STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495097	A. Building B. Wing	09/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parham Health Care & Rehab Center	2400 E Parham Road Richmond, VA 23228

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. (continued on next page)

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.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and staff and resident interviews, the facility staff failed to ensure the residents' right to a safe, clean, comfortable, homelike environment for the entire facility and for Residents #128, #103, and #109 in a survey sample of 21 Residents.The following observations were made during the survey period: On 8/27/25 at 10:30 AM and 8/29/25 at 9:00 Am there was a strong urine odor in hallway past the lobby. On 8/27 through 8/29/25 flies were observed throughout the facility in resident rooms and in the hallways.On 8/29/25 at 9:00am observed breakfast trays being served with plastic utensils. An interview was conducted at approximately 9:10 AM with the Dietary Manager Employee #3 who stated due to callouts they opted to use plastic ware to save time on dish washing.8/27/25 through 8/29/25 observed wall mounted hand sanitizer units either missing or loose on the wall. Missing tiles in hallways or in resident rooms 12, 34; baseboard pulled away from the wall in room [ROOM NUMBER] near window and wall appeared to have a blackish gray residue. Mattresses in room [ROOM NUMBER]A were noted to be heavily stained, room [ROOM NUMBER]A mattress crackled appearance. On 8/29/25 at approximately 9:00 AM observed staff serving breakfast. The tray for Resident #128 was observed to have two (2) corners damaged. The corners were noted to be very sharp. An interview with LPN #1 and C.N.A #3 was conducted, and they were asked what they should do when they observe a tray with sharp edges, and both replied they should pull the tray and report it to the Dietary Manager for replacement. LPN #1 delivered the breakfast tray to Resident #128 and pulled the tray. An interview with the Dietary Manager Employee #3 conducted at approximately 9:10 AM to ask him about the damaged tray and he stated he was not aware of any damaged trays but if the staff observed any, they should bring them back to the kitchen.Resident # 128 was admitted to the facility on [DATE] with diagnosis including but not limited to hypertension, obstructive sleep apnea, heart failure, peripheral vascular disease, chronic kidney disease stage 3, major depressive disorder and chronic obstructive pulmonary disease.Resident #128's most recent Minimum Data Set (MDS) assessment was a Quarterly Assessment with an Assessment Reference Date (ARD) of 7/1/2025. Resident #128 was coded in Section C. Cognitive Summary with a Brief Interview of Mental Status score of 15 out of 15 which means the resident is cognitive intact in daily decision making. Resident #128 was coded in Section GG0130 Self Care as 0.5 Eating ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and or liquid once the meal is placed before the resident as requiring set-up or clean-up assessment.On 8/29/25 at approximately 9:05 AM observed Resident #128 eating breakfast, noting plate and cup were on overbed table, no tray and when asked where his tray was, he stated they took it back to the kitchen because it was broken at the corners. We get that sometimes.On 8/27/25 at 2:35 PM water was observed on the floor as you entered room [ROOM NUMBER]A Resident #103's room, a bath basin was observed on the floor under the sink full of water. On 8/28/25 at 9:31 AM, a bath basin was observed on the floor under the sink with approximately one (1) inch of water in the basin. On 8/29/25 at approximately 9:45 AM a bath basin was observed under the sink with approximately one (1) inch of water in the basin. Resident #103 was admitted to the facility on [DATE] with diagnosis including but not limited to human immunodeficiency virus, hypertension, seizures, chronic obstructive pulmonary disease, Adrenocortical insufficiency, pancreatitis, fibromyalgia, psychoactive substance abuse and major depressive disorder. Resident #103's most recent Minimum Data Set (MDS) assessment was a Quarterly Assessment with an Assessment Reference Date (ARD) of 6/18/2025. Resident #3 was coded in Section C. Cognitive Summary with a Brief Interview of Mental Status score of 15 out of 15 which means the resident has been cognitively intact with daily decision making. On 8/27/25 at 2:35 PM an interview was conducted with Resident #103 regarding had she had issues with her sink leaking and she replied yes, I thought they had fixed it. On 8/28/25 at 9:35 AM, a further interview with Resident #103 on had anyone come in to check on the leaking sink and she said they had emptied the pan. On 8/29/25, when interviewing Resident #103 about her sink she stated, they haven't fixed that thing yet? On 8/28/25 at approximately 10:15 AM, observed a footboard leaning against the wall in room [ROOM NUMBER]D. Resident #109 was admitted to the facility on [DATE] with diagnosis including but not limited to the following human immunodeficiency virus, hypertension, anxiety, traumatic subdural hemorrhage without loss of consciousness, Type 2 diabetes mellitus, long term use of insulin, alcohol abuse, psychosis, major depressive disorder cerebral infarction, vascular dementia, neurocognitive disorder with [NAME] Bodies and obstructive pulmonary disorder Resident #109's most recent Minimum Data Set (MDS)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Resident interview, facility staff interviews, clinical record review, and facility documentation review, the facility staff failed to provide Activity of Daily Living (ADL) care to a dependent Resident (Resident #123) in a survey sample of 28 Residents. The findings included: For Resident #123, the Resident, and Resident's bed, were soaked in a brown halo of partially dried old urine from 10:00 A.M. until 1:40 PM. Resident #123 was admitted to the facility on [DATE] with diagnoses including: Parkinson's disease, muscle atrophy, diabetes type 2 hypertension, and anemia. The Resident was her own responsible party and by facility agreement cognitively intact and able to make her own decisions. Her MDS (an assessment) recorded a Brief Interview for Mental Status (BIMS) score of 15 of a possible 15 points, indicating no cognitive impairment. During an initial interview on 8-29-25, at 10:00 A.M., and again at 1:40 PM, Resident #123 was found to be alert and oriented to person, place, time, and situation. During the 1:40 PM interview, Resident #123 verbalized that she was uncomfortable and need to have her brief changed as she was Wet head to toe. The Resident was noted to have her body and bed smell strongly of urine, and in fact the entire room had a pervasive odor of urine, feces, and body odor. The Resident wore socks which were meant to be white, however, had brown stains on them which were dried on. The Resident stated that there just were not enough staff to take care of Residents, and this situation happened to her often. The Resident's bed had a brown halo of partially dried strong-smelling urine around her body from her knees to her mid back. Her mattress was soaked as well with a permanent divot in the area directly under her bottom that did not spring back into place when she rolled off of it onto her side. A pervasive smell of urine and feces permeated the room and the entire unit. ADL care records were reviewed for Resident #123 and revealed that the Resident was totally dependent on one staff member. The document indicated that a bath was given every morning, however, the Resident was observed on 8-29-25 during survey and found to be soiled from 10:00 A.M. until 1:40 PM. in a soiled bed with soiled linens. The Resident was never seen out of bed during daytime hours for the entire survey. On 8-29-25 during an end of day meeting with the Administrator, Director of Nursing, and Corporate clinical support consultant, the facility staff were made aware of the above concerns. Furthermore they were made aware that Residents were not being bathed and given hygiene timely, nor as often as needed, as this was the observation on days during the survey with Residents being soiled with dirty linens and clothing. On 9-3-25, prior to the survey exit the Director of Nursing informed surveyors that Resident #123 was now receiving needed care every 2 hours, and stated they had nothing further to provide.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Resident interview, facility staff interviews, clinical record review, and facility documentation review, the facility staff failed to provide timely medication administration to one Resident (Resident #123) in a survey sample of 28 Residents. The findings included: For Resident #123, the Resident received her medications in March, April, and May 2025 Late, and in some cases hours after they were scheduled to be given. Resident #123 was admitted to the facility on [DATE] with diagnoses including: Parkinson's disease, muscle atrophy, diabetes type 2 hypertension, and anemia. The Resident was her own responsible party and by facility agreement cognitively intact and able to make her own decisions. Her MDS (an assessment) recorded a Brief Interview for Mental Status (BIMS) score of 15 of a possible 15 points, indicating no cognitive impairment. During an initial interview on 8-29-25, at 10:00 A.M., and again at 1:40 PM, Resident #123 was found to be alert and oriented to person, place, time, and situation. During the 1:40 PM interview, Resident #123 verbalized that she received her medications late on occasion, and sometimes hours later than they were scheduled to be given. The Resident was laying in bed and noted to have her body and bed smell strongly of urine, and in fact the entire room had a pervasive odor of urine, feces, and body odor. The Resident wore socks which were meant to be white, however, had brown stains on them which were dried on. The Resident stated that there just were not enough staff to take care of Residents, and this situation happened to her often. ADL care records were reviewed for Resident #123 and revealed that the Resident was totally dependent on one staff member. The document indicated that a bath was given every morning, however, the Resident was observed on 8-29-25 during survey and found to be soiled from 10:00 A.M. until 1:40 PM. in a soiled bed with soiled linens. The Resident was never seen out of bed during daytime hours for the entire survey. The Resident's Medication administration record was reviewed with time stamps for the time medications were administered for 3 months, in March. April, and May of 2025. The records revealed that medications were being administered later than they were ordered to be administered. The examples follow below. March 2025 - 3-25-25, Carbidopa/levodopa ordered for 1:00 P.m., given at 2:31 P.m. April 2025 - 4-25-25, Carboxymethylcellulose-glycerin eye drops, multivitamin, docusate sodium, Carbidopa/levodopa, Meloxicam, amlodipine, Sitagliptin phosphate, house supplement drink, ordered for 9:00 A.m., given at 11:00 A.m. May 2025 - 5-25-25, Carbidopa/levodopa ordered for 5:00P.m., given at 7:42 P.m., Ascorbic acid, ferrous sulfate, Carboxymethylcellulose-glycerin eye drops, melatonin, tizanidine, Carbidopa/levodopa, doxepin, atorvastatin, oxycodone, mirtazapine, and gabapentin all ordered for 9:00 P.m. , and not given until the next morning on 5-26-25 at 8:15 A.m., (11 hours late). Review of the Facility Medication Administration policy indicated medication administration would be completed according to the doctor's orders. The Resident's care plan was reviewed and indicated medications would be administered according to the doctor's orders. On 8-29-25 during an end of day meeting with the Administrator, Director of Nursing, and Corporate clinical support consultant, the facility staff were made aware of the above concerns. On 9-3-25, prior to the survey exit, the Director of Nursing informed surveyors that Resident #123 was now receiving needed care every 2 hours, and medications timely. They further stated they had nothing further to provide.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Resident interview, facility staff interviews, clinical record review, and facility documentation review, the facility staff failed to implement an safe replacement for failing closet doors and insect pest prevention and control program concerns for 1 Resident (Resident #124) in a survey sample of 28 Residents. The findings included: For Resident #124 the facility staff failed to provide safe clothing and storage closets in a Resident's room which resulted in a door falling from the closet onto a Resident while she sat in her wheelchair causing an abrasion to her face. Further the facility did not treat an infestation of cockroaches in the failing closet. Resident #124 was admitted to the facility on [DATE] from the hospital. The Resident had a diagnosis history of a stroke with left side weakness, hypertension, chronic heart disease, and was unable to stand alone. The Resident's most recent MDS (an assessment) on 8-20-25 revealed a brief interview for mental status (BIMS) score of 15 out of a possible 15 points indicating no cognitive impairment. On 8-29-25 while completing observations for a Resident neighbor of Resident #124, the surveyor was moving out into the hall facing Resident #124's room and saw an upper closet door fall and strike Resident #124 while seated in her wheelchair by the closet, on the right side of her face causing 3 abrasions on her cheek and just below her right eye. The wooden upper doors to the wall closet were approximately 24 inches by 24 inches square, and approximately 1 inch thick. There were 2 upper doors that opened in opposite directions from the middle and were located between 6 and 7 feet above the floor requiring a standing posture while reaching up to access. The closet had 4 doors in total and the 2 lower doors concealed an area to hang clothing and were much larger. The Resident was not accessing the lower hanging portion of the closet when the door fell. Resident #124 cried out Help the door just hit me. She was visibly shaken and trembling as the surveyor ran to her. A staff CNA (Certified Nursing Assistant) #4 ran into the room followed by LPN (licensed Practical Nurse) #2. An assessment was completed, and the Resident denied pain, and denied being seriously hurt, stating it just scared me. No bruising or swelling was noted; however, Resident #124 was sent out to the hospital out of an abundance of caution for a CT (computed tomography) and x-rays of her face to reveal any hidden serious injuries or fractures. The Resident returned the same day revealing only soft tissue abrasions and no serious injury or fractures. The closet was examined and found to have no screws in the 2 door hinges of the door that fell, no screws in the wall of the door that fell and none on the floor, indicating the door had not been fastened with the required screws at all. The screws in the opposite upper door were only screwed in 1/2 way, with 3 screws required for each of the 2 hinges on each door and having only 2 screws in each hinge of the second door. CNA #4 removed the fallen door from the room, and the housekeeping director, unit manager, and Corporate Registered Nurse entered the room. The closet was opened and inspected, and as the larger lower doors were opened cockroaches darted into the closet and cracks in the wall around the closet observed by everyone in attendance with surprised gasps coming from all involved. The closet wooden structure was separated and chipped and peeling with saw dust like disintegration noted from the failing particle board construction. The ceiling above the closet showed water staining and damage on ceiling tiles and metal grid work that the fiber ceiling tiles rested in. This observation revealed water damage affecting the particle board closet structure causing disintegration coming from condensation dripping from above. It was known by the facility that the Air conditioning chiller and other parts of the heating and air system in the building had been inoperable, and facility staff assured surveyors that the problem was currently under planning for repair or replacement. Portable air conditioning units were staged and in active use throughout the building. Closet replacements and repairs in other Resident rooms were also ongoing during the survey as other units were in need of replacement. The facility knew or should have known that the closets were a hazard, and did not act quickly enough to mitigate the hazard resulting in a minor injury requiring only first aid to Resident #124. Teams were then dispatched to identify any other doors that could fall for immediate repair or removal. The housekeeping and maintenance directors notified the pest control contractor who responded immediately to treat the cockroach infestation in Resident #124's room. On 8-29-25 at the end of day debrief, the Administrator, Corporate RN, and DON were notified of the above findings. They stated there was no further evidence to present.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and facility documentation the facility staff failed to maintain an effective pest control program for 3 out of 3 units,. 1. For the facility, on 8/27/25 at 10:30 AM and 8/29/25 at 9:00 Am there was a strong urine odor in hallway past the lobby. 2. For the facility, on 8/27 through 8/29/25 flies were observed throughout the facility in resident rooms and in the hallways. 3. For the facility, on 8/29/25 at 9:00am observed breakfast trays being served with plastic utensils. An interview was conducted at approximately 9:10 AM with the Dietary Manager Employee #3 who stated due to callouts they opted to use plastic ware to save time on dish washing. 4. For the facility, on 8/27/25 through 8/29/25 observed wall mounted hand sanitizer units either missing or loose on the wall. Missing tiles in hallways or in resident rooms 12, 34; baseboard pulled away from the wall in room [ROOM NUMBER] near window and wall appeared to have a blackish gray residue. Mattresses in room [ROOM NUMBER]A were noted to be heavily stained, room [ROOM NUMBER]A mattress crackled appearance. 5. On 8/29/25 at approximately 9:00 AM observed staff serving breakfast. The tray for Resident #128 was observed to have two (2) corners damaged. The corners were noted to be very sharp. An interview with LPN #1 and C.N.A #3 was conducted, and they were asked what they should do when they observe a tray with sharp edges, and both replied they should pull the tray and report it to the Dietary Manager for replacement. LPN #1 delivered the breakfast tray to Resident #128 and pulled the tray. An interview with the Dietary Manager Employee #3 conducted at approximately 9:10 AM to ask him about the damaged tray and he stated he was not aware of any damaged trays but if the staff observed any, they should bring them back to the kitchen. Resident # 128 was admitted to the facility on [DATE] with diagnosis including but not limited to hypertension, obstructive sleep apnea, heart failure, peripheral vascular disease, chronic kidney disease stage 3, major depressive disorder and chronic obstructive pulmonary disease. Resident #128's most recent Minimum Data Set (MDS) assessment was a Quarterly Assessment with an Assessment Reference Date (ARD) of 7/1/2025. Resident #128 was coded in Section C. Cognitive Summary with a Brief Interview of Mental Status score of 15 out of 15 which means the resident is cognitive intact in daily decision making. Resident #128 was coded in Section GG0130 Self Care as 0.5 Eating ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and or liquid once the meal is placed before the resident as requiring set-up or clean-up assessment. On 8/29/25 at approximately 9:05 AM observed Resident #128 eating breakfast, noting plate and cup were on overbed table, no tray and when asked where his tray was, he stated they took it back to the kitchen because it was broken at the corners. We get that sometimes. 6. On 8/27/25 at 2:35 PM water was observed on the floor as you entered room [ROOM NUMBER]A Resident6 #103's room. A bath basin was observed on the floor under the sink full of water. On 8/28/25 at 9:31 AM, a bath basin was observed on the floor under the sink with approximately one (1) inch of water in the basin. On 8/29/25 at approximately 9:45 AM a bath basin was observed under the sink with approximately one (1) inch of water in the basin. Resident #103 was admitted to the facility on [DATE] with diagnosis including but not limited to human immunodeficiency virus, hypertension, seizures, chronic obstructive pulmonary disease, Adrenocortical insufficiency, pancreatitis, fibromyalgia, psychoactive substance abuse and major depressive disorder. Resident #103 ‘s most recent Minimum Data Set (MDS) assessment was a Quarterly Assessment with an Assessment Reference Date (ARD) of 6/18/2025. Resident #103 was coded in Section C. Cognitive Summary with a Brief Interview of Mental Status score of 15 out of 15 which means the resident has is cognitively intact with daily decision making. On 8/27/25 at 2:35 PM an interview was conducted with Resident #103 regarding had she had issues with her sink leaking and she replied yes, I thought they had fixed it. On 8/28/25 at 9:35 AM, a further interview with Resident #103 on had anyone come in to check on the leaking sink and she said they had emptied the pan. On 8/29/25, when interviewing Resident #103 about her sink she stated, they haven't fixed that thing yet? 7. On 8/28/25 at approximately 10:15 AM, observed a footboard leaning against the wall in room [ROOM NUMBER]D. Resident #109 was admitted to the facility on [DATE] with diagnosis including but not limited to the following human immunodeficiency virus, hypertension, anxiety, traumatic subdural hemorrhage without loss of consciousness, Type 2 diabetes mellitus, long term use of insulin, alcohol abuse, psychosis, major depressive disorder cerebral infarction, vascular dementia, neurocognitive disorder with [NAME] Bodies and obstructive pulmonary disorder.Resident #109 ‘s most recent Minimum Data Set (MDS) assessment was a Quarterly Assessment with an Assessment Reference Date (ARD) of 7/7/2025. Resident