at substantial ieved.	
	11/21/2022 - 95.2 lbs.					

Event ID: 05LE11

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOF	RM APPROVED IO. 0938-0391
STATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		495097	B. WING			0	9/14/2023
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
PARHAM	HEALTH CARE & REHAE	3 CEN			2400 E PARHAM ROAD		
					RICHMOND, VA 23228		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 692	Continued From page	9 18	F	692	2		
	10/11/2022 - 100.0 lb	S.					
	10/6/2022 - 96.7 lbs.						
	07/07/2022 - 118.2 lb	s.					
	06/28/2022 - 116.0 lb						
	05/11/2022 - 117.0 lbs						
	03/10/2022 - 110.8 lb	S.					
	monthly from January November 2021 of 12	ghts taken monthly to twice v 2021 of 125.5 lbs. to 24 lbs. showed weights that t fluctuations in weight.					
	2022 and was docum	lated for 2022 was in March ented as 110 lbs., which erence from the November s.					
	Resident #6 was seen plan was to continue due to dysphagia, and	ian's notes stated that n on 07/18/2022 and the the mechanically altered diet d continue with staff . "Gradual weight gain" was					
	has dementia and we Decreased oral intake supplements increase Weight loss may be u	n Weight Change nt loss noted and resident ight loss is expected. a noted. Ensure ed to three times daily.					

Facility ID: VA0184

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 01/05/2024 APPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		495097	B. WING		_		C 14/2023
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
PARHAM	HEALTH CARE & REHAE	3 CEN		2400 E PARHAM ROAD RICHMOND, VA 23228			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 692	who stated the Certific were expected to repo- LPN C stated the nurs all residents, follow the physician's orders reg- nutritional supplement physician should be nor residents. On 09/14/2023 at 2:44 conducted with the Di- who stated Resident at to thrive. The DON states the staff to assess and weight loss. The DON weights for August 20 When asked if the nur- expected to monitor the weight loss due to the decreased food intakes stated "Yes." The DOD with a weight of 117 w pounds. There would a change in weight. Resident #6's care pla	sed Practical Nurse (LPN) C ed Nursing Assistants (CNA) ort food intake to the nurses. ses review the care plans of e plan of care, follow the garding diets, weights, and ts. LPN C stated the notified to assess the 5 p.m., an interview was rector of Nursing (DON) #6 had dementia and failure ated the expectation was for d monitor for significant I stated she did not see any 22 and September 2022. rsing staff would be his resident closely for e medical diagnoses, history, e, and prognosis, the DON N agreed that a resident would look different at 96 be an obvious indication of	F 693		DEFICIENCY)		
		ated to) advanced age, mechanically altered e of chewing/swallowing.					
	Goal: The resident wi nutritional status aeb significant weight cha Date Initiated: 01/06/2 06/12/2018 Revision on: 10/25/20 Interventions:	(as evidenced by) no nge by next review. 2022 -Created on:					

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0.0938-0391
STATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		495097	B. WING				C 14/2023
NAME OF PI	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
PARHAM	HEALTH CARE & REHAE	3 CEN			2400 E PARHAM ROAD RICHMOND, VA 23228		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 692 F 755 SS=E	<ul> <li>Monitor/document/resymptoms) of dyspha Coughing, Drooling, H Several attempts at st Appears concerned d 07/18/2022</li> <li>Monthly Weights Date Provide adaptive eq plate Date Initiated: 0</li> <li>Provide and serves st Initiated: 01/06/2022</li> <li>Provide and serves st Initiated: 01/06/2022</li> <li>Provide staff superv feeding at meal times</li> <li>The care plan did not significant weight loss</li> <li>On 09/14/2023 at 3:00</li> <li>Director of Nursing ar Nursing were notified</li> <li>No further information Pharmacy Srvcs/Proc CFR(s): 483.45(a)(b)(</li> <li>§483.45 Pharmacy St The facility must prov drugs and biologicals them under an agreen §483.70(g). The facil personnel to administ permits, but only under a licensed nurse.</li> <li>§483.45(a) Procedure pharmaceutical service</li> </ul>	eport PRN any s/sx (signs or gia: Pocketing, Choking, folding food in mouth, wallowing, Refusing to eat, uring meals. Date Initiated: te Initiated: 01/06/2022 uipment for feeding; divided 1/06/2022 upplements as ordered Date ision/assistance with ." t address the actual s identified in October 2022. 0 p.m., the Administrator, ad Assistant Director of of the findings. was received. redures/Pharmacist/Records (1)-(3) ervices ide routine and emergency to its residents, or obtain ment described in ity may permit unlicensed		692			10/23/23

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		ID HUMAN SERVICES MEDICAID SERVICES				F	ITED: 01/05/202 ORM APPROVE NO: 0938-039		
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		495097	B. WING				C 09/14/2023		
NAME OF PR	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE				
	HEALTH CARE & REHAI	R CEN		24	00 E PARHAM ROAD				
		5 5214		RI	CHMOND, VA 23228				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE		
F 755	Continued From page	e 21	F 7	755					
		inistering of all drugs and he needs of each resident.							
	<b>-</b> ( )	consultation. The facility n the services of a licensed							
<b>S</b>		es consultation on all on of pharmacy services in							
		shes a system of records of n of all controlled drugs in able an accurate							
	order and that an acc is maintained and per	nines that drug records are in count of all controlled drugs riodically reconciled. is not met as evidenced							
	Based on staff interv and clinical record re- to provide routine me	iew, facility documentation, view, the facility staff failed dications to one resident rvey sample of eight (8)			<ul> <li>F755 Pharmacy</li> <li>Srvcs/Procedures/Pharmacist/Rec</li> <li>1. Resident #6 no longer resides</li> <li>facility.</li> <li>2. All residents have the potentia</li> <li>affected by this deficient practice.</li> </ul>	s in the al to be			
	The findings included	:			by the DON or designee was cond on all current resident records to e	lucted			
	For Resident #6, the	facility staff failed to ensure			physician ordered medications are				
	the medication, Loraz	zepam, was available for			available and administered. No oth				
	administration as ord	ered by the physician.			<ul><li>residents were identified.</li><li>3. The Director of Nursing or des</li></ul>	signee			
	Review of the clinical	record was conducted			will educate current licensed nurse				
	09/12/2023 through 0	9/14/2023.			ensuring physician ordered medica	ations			
		nitted to the facility in June uded but were not limited to:			are available and administered. Medications that are determined to unavailable, the OMNI Cell STAT E be checked to see if the medicatio	Box will			

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		MEDICAID SERVICES	(X2) MULTIF	PLE CONSTRUCTION	OMB NO. 093 (X3) DATE SURV	
	CORRECTION	IDENTIFICATION NUMBER:	. ,	G	COMPLETED	
					С	
		495097	B. WING		09/14/20	23
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 2400 E PARHAM ROAD	DE	
PARHAM	HEALTH CARE & REHA	B CEN		RICHMOND, VA 23228		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE COM E APPROPRIATE	(X5) IPLETIOI DATE
F 755	Continued From page	e 22	F 75	55		
	psychotic disturbance anxiety. Review of the progres	e, mood disturbance, and ss notes revealed the		available. If the medication is available, the medical provid notified to receive new orders but not limited to an alternati or an order to hold the medic	er will be s to include ve medication	
	Administration Note Note Text : LORazep (milligrams) Give 1 ta day for anxiety may give when arrive Responsible Party) is "Effective Date: 12/24 Administration Note	ffective Date: 12/25/2022 11:25 Type: Orders - Iministration Note ote Text : LORazepam Tablet 0.5 MG iilligrams) Give 1 tablet by mouth two times a y for anxiety ay give when arrive per MD RP (medical doctor, esponsible Party) is aware." ffective Date: 12/24/2022 20:56 Type: Orders -		<ul> <li>arrives from the pharmacy.</li> <li>4. Unit Managers or design complete audits weekly x 4 a 2 to ensure physician ordere medications are available an administered. Any discrepan immediately addressed. The be reported to the QA Comm review and revise the action needed. The plan of action w until the QA Committee deter substantial compliance has b achieved.</li> </ul>	Ind monthly x d d cies will be findings will iittee who will plan as vill continue rmines that	
	Pending to due pharr "Effective Date: 12/24 Administration Note	imes a day for anxiety nacy." 4/2022 09:13 Type: Orders - a new rx (prescription)"		5. Date of Compliance: 10/	23/2023	
	Administration Note Note Text : LORazep	3/2022 20:08 Type: Orders - am Tablet 0.5 MG Give 1 imes a day for anxiety"				
	Administration Note Note Text : LORazep	3/2022 10:40 Type: Orders - am Tablet 0.5 MG Give 1 imes a day for anxiety				
	revealed the medicat	Cell STAT Box contents ion Lorazepam 0.5 mg ablets, were on hand. The				

Facility ID: VA0184

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391	
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495097	B. WING				C / <b>14/2023</b>	
NAME OF P	ROVIDER OR SUPPLIER	I			STREET ADDRESS, CITY, STATE, ZIP CODE			
PARHAM	HEALTH CARE & REHA	3 CEN			2400 E PARHAM ROAD RICHMOND, VA 23228			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 755	• • • • • • • • • • • • • • • • • • •	trieved the medication from	F	75	55			
		orders revealed valid tions not available for						
	problem: "The resident has his	an revealed the following tory of anxiety and ted: 01/06/2022 Revision						
		ill have decreased signs iety and psychosis through 2022 Target Date:						
	Intervention: Adminis	ter medications as ordered."						
	conducted with Licen who stated "the staff when medications are administration, check	the OMNI Cell STAT box, ctor (MD) and make sure the						
	conducted with the D who stated the expect to make sure medicat administration as per DON also stated the t OMNI Cell STAT box missing medication is	2 p.m., an interview was irector of Nursing (DON) tation was for the pharmacy tions were available for the physician's orders. The facility staff should check the for medications to see if the available in that supply.						

Facility ID: VA0184

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STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:			` ´	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495097	B. WING			C 9/14/2023
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C		5/14/2025
				2400 E PARHAM ROAD		
PARHAM	HEALTH CARE & REHA	B CEN		RICHMOND, VA 23228		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE
F 755	Continued From page	24	F 75	55		
		n the next run if it was not in				
	revealed the medicat capsule 10 milliequiv available to the staff. documentation the st that the Potassium C available as ordered capsules were availa On 09/14/2023 during the Administrator, Ad Director of Nursing an Nursing were informe Administrator and Dir pharmacy should ens	aff informed the physician hloride Powder was not and that Potassium Chloride ble. g the end of day debriefing, ministrator in Training, nd Assistant Director of				
	No further information Residents are Free o CFR(s): 483.45(f)(2)	n was provided. f Significant Med Errors	F 76	60		10/23/23
	medication errors. This REQUIREMENT by: Based on staff interv review, and clinical re failed to ensure one r eight (8) residents in of significant medicat	nts are free of any significant is not met as evidenced iew, facility documentation ecord review, the facility staff esident (Resident # 4) of the survey sample was free		<ul> <li>F760 Residents are Free of Med Errors</li> <li>1. Resident #6 no longer facility.</li> <li>2. All residents have the paffected by this deficient praby the DON or designee was</li> </ul>	resides in the potential to be actice. An audit	

Event ID: O5LE11

Facility ID: VA0184

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		ID HUMAN SERVICES MEDICAID SERVICES				PRINTED: FORM A OMB NO. (	PPROVED
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE SU COMPLE	
		495097	B. WING			C 09/14	/2023
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT	E, ZIP CODE		
PARHAM	HEALTH CARE & REHAE	3 CEN		2400 E PARHAM ROAD RICHMOND, VA 23228			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIA FICIENCY)	-	(X5) COMPLETION DATE
F 760	Continued From page	25	F 760				
	administration as per	physician's orders.		physician ordered me available and administ			
	The findings included	:		residents were identi3.The Director of N		e	
		nitted to the facility in March		will educate current li			
		in April 2023. Resident # 4's ut not limited to diabetes,		ensuring physician of are available and adr			
	0	e staphyloccoccus aureus		a potential significant		/11	
		and diabetic foot ulcer.		Medications that are unavailable, the OM	determined to be	vill	
	Review of the physici	an's orders revealed an		be checked to see if			
	order for the medicati			available to be admir			
	Medrol Oral Tablet Th			medication is not ava			
	(milligrams) (Methylpr Give 4 mg by mouth g	,		provider will be notifie orders to include but alternative medicatio	not limited to an	Id	
	The times of schedule	ed administration of the		the medication until it			
		milligrams by mouth four		pharmacy.			
		cumented on the medication		4. Unit Managers o			
	administration record	(MAR) as to be a.m., 12:00 noon., 6:00		complete audits week	•	ух	
	p.m., and 9:00 p.m.	a.m., 12.00 1001., 6.00		2 to ensure physiciar medications are avai administered to preve	lable and		
		4's MAR revealed the administer the medication		significant medication discrepancies will be	n error. Any		
		sician on several dates and		addressed. The findi		d	
	times to include:			to the QA Committee	who will review ar	nd	
		a.m., 12:00 noon., 6:00 p.m.,		revise the action plan			
	and 9:00 p.m.	a.m., 12:00 noon., 6:00 p.m.,		plan of action will cor Committee determine			
	and 9:00 p.m.	a.m., 12.00 noon., 0.00 p.m.,		compliance has been			
	-	a.m., 12:00 noon., 6:00 p.m.,		5. Date of Complia			
	and 9:00 p.m.						
	April 17, 2023 - 9:00 a p.m.	a.m., 6:00 p.m., and 9:00					
	-	the initial tour, Licensed					
		) B was observed passing vas interviewed. LPN B					

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NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE       PARHAM HEALTH CARE & REHAB CEN     2400 E PARHAM ROAD       (X4) ID     SUMMARY STATEMENT OF DEFICIENCIES     ID     PROVIDER'S PLAN OF CORRECTION	ED: 01/05/2024 RM APPROVED NO. 0938-0391
495097         B. WING         09/14/           NAME OF PROVIDER OR SUPPLIER         STREET ADDRESS, CITY, STATE, ZIP CODE         2400 E PARHAM ROAD           PARHAM HEALTH CARE & REHAB CEN         RICHMOND, VA 23228         RICHMOND, VA 23228           (X4) ID         SUMMARY STATEMENT OF DEFICIENCIES         ID         PROVIDER'S PLAN OF CORRECTION	MPLETED
PARHAM HEALTH CARE & REHAB CEN     2400 E PARHAM ROAD       (X4) ID     SUMMARY STATEMENT OF DEFICIENCIES     ID     PROVIDER'S PLAN OF CORRECTION	9/14/2023
PARHAM HEALTH CARE & REHAB CEN     RICHMOND, VA 23228       (X4) ID     SUMMARY STATEMENT OF DEFICIENCIES     ID     PROVIDER'S PLAN OF CORRECTION	
PREFIX TAG     (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)     PREFIX TAG     (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)     OPENING	(X5) COMPLETION DATE
F 760       Continued From page 26 stated if the medications were not available, she would notify the pharmacy, check the STAT box, notify the pharmacy, notify the doctor, and notify the family.       F 760         On 09/13/2023 at 12:10 p.m., an interview was conducted with the Assistant Director of Nursing (ADON) who stated it was important to administer medications as ordered by the physician. The ADON stated the expectation was that the pharmacy would ensure medications were available for administration and provide them on the next run after notification was received that the medication was not available. She stated the staff should notify the doctor and family if the medications are not available. She stated the staff should notify the doctor and family if the medication sa ordered.         On 09/13/2023 at 4:15 p.m., the Administrator and Director of Nursing (Admin D) were informed of the findings.         An interview was conducted with the Director of Nursing (DON) on 09/14/2023 at 2:25 p.m. regarding the medication not being administred. The DON stated she reviewed the clinical record and noted the Medrol was not available from 04/13/2023 : 04/15/2023 the vas available from 04/16/2023. She stated the facility staff did not administer the medication not being administered on 04/16/2023. She stated the facility staff did not administer the medication and did notify the physician. The DON stated the expectation was the medication would have been available on the next delivery as documented by the nursing staff. The DON stated ti was not the expectation for	

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CENTERS FOR MEDICARE & MEDICAD SERVICES     OMB NO. 0938-0331       MARE DAY OF CORRECTION     (I) PROVIDER VERVILEQUAL IDENTIFICATION NUMBER     (C) MULTIPLE CONSTRUCTION A BUILDING     (P) OWE LEW PC OUPLIED       MARE OF PROVIDER OR SUPPLIER     495097     IIII STREET AUDRESS. CITY STREE, CP CODE 2006 E PARHAM ROAD RCHMONO, VA 2228       PARHAM HEALTH CARE & REHAR CEN     IIIII STREET AUDRESS. CITY STREE, CP CODE 2006 E PARHAM ROAD RCHMONO, VA 2228     IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII			D HUMAN SERVICES				FORM	APPROVED	
Multic OF PROVIDER OF SUPPLIER         Description         09974/2023           VMME OF PROVIDER OF SUPPLIER         STREET ADDRESS, CITY, STATE, ZIP CODE 2006 F PARIAM RCAD RCHMOND, VA 32328         STREET ADDRESS CITY, STATE, ZIP CODE 2006 F PARIAM RCAD RCHMOND, VA 32328         Continues	STATEMENT C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
200 E PARHAM ROAD RCHMOND, VA 2323           CHILD ONL         CHILD ONL <thchild onl<="" th="">         CHILD ONL         &lt;</thchild>			495097	B. WING _				-	
PARHAM HEALTH CARE & REHAB CEN     RICHMOND, VA 23228       (04) ID PRETX TAG     ISUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY WLST OF REFICIENCE W FULL REGULATORY OR LSC IDENTEYING INFORMATION)     ID PRETX TAG     ID PRETX TAG     PROVIDERS PLAN OF CORRECTION (CARE CORRECTIVE ALCON SHOULD BE CARE CORRECTIVE ALCON SHOULD BE CARE CORRECTIVE ALCON SHOULD BE PRETX TAG     ID PRETX CARE CORRECTIVE ALCON SHOULD BE CARE CORRECTIVE ALCON SHOULD BE CARE CORRECTIVE ALCON SHOULD BE CORRECTIVE	NAME OF PF	ROVIDER OR SUPPLIER							
Prefix TG         CEACH DEFICIENCY MUST BE PRECEDED BY FULL         PREFIX TAG         CEACH CORRECTVE ACTION SHOULD BE COMMUNICING INFORMATION)         COMMUNICING TAG           F 760         Continued From page 27 prescribed medications to be unavailable for administration for several days. Valid physician's orders were evident for the medications and treatments not documented as administered.         F 760         F 760         F 760         F 760         F 760           No 09/13/2023 at 3:30 PM, an interview was conducted with the Administrator of the medication sould be available for administrator to the check the OMNI Cell STAT box and notify the pharmacy so the medication could be delivered on the next run. The Administrator also stated staff should administrator also stated staff should administration.         F 760         F 760           On 09/13/2023 at 4:00 p.m., the Administrator and DNN were informed that medications were administrator also stated staff should administration.         F 760         F 760           On 09/13/2023 at 4:00 p.m., the Administrator and DNN were informed the tast fit to ensure significant medications were administered inmediately following administration.         F 761         F 761           On 09/13/2023 at 4:00 p.m., the Administrator and DNN were informed that more than 10 consecutive doses were not available for administrator. Director of Nursing and Assistant Director of Nursing were informed of the failure of the staff to ensure significant medications were administrator.         F 721         10/23/23	PARHAM HEALTH CARE & REHAB CEN								
F 921       Safe/Functional/Sanitary/Comfortable Environ       F 921       Safe/Functional/Sanitary/Comfortable Environ       F 921	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	x	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		COMPLETION	
F 921   Safe/Functional/Sanitary/Comfortable Environ   F 921   10/23/23	F 760	prescribed medication administration for sev orders were evident for treatments not docum Review of the facility's Administration," revea to be given according On 09/13/2023 at 3:3 conducted with the Ad expectation was that available for administ also stated staff were OMNI Cell STAT box the medication could run. The Administrato administer medication physician's orders and having been administ administration. On 09/13/2023 at 4:0 and DON were inform to ensure significant r administration. On 9/14/2023 during t the Administrator, Din Assistant Director of N the findings.	ns to be unavailable for eral days. Valid physician's or the medications and hented as administered. Is policy entitled, "Medication aled that all medications are to the prescriber's order. O PM, an interview was dministrator who stated the medications would be ration. The Administrator expected to check the and notify the pharmacy so be delivered on the next r also stated staff should hs and treatments per d to document them as ered immediately following 0 p.m., the Administrator hed of the failure of the staff nedications were ere informed that more than a were not available for the end of day debriefing, ector of Nursing and Nursing were informed of	F7	760				
		Safe/Functional/Sanit	•	FS	921			10/23/23	

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION		NO. 0938-039 TE SURVEY	
AND PLAN OF	CORRECTION	DENTIFICATION NUMBER:	A. BUILDING	Co	COMPLETED		
		495097	B. WING			С	
	ROVIDER OR SUPPLIER	495097		STREET ADDRESS, CITY, STATE, ZIP CODE		9/14/2023	
	NOVIDEIX OIX SUI I EIEIX			2400 E PARHAM ROAD			
PARHAM	HEALTH CARE & REHAI	B CEN		RICHMOND, VA 23228			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 921	Continued From page	e 28	F 92	21			
		ironmental Conditions	1 32	- '			
		ride a safe, functional,					
	sanitary, and comfort						
	residents, staff and th						
		is not met as evidenced					
	by:						
		n, interview, clinical record		F921			
		ocumentation, the facility		Safe/Functional/Sanitary/Com	fortable		
		a safe, functional, sanitary,		Environ			
		ronment for residents, staff,		1. The chiller system is tenta	-		
	and the public for the	facility in general.		scheduled to be replaced in 20			
	The findings included			current cooling system will be maintained until replacement.	utilized and		
	The findings included			Ice machines located in the Ea	est and		
	For the facility the fa	cility staff failed to maintain a		Central were serviced and all i			
	-	ture throughout the entire		machines are functional.			
		erate portable air conditioners		2. All residents in the facility	have the		
		to the manufacturer's		potential to be affected by this			
		d to maintain working ice		practice. Portable units in the f			
	machines on 2 of the	-		checked by the Director of Mai ensure they were vented, and			
	On 09/12/2023 during	g the initial tour of the facility,		condensation was drained as i	needed to		
		h hall had 2 portable air		ensure they operated efficientl			
	•	ne West unit felt much cooler		thermostat switches on the east			
		ntral units. Temperatures		switched on to ensure the chill			
		es on the West unit to 78.8		operating properly to cool the			
	on the East and Cent	iral units.		machines on East and Central			
	On 00/12/2022 at any	proximately 3:30 p.m., an		<ul><li>serviced and all units are funct</li><li>3. The Administrator or designation</li></ul>			
		ted with Employee E who		educate the Maintenance Dire	-		
		s the air on East and Central		ensuring the portable units are			
		Vest unit has its own air		drained as needed to ensure e			
		stated that the chiller has		operation. Education also inclu			
		since before he started		ensuring the thermostat switch			
	working there. Survey	yors B & C noted the units		east unit were switched on to e			
		vented to the drop ceiling.		chiller was operating properly			
		its were safe to operate		the unit. Repairing of ice mach			
		gh a window, Employee E		informing Administrator, arrang			
	stated they were safe	e to operate like that. When		external services for equipmer	nt that		

Facility ID: VA0184

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	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DA	TE SURVEY		
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	i	со	COMPLETED		
						С		
		495097	B. WING			9/14/2023		
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	ODE				
PARHAM	HEALTH CARE & REHAI	B CEN		2400 E PARHAM ROAD RICHMOND, VA 23228				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE		
F 921	Continued From page	e 29	F 92	1				
	-	fe to operate without venting		cannot be repaired internall	<b>V</b> .			
		iling, he stated they were		4. The Administrator or de				
		vay as well. When asked		complete audits weekly x 4				
		vented and some were not,		2 to ensure the temperature				
		e facility ran out of tubing.		comfortable for the resident				
		ne residents' rooms have me do not, he stated it is the		the regulatory guidelines an machines are functional. Ar				
		ector of Maintenance that		discrepancies will be immed	•			
		which rooms have portable		corrected, and ice machine	•			
		them where they tell me to."		functional. The findings will				
				the QA Committee who will				
		ximately 11:45 a.m., an		revise the action plan as ne				
		ted with Employee D who		plan of action will continue of				
		e residents' rooms have me do not, he stated that		Committee determines that compliance has been achie				
		Iding are warmer than		5. Date of Compliance: 10				
	others and some resi supplied their own un	dents' families have			572672626			
		ced to the manufacturer's						
		nd that the air conditioning						
		PAC105W Portable Air Home A/C Cooling Unit with						
		10,000 BTU. When asked if						
		mercial or for home use, the						
		were ideally designed for						
		ed if they could be used						
		gh the window, he stated the						
	-	to be vented to the outside						
	-	portable air conditioners r into a room and vent hot						
		mpressor to the outside						
	-	e stated not properly venting						
	a portable air conditio	oning unit can result in the						
		as moisture builds up, it will						
		ind shut off. He also stated						
	that a 10,000 BTU air to cool a 20 ft x 20 ft	conditioner was only meant						

	MENT OF HEALTH AN					FORM	): 01/05/2024 APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE COMP	SURVEY LETED
		495097	B. WING		-		C 14/2023
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STA	ATE, ZIP CODE		
PARHAM	HEALTH CARE & REHAE	3 CEN		400 E PARHAM ROAD RICHMOND, VA 23228			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 921	On 09/13/2023 at 12: conducted with LPN E conditioning has beer years and it never get units do not cool enou difference. We have of and families complain Throughout the surve family members voice conditioning not being resident council meet lack of air conditioning every meeting since N Observations were m p.m., and the ice mach Central, and West uni was conducted with E ice machine on East at cleaning." The ice mach having to produce ice that is why they were On 09/13/2023, an int the Administrator who department had purch until the ice machines catch up and fill the b On 09/14/2023, the ice Central units was still the West unit had ice of the bin. Residents' full of water; however ice. On 09/14/2023 during	55 p.m., an interview was 3 who stated "the air n a problem in this facility for its fixed. These portable ugh to make a big complained and residents a but nothing gets done." y, staff, residents, and ed complaints about the air g effective. A review of ing minutes revealed the g has been brought up in May. ade on 09/12/2023 at 2:00 whines that serves the East, its were empty. An interview Employee E who stated the and Central was "down for icchine on the West unit was for the entire building and both empty. terview was conducted with o stated the maintenance hased ice for distribution a could be on long enough to	F 921				

Facility ID: VA0184

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TATEMENT (	DF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE	D. 0938-039 SURVEY PLETED
		495097	B. WING				C / <b>14/2023</b>
NAME OF PI	ROVIDER OR SUPPLIER				IREET ADDRESS, CITY, STATE, ZIP CODE	09/	14/2023
					100 E PARHAM ROAD		
PARHAM	HEALTH CARE & REHA	B CEN			ICHMOND, VA 23228		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 921	Continued From page	e 31	F	921			
	No further information	n was provided					
F 925		-	F	925			10/23/23
SS=E				525			10/20/20
	8483 90(i)(4) Maintai	n an effective pest control					
		acility is free of pests and					
	This REQUIREMENT	Γ is not met as evidenced					
	by: Based on observatio	on, interview, and facility			F925 Maintains Effective Pest Control		
	documentation, the fa			Program			
		trol program so the facility is			1. Room #⊡s 64, 59, 26, 14, and 44		
	free of pests.				were all serviced by the pest control		
					provider on 10/17/2023. A replacement		
	The findings included	1:			bulb for the fly light by room #82 has be ordered. It will be installed upon arrival.	en	
	For the facility in gen	eral, the facility staff failed to			The bee/wasps nest located under the		
	maintain an environm flies, ants, and roach	nent free of flies, gnats, fruit es.			bench in the east courtyard has been removed.		
	Energy 00/40/2020 11				2. All areas of the facility have the		
		ough 09/14/2023 flies and oughout the facility by			potential to be affected by this deficient		
	•	the conference room, the			practice. 3. The Administrator or designee will		
	hallways, and resider				educate the Maintenance Director on ensuring any area identified as having		
	On 09/14/2023 at ap	proximately 1:00 p.m., a			pest control is serviced by the pest cont	trol	
		was noted under a chair in			provider in a timely manner.		
	the hall just outside the	he kitchen area.			The facility staff will be educated by the SDC or designee on the process for		
	A review of the grieva	ances revealed the following:			documentation in the pest control book pest sightings.	for	
	08/24/2023 - Room 6	64 A - Resident states there			4. The Administrator or designee will		
	are ants in her bed.				complete weekly inspections x 4 weeks	to	
	09/01/2023 - Room 2	26 B - Resident requested			review pest control book and ensure		
	pest control services.				areas noted to have pest will be service	ed	
		4 - Resident requested pest			by the pest control provider in a timely		
	control services.				manner. The findings will be reported to	)	

Event ID: 05LE11

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 01/05/2024 APPROVED ). 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		(X3) DATE SURVEY COMPLETED		
		495097	B. WING				C 14/2023
NAME OF PF	NAME OF PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
PARHAM	HEALTH CARE & REHAE	3 CEN			400 E PARHAM ROAD ICHMOND, VA 23228		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG	x	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		COMPLETION DATE
F 925	Continued From page	32	F	925			
		4 B - Resident requests pest		20	the QA Committee who will review and		
	control services.				revise the action plan as needed. This		
	ants while interviewing	9 B - Social Worker noticed g residents.			plan of action will continue until the QA Committee determines that substantial compliance has been achieved.		
	A review of the reside the following:	ent council minutes revealed			5. Date of Compliance: 10/23/2023		
		ident #8: Excessive trash in J bees, and wasps. Both ests in benches."					
	A review of the Servic revealed:	e Inspection Report					
	"Inspected and treate	d rooms 28 and 58 for 1s 18 and 79 for roach					
	-	ooms 37 and 59 for ants.					
	•	pected rooms 3, 5, 7, 9, 21, 7 for flies. Recommend to					
	clean trash cans, drai	ns, and floor areas to help					
	-	ck pest sightings book at ht near room 82 is out."					
		ly 1 room (#59) out of the 5 ms were treated by pest					
	Employee E who state	erview was conducted with ed the process of obtaining for a specific room is that if					
	a staff or resident rep they inform maintenar	orts seeing bugs or flies, nce so they can enter it into . When the exterminator					
	comes he will look at	the book and know which eed to be treated and for					
		y the end of day meeting, the ide aware of the findings.					

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DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES					1 APPROVED	
CENTER	S FOR MEDICARE &	MEDICAID SERVICES					. 0938-0391	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL		(X3) DATE SURVEY COMPLETED			
	CONTRECTION	IDENTIFICATION NOMBER.	A. BUILDI	ING _				
		495097	B. WING			C 09/14/202		
NAME OF PF	ROVIDER OR SUPPLIER		- 1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	1-1/2020	
	PARHAM HEALTH CARE & REHAB CEN			2	400 E PARHAM ROAD			
	IEALIN CARE & RENAD	5 CEN		R	ICHMOND, VA 23228			
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	-	(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI		COMPLETION DATE	
					DEFICIENCY)			
F 925	Continued From page	e 33	F	925				
	No further informatior	was provided						

Event ID: 05LE11

Facility ID: VA0184

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