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	12/17/2025

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview, staff interview, clinical record review and facility documentation review, the facility staff failed to ensure it was clinically appropriate for the self-administration of medications for one resident (Resident #33) in survey sample of forty-eight residents. Findings included:For Resident # 33, the facility staff failed to ensure there was a self-administration of medication assessment related to medication found at the bedside. Resident # 33 was admitted to the facility on [DATE] and readmitted on [DATE]. Diagnoses included but were not limited to: Cerebral Infarct due to Thrombosis of the right posterior Cerebral Artery, Hemiplegia with hemiparesis, Cognitive Communication Deficit, and Asthma. The most recent Minimum Data Set (MDS) was an Annual Assessment with an Assessment Reference Date (ARD) of 09/05/2025. Resident # 33's BIMS (Brief Interview for Mental Status) Score was a 15 out of 15, indicating no cognitive impairment. Resident # 33 required assistance with Activities of Daily Living. Review of the clinical record was conducted on 12/09/2025-12/14/205. During the initial tour on 12/08/2025 at approximately 1:10 p.m., through 12/11/2025 an Over- the-Counter (OTC) bottle of Thera-Flu Max was observed on the overbed table next to the Resident. The resident was sitting up in wheelchair when the surveyor walked into the room. Resident # 33 stated that he bought the medication and that he takes a sip every day when he feels congested. On 12/11/2025 at 1:34 p.m., an interview was conducted with the Licensed Practical Nurse (LPN) #3/Unit manager who stated medications should not be left at the bedside without self-administration assessments and orders from the Physician. LPN#3 stated none of the residents on the unit had assessments with orders for self-administration of medications. LPN#3 entered Residents #33 room to discuss medication at the bedside. Resident #33 became angered and with raised voice and profanity yelled he wanted his medication that he paid for to stay in his room. LPN #3 discussed the policy regarding self-administration of medications with Resident #3 and that the Provider would come to discuss self-administration with Residen#33 Review of the Physicians Orders revealed no active order for the medication found at the bedside or an order for self-administration for Resident #33. Review of the Self-Administration of Medication and Treatments Policy was reviewed and revealed Residents have the right to self-administer medications/treatments if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. During the end of day debriefings on 12/11/2025, the Director of Nursing (DON) and Regional Directive of Clinical Services (RDCS) were informed of the findings. They stated medications should not be left at the bedside unless a resident has been assessed for self-administration of medications. No further information was provided.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview, staff interview, facility document review, and clinical record review, the facility staff failed to protect the residents' right to be free from physical abuse by other residents for 11 of 48 residents in the survey sample, Residents #43, #12, #37, #40, #39, and #41, resulting in the identification of immediate jeopardy; and for Residents #48, #38, #24, #42, and #10. The findings include: 1. For Resident #43 (R43), the facility staff failed to protect the resident's right to be free from physical abuse on 7/30/25, resulting in harm to R43. On 7/30/25, Resident #43 was punched in the face by Resident #32, resulting in Resident #43 being transferred to the hospital for a trauma evaluation for bruising and facial lacerations. A review of a facility synopsis of events dated 7/30/25 revealed, in part: Resident [#32] brought Resident [#43] to Nurse.[R32] reported that [R43] was bleeding on his bed. [R43] reported 'Why do y'all let him keep beating me?' Residents were separated due to being roommates and [R32] moved and placed on 1:1.[R43 was assessed with noted injuries to face and general discomfort was expressed. Resident was sent out to hospital for eval (evaluation) and treat.[R43] only resident noted with injuries and discomfort.911 called. A review of R43's clinical record revealed the following progress notes dated 7/30/25: 10:30 p.m. Resident was being assisted out in the hallway by [Resident #32]. Upon assisting [R43] back in room, resident stated, 'Why do you keep letting him hit me like that?' Writer asked resident who he stated 'him.' Writer assisted resident to his wheelchair and assisted him to the desk. During assessment resident stated, 'My face and chest hurts.' Writer assessed resident, noted to (sic) bilateral eyes were both dark bluish like around his eyes, and laceration to left eye brow. Previous area to upper eye also bleeding noted. Writer made sure resident was safe.Resident seems to be slightly lethargic but responds to his baseline. 11:12 p.m. All disciplines made aware resident sent out to [name of local hospital] trauma unit for evaluation. 11:48 p.m. Writer was informed by resident charge nurse that resident roommate had brought him out of the room by the arms when she noticed bruising to resident's face. Residents separated.Writer observed scratches to resident's forehead with bilateral orbital bruising. A review of R43's visit summary from the local hospital dated 7/31/25 revealed, in part: You were seen today for alleged assault, contusion of face. 2. For Resident #12 (R12), the facility staff failed to protect the resident's right to be free from physical abuse on 9/24/25. On 9/25/25, Resident #12 was punched in the face twice by Resident #32, resulting in five small abrasions on Resident #12's cheek bone. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A review of a facility synopsis of events dated 9/24/25 revealed, in part: [Resident #12] reported to Activities Director that [R32] punched him in the face. [R12] asked the resident to 'come on by and move' so that he could pass through. [R32] stated that he felt he was being 'offended and didn't like it and he swung on him and didn't miss.' Residents were separated upon initial report and [R32] placed on 1:1. [R12] was assessed for further injuries with 5 small abrasions noted around the left cheek bone and left orbital (sic) of the eye. Neurochecks initiated. A review of R12's clinical record failed to reveal any note describing the altercation between R12 and R32. 3. For Resident #37 (R37), the facility staff failed to protect the resident's right to be free from physical abuse on 12/8/25, resulting in harm to R37. On 12/8/25, Resident #37 was punched in the head and face by Resident #32, who had orders for 1:1 supervision. This resulted in Resident #37's injuries requiring a provider's order for treatment. A review of a facility synopsis of events dated 12/8/25 revealed, in part: Staff reported that while in the Dining room [Resident #32] got up and struck [R37] in the face related to saying something to him that he couldn't recall when questioned by staff. Residents separated.First aide (sic) provided to [R37] and [R32] will continue with 1:1 services. A review of R37's clinical record revealed the following progress note dated 12/8/25: Brought to writer's attention that resident was being hit in the head repeatedly by another resident. Residents were separated. Injuries, small cut to right eye and some redness noted. A review of R37's revealed a new order dated 12/8/25 for cleansing of the R37's right eye and the application of triple antibiotic ointment to treat an injury sustained in the altercation with R32. 4. For Resident #40 (R40), the facility staff failed to protect the resident from being physically abused and assaulted by another resident (Resident #26-R26), who was known for having aggressive behaviors and was to have supervision while smoking, which is where/when the incident occurred. R40 sustained injuries which resulted in new physician orders for R40's injuries and orders for the resident to be evaluated at the hospital, which constituted harm. On 10/18/25, Resident #26 and #40 were in the designated smoking area. Both Residents #26 and #40 had been assessed to require supervision while smoking. Resident #26, who was known to have behaviors, pulled Resident #40 to the ground out of his wheelchair and began hitting Resident #40 in the face and head. The provider gave an order for Resident #40 to be transferred to the hospital for evaluation of his injuries. On 12/12/25 during a clinical record review of R26's chart, it was noted that he had an altercation with another resident. According to a nursing progress note dated 10/19/25 it read, Resident remains on 1:1 for physical assault. No behaviors observed or reported. In the week prior there was no documentation regarding details of an assault. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 12/12/25, the facility's director of nursing (DON) was asked to provide any information regarding an incident involving R26 in October. According to a facility incident summary dated 10/18/25, it noted R26 and R40 and read, CAN [sic] (certified nursing assistant) observed resident [name redacted] punch resident [R40's name redacted] in the face. Residents were immediately separated. Non-emergency services called treatment initiated. Resident [name redacted of another resident listed whose name was inaccurately noted in report] placed on 1:1. RP [responsible party], provider and police notified. Skin assessments and pain assessments were conducted for both residents. Resident [R40 name redacted] noted with abrasion to head. Investigation initiated. On 12/12/25, upon receipt of the facility documentation regarding the incident involving R26 and R40, the DON was asked about another resident identified in the incident summary. The DON acknowledged that the wrong resident had been noted in the report, and it should have been R26, who was the aggressor. The DON was asked about the incident and reported that it took place out front and stated it was in front of the facility. The DON could not give any further details about the incident. The facility provided in their documents a statement written by Resident #44 (R44). The statement read, I was sitting smoking when I heard [R26 name redacted] shouting profanity at another resident, next he wheeled over to him, grabbed him in the collar, and pulled him to the ground and proceeded to hit him with both fist about the head and face. I yelled several times for him to stop. He finally stopped after punching him four or five times. At this point the nurse [registered nurse #1- RN #1 name redacted] arrived. On 12/15/25, during a clinical record review of R26's chart it was noted that a Smoking Safety Screen was most recently conducted 8/27/25, prior to the incident. According to that safety screen, R26 was to have supervision while smoking. R26's care plan with a revision date of 10/27/25, read, Physical aggression towards staff/other residents- not easily redirected. interventions included, 1:1 related [sic], assure the resident they are safe if they become distressed, constant redirection with inappropriate behaviors or verbiage, monitor behaviors/concerns, psych referral PRN [as needed], provide medication list to resident and have him sign, psych eval [evaluation], psych services referral as needed, redirect resident to subjects that matter to them when behaviors occur, send out for psych eval. R26's clinical record also noted that the resident smoked cigarettes and had an intervention dated 5/21/25 that read, Supervise with smoking. On 12/15/25, during a clinical record review of R40's chart, a nursing progress note dated 10/18/25 read, EMS/ [emergency medical services] [locality redacted] Fire at facility to transport resident to ED [emergency department] d/t [due to] allegedly being pulled out of chair and hit in head multiple times by another resident. Resident noted with abrasion to top of scalp. Despite education and encouragement, resident refused to be taken to hospital. RP [responsible party] contacted x2 but unsuccessful, unable to leave message as voicemail was full. NP [nurse practitioner] notified, no new orders. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 10/18/25, a change in condition note was entered into R40's chart that noted, . Skin status evaluation: abrasion, pain status evaluation: Does the resident/patient have pain? Yes. R40 also had a new physician order dated 10/18/25 that read, wound care: Cleanse area to top right side of head with wound cleaner. Apply xeroform gauze and cover with band aid. Change daily as needed. According to R40's most recent smoking safety evaluation conducted prior to the incident, on 10/3/25, R40 required supervise with smoking. On 12/12/25 at 10:30 AM, an interview was conducted with R44. When asked about the incident R44 stated that they [multiple residents] were all in the smoking area. R44 identified that resident #41 (R41) and R40 were at a table talking. Resident #26 thought [R40's name redacted] said something to R41, but R40 had not opened his mouth. R26 then went over to R40 cursing at him. Everyone keep saying stop. R44 then stated that R26 grabbed R40 by the collar, pulled him to the ground and started punching him in the face. I rolled up and yelled at [R26's name redacted] to stop it! R44 went on to state that R40 sustained a cut on his head. R44 reported that no staff were present, and another resident came inside the facility to get help and [RN #1's name redacted] came. R44 explained that normally a staff member is present but I think the lady [employee scheduled to supervise smoking] was sick. R44 recalled there were about seven or eight residents in the smoking area but couldn't recall who the other residents were. When asked if R44 had seen R26 with behavior before, R44 said, Constantly. He is always cursing and fighting. When asked if R44 was afraid of R26, the resident said, I'm not, but a lot of people are. On 12/12/25 at 10:45 AM, an attempt was made to interview R41, but the resident was not available. On 12/12/25 at 11:52 AM, an interview was conducted with RN #1. RN #1 reported that the incident occurred a little before 4:30 PM. RN #1 said, One resident said a resident needed help. When I got out there, we got [R40's name redacted] back in the chair and blood was coming from the top of the scalp. They said [R26's name redacted] pulled him out of the chair and was hitting him. They were in the smoking area [enclosed courtyard] at the table and chairs designated for smokers. We brought [R40's name redacted] inside, cleaned the wound and called the nursing supervisor. When asked about R26's behaviors, RN #1 reported, he has a TBI [traumatic brain injury] and starts yelling and getting angry over nothing. RN #1 went on to report that the doctor wanted to send R40 to the hospital, but the resident refused. 5. For Resident #39 (R39), the facility staff failed to protect the resident's right to be free from physical abuse on 10/5/25. On 11/12/25, Resident #41 was punched in the chest by R7, who had a history of requiring additional supervision related to her behaviors A review of a facility synopsis of events dated 10/5/25 revealed, in part: [Resident #39] was trying to go into Family Parlor while [R7] was sitting in the entrance. When trying to pass by[R7] struck [R39] in the chest. Staff was informed of incident.Staff immediately separated both residents. [R7] was placed on 1:1. A review of R39's clinical record revealed the following progress note dated 10/5/25: Resident informed this nurse that another resident hit her with a closed fist in her chest for no apparent reason as she was attempting to wheel herself into the family pallor (sic) room. The other resident was positioned at the entrance of the family pallor (sic) room sitting in her wheelchair.Residents immediately separated for safety, aggressor placed on 1:1. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	6. For Resident #41 (R41), the facility staff failed to protect the resident's right to be free from abuse on 11/12/25. A review of a facility synopsis of events dated 11/12/25 revealed, in part: [Resident #41] was sitting in her wheelchair being assisted down the hall by another resident going outside to courtyard when they came up to the double doors near the nurses desk.[R7] was blocking the hall, they asked her [to] 'please move.' She responded with 'No your mama.' [R41] asked her to repeat, 'what did you say, I can't hear you,' and [R7] fanned her hand toward [R41's] face and [R41] started yelling, 'She hit me right in the mouth.' LPN (licensed practical nurse) intervened and separated residents. [R7] placed on 1:1, skin, pain, and trauma assessment completed on residents with no abnormalities. A review of R41's clinical record revealed the following progress note dated 11/12/25: Resident was sitting in her wheelchair being assisted down the hall by another resident going outside to courtyard when they came up to the double doors near the nurses' desk.[Resident #7] was blocking the hall, they asked [R7] to please move and she responded with, 'No your [NAME].' [R39] asked her to repeat.and [R7] swung her hand near the face of [R39], and [R39] started yelling [R7] had hit her in the mouth. A review of R38's clinical record revealed the following progress note dated 10/13/25: [Resident #7] entered R38's room and was asked to leave several times. [R38] then adamantly told [R7] to leave room. [R7] then struck [R38] on her lower left back side. Residents separated. On 12/10/25 at 2:48 p.m., ASM (administrative staff member) #2, the director of nursing, was interviewed. She stated that physical abuse is when one resident intentionally hurts another resident. She added that abuse is one person doing something with the intent to harm another resident. She explained that it is the facility's responsibility to protect residents from abuse of any kind, whether from another resident, staff member, or visitor. On 12/16/25 at 10:16 a.m., OSM (other staff member) #5, the social services assistant, was interviewed. She stated that physical abuse is defined as someone hitting someone else or doing something that affects another person in a negative physical way. She added that all facility staff are responsible for protecting all residents from abuse. On 12/16/25 at 1:26 p.m., LPN (licensed practical nurse) #3, a unit manager was interviewed. She stated physical abuse is when someone hits, strikes, wounds, or injures a resident in an intentional manner. She stated that the facility staff is responsible for preventing any kind of abuse for all residents. On 12/17/25 at 10:02 a.m., OSM #8, the social services director, was interviewed. She stated that all residents should be free of physical abuse. She explained that any resident to resident altercation that resulted in one resident striking, hitting, injuring, or wounding another resident is considered physical abuse. On 12/10/25 at 2:48 p.m., ASM (administrative staff member) #2, the director of nursing, was interviewed. She stated that physical abuse is when one resident intentionally hurts another resident. She added that abuse is one person doing something with the intent to harm another resident. She explained that it is the facility's responsibility to protect residents from abuse of any kind, whether from another resident, staff member, or visitor. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 12/16/25 at 10:16 a.m., OSM (other staff member) #5, the social services assistant, was interviewed. She stated that physical abuse is defined as someone hitting someone else or doing something that affects another person in a negative physical way. She added that all facility staff are responsible for protecting all residents from abuse. On 12/16/25 at 1:26 p.m., LPN (licensed practical nurse) #3, a unit manager was interviewed. She stated physical abuse is when someone hits, strikes, wounds, or injures a resident in an intentional manner. She stated that the facility staff is responsible for preventing any kind of abuse for all residents. On 12/17/25 at 10:02 a.m., OSM #8, the social services director, was interviewed. She stated that all residents should be free of physical abuse. She explained that any resident to resident altercation that resulted in one resident striking, hitting, injuring, or wounding another resident is considered physical abuse. A review of the facility policy, Patient Protection, revealed, in part: There is zero tolerance for mistreatment, abuse, neglect, misappropriation of property, or any crime against a patient of the Health and Rehabilitation Center.Patients of the Center have the legal right to be free from verbal, sexual, mental, and physical abuse. The facility's deficient practice placed all facility residents at risk of being abused. This resulted in a determination of Immediate Jeopardy (IJ), cited at level four widespread. On 12/15/25 at 3:45 p.m., ASM #2 and ASM #3, the regional director of clinical services, were informed of these concerns and that the facility was in immediate jeopardy (IJ). On 12/15/25 at 8:00 p.m., the facility's IJ Removal Plan was accepted by the SA (state agency) supervisor. Facility Removal Plan Immediate Supervision. Resident #32, # 7, #26 is now under 1:1 supervision 24/7 being close proximities of resident to ensure that staff member can deescalate or intervene with any possible altercationsResident #40 will not be allowed to smoke unsupervised. Resident #26 will not be allowed to smoke unsupervised.A dedicated staff member has been assigned to always monitor residents 40 and #26 during smoking breaks. The dedicated staff member has been established to the designated smoking area within a secure part of the facility grounds.Resident #37, #41, and #39 will have trauma screens performed on all resident that were abused by other residents. Resident #12 and #43 no longer resides in facility Corrective Actions taken for residents with potential to be affected by deficient practice (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	All residents have the potential to be affected by this deficient practice. The Facility will educate all staff on the abuse policy. The DON or designee will educate on abuse and 1:1 ensuring that staff doing 1:1 being close proximities of resident to ensure that staff member is able to de-escalate or intervene with any possible altercations and will provide privacy while performing bodily functions outside of the door. The DON or designee will conduct an audit of those residents currently on 1:1 to ensure the person assigned is monitoring the patient. Nursing staff on all shifts will document any unusual, increased, or change in behaviors will be reported and documented in the medical records. Then during clinical review will determine residents at risk for aggressive behaviors and appropriate interventions will be put in place.All residents that require supervised smoking have the potential to be affected by this deficient practice. Patients who wish to smoke will be evaluated using the Smoking Safety Screen Assessment upon admission and as needed to determine a need for supervision. Current residents that smoke will be reassessed using the Smoking Safety Screen Assessment to determine if supervision is required. The facility will schedule staff member to be in the courtyard while smoking occurs Systemic changes put into place to ensure the deficient practice does not reoccur:The Interdisciplinary Team(Director of Nursing, Assistant Director of Nursing, Social Services, Activities Director, Dietary Manager, Business Office Manager, Maintenance, Human Resources, and Unit Managers) will be educated by the Regional Director of Clinical Services on the policy and procedures to identify abuse. IDT will be educated on what a 1:1 entails which will includes maintaining arms length while inside and outside of the room. Nursing staff on all shifts will document any unusual, increased , or change in behaviors will be reported and documented in the medical records. Anyone providing 1:1 care will be scheduled by staffing that will have their relief person for break noted on schedule. Resident on 1:1 will be documented on daily by assigned staff that will be collected daily by charge nurse. Staff will be educated that you may not leave the resident until you have a relief person, you have to remain in close proximities of resident to ensure that staff member is able to deescalate or intervene with any possible altercations while on one to one inside and outside of room. The Regional Director of Clinical Services will also educate the IDT team on the need for supervision for residents identified as supervision while smoking on ensuring all residents requiring supervision are supervised while smoking. The DON or designee will create a schedule for supervision of residents that smoke and ensure they are in the smoking courtyard while residents requiring supervision are present. This education will be provided to all staff, and no employee will be allowed to work after 11:59 pm until they are educated to include agency staff. Monitoring for corrective actions to ensure deficient practice does not recur:While the resident remains in the facility, a monthly review of resident #32, #7, #26 care plan will be conducted to assess the effectiveness of the interventions and make adjustments .The DON or designee will audit residents with 1:1 supervision to ensure staff is remaining in close proximities of resident to ensure that staff member is able to deescalate or intervene with any possible altercations. five times a week times 4 weeks then 3 times a week times 4 weeks. Facility will monitor all residents who have been identified as supervised smokers. All supervised smokers will smoke in the designated smoking area that has been established within a secure part of the facility grounds. If supervision is deemed necessary, the resident will be supervised by a designated staff. The DON or designee will audit residents who are supervised smokers five times a weeks for 4 weeks then 3 times a week times 4 weeks to ensure they are supervised while smoking. The facility alleges removal of the Immediate Jeopardy on 12/16/25 at 1900 (7:00 p.m.). (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 12/17/25 at 9:08 a.m., the survey team began verification of the facility's removal plan. This verification process included observation of residents on 1:1 supervision, observation of residents in the smoking area, staff interviews on all elements of the plan, and review of all smoking safety assessments and trauma screens completed as part of the abatement plan. The survey team was able to verify that the facility completed the abatement plan on 12/16/25 at 10:22 p.m. After Immediate Jeopardy was removed, the scope and severity were lowered to level three pattern. 7. For Resident #48 (R48), the facility staff failed to protect the resident's right to be free from physical abuse by another resident (Resident #26- R26). On 12/15/25-12/16/25, during a clinical record review of R26's chart, it was noted that on 10/18/25, R26 assaulted another resident and was placed on one-to-one observations. There was almost daily entries in R26's progress notes of behaviors from 10/18/25-10/25/25. According to a nursing note entry dated 10/25/25 at 1 AM, which read, Writer was called to the unit by the charge nurse to assess Resident [R26's name redacted] who hit another resident also threaten and accuse the charge nurse of not given him his medication and loud verbalization causing peers to be alarmed/frighten. Resident was not able to be deescalated for some time frame for at least 30 to 45 minutes so 911, DON [director of nursing] and Provider was called. 911 team responded, felt that he should go to the hospital because if he was to have a repeat episode other resident or staff may be harmed since he could not be restrained. Resident [R26's name redacted] R/P (responsible party) was called no answer message left for her to call the facility Resident was sent out to hospital to be evaluated since this was the second incident within last 12 hours Resident [R26's name redacted] have a DX. [diagnosis] TTAUMATIC [sic] brain injury which could be worsening [sic]. There was an additional progress note in R26's chart dated 10/25/25 at 1 AM, that read, Nurses was checking in the room since he is a 1 on 1 on the other patient and the resident stated he never got his medication. Both nurses informed him that he did in fact receive his medication and that he cannot get any more at the time. The resident then stated that he would know if he got his medication and that we were liars. Nurses attempted to deescalate the situation, and he got even more agitated. Resident got up and cursed out the nurse and stated he was going to kill her if he got his hands on her. He then chased her around the facility and punch another resident in the face in the process. Non-pharmacological Intervention: Staffed reassured him that he got his medication and attempted to deescalate the situation. Outcome: Resident has been sent to hospital for reevaluation. According to R26's physician orders, there was an order for Resident on 1:1 supervision initiated on 10/18/25 which was discontinued on 10/25/25 at 12:16 PM, following the resident being sent to the hospital for evaluation. Another progress note entry dated 10/25/25, indicated that the facility staff had spoken to hospital staff who were . looking for a BHU (behavioral health unit) bed for the resident. According to progress notes, the census tab, and physician orders, R26 returned to the facility on [DATE], at which time the one-to-one observation resumed. (continued on next page)

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Parham Health Care & Rehab Center	2400 E Parham Road Richmond, VA 23228

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	According to a progress note in R26's chart dated 10/28/25 at 11:01 PM, it read, Writer was at nurses station talking with resident [Resident #48's room number redacted] who was in front of nurse station near soiled utility room. As we where [sic] talking this resident [R26] could be heard coming down the main hallway (connecting all units)yelling out and cursing. Writer immediately came from behind nurses station due to [Resident #48's room number redacted] also going around nurses station to see who was yelling. When writer observed that it was this resident [R26] I stepped in between both parties as this resident was attempting to lunge toward resident [Resident #48's room number redacted] and fell onto his buttocks out the w/c [wheel chair] in front ice machine room. Resident was yelling I didn't forget you stupid mother fucker, you wanna pick on somebody in a w/c, I'll kill you I have killed all the people that needed to be killed, You bitch ass ni**** come on I'm ready to die, come on mother ***** hit me what you go do I'm a cripple but I still will beat you're a$$. Resident continued with behaviors and threats. Other staff members ran to assist resident in calming down and to assist resident back in w/c after assessing that he did not have any injuries and writer continued to stay in between both residents. Resident in [Resident #48's room number redacted] kept telling resident to leave him alone, this not what you want I'm telling you. informed him not to say any thing d/t [due to] it further increased this resident's agitation. This resident was removed from the unit and taken back to his unit, had calmed down shortly after redirection and change of subject. Stated he was tired and wanted to go to bed. His nurse and supervisor made aware of incident and that no physical contact was made between resident's. On 12/16/25, the director of nursing (DON) was asked to provide any information she had regarding R26's incident with another resident on 10/25/25, to identify who the other resident was. On 12/16/25, the DON provided the surveyor with an incident summary that identified Resident #48. The facility's incident summary noted, Staff reported that resident [R26's name redacted] was arguing with staff and when resident [R48's name redacted] walked out the room to see what was going on resident [R26's name redacted] punched him [R48] in the face. Residents separated. On 12/16/25, a clinical record review of R48's chart was performed. A nursing note entry dated 10/25/25 read, Resident was standing in the hall while another resident was being aggressive and got struck in the face. There was another progress note in R48's chart dated 10/28/25 at 21:15 that read, Writer prevented resident from altercation with another resident: As resident was talking with writer at nurses station resident room [Resident #26's room number redacted] came down hallway yelling and cursing. Writer stepped in between residents as [Resident #26's room number redacted] lunged at this resident. [Resident #26's room number redacted] fell onto floor out of w/c [wheelchair] because of this action. This resident kept telling [Resident #26's room number redacted] to go ahead and leave him alone, this is not what he want. Writer informed resident that it was best if he did not say anything d/t [due to] increased agitation of [Resident #26's room number redacted]. Residents was kept separated and resident [Resident #26's room number redacted] was removed from the unit no physical contact between residents was made. Supervisor made aware of incident. Resident is own RP [responsible party]. 8. For Resident #38 (R38), the facility staff failed to protect the resident's right to be free from physical abuse on 10/13/25. A review of a facility synopsis of events dated 10/13/25 revealed, in part: [R7] was noted sitting in the doorway of [Resident #38's] door. When [R38] attempted to move her wheelchair, she was swatted at her (sic) leg striking her leg wi

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. (continued on next page)

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident and staff interviews, clinical record review, and facility documentation review, the facility staff failed to implement their abuse policy for reporting and conducting a thorough investigation for five residents (Resident #33, 48, 40, 26, and 33) in a survey sample of forty-eight residents. The findings included:1. For Resident #26 (R26) and Resident #48 (R48), the facility staff failed to implement their abuse policy regarding the timing of reporting incidents of abuse. On 12/12/25 during a clinical record review of R26's chart, it was noted that he had a physical altercation with another resident. According to a nursing note entry dated 10/25/25 at 1 AM, which read, Writer was called to the unit by the charge nurse to assess Resident [R26's name redacted] who hit another resident also threaten and accuse the charge nurse of not given him his medication and loud verbalization causing peers to be alarmed/frighten. Resident was not able to be deescalated for some time frame for at least 30 to 45 minutes so 911, DON [director of nursing] and Provider was called. 911 team responded, felt that he should go to the hospital because if he was to have a repeat episode other resident or staff may be harmed since he could not be restrained. Resident [R26's name redacted] R/P (responsible party) was called no answer message left for her to call the facility Resident was sent out to hospital to be evaluated since this was the second incident within last 12 hours Resident [R26's name redacted] have a DX. [diagnosis] TTAUMATIC [sic] brain injury which could be worsening [sic]. According to hospital records within R26's chart it noted that R26 admit date and time to the hospital was 10/25/25 at 1:57 AM. According to the fax confirmation sheets for the incident summary, it indicated the report was not sent to the state survey agency, adult protective services, or the ombudsman until 9:13 AM on 10/25/25, which was outside of the 2-hour reporting requirement for allegations of abuse. On 12/17/25 at 2:09 PM, an interview was conducted with the facility's director of nursing. The facility administrator was not present during the survey and was not available for interview. The DON confirmed that the facility administrator is the abuse coordinator but in her absence the DON serves in that capacity. When asked about the process when an allegation is made the DON explained that they report all allegations to the state survey agency, adult protective services and the ombudsman within 24 hours of the allegation. The facility policy titled, Patient Protection with an effective date of 10/17/23, was received and reviewed. The policy read in part, . 3. All employees are responsible for immediately (no later than two hours after the allegation is made if the incident involves abuse or bodily injury, no later than 24 hours if the incident does not involve abuse or bodily injury) reporting to the Administrator, or in their absence, the Director of Nursing, or their immediate supervisor any and all suspected or witnessed incidents of patient abuse, neglect, theft, exploitation and/or mistreatment of a patient as well as any reasonable suspicion of a crime against a patient. 4. Any and all suspected or witnessed incidents of patient/ patient abuse, neglect, theft, and/or exploitation or any reasonable suspicion of a crime against a patient/patient Center brought to the attention of the Center's administration will result in internal investigation, appropriate and timely reporting to the state survey agency (SSA) and other legally designated agencies, as well as staff corrective action, suspension, and/or termination as necessary . According to the facility policy titled, Reporting Requirements/Investigations with an effective date of 2/5/23, it read in part, . 1. Immediately upon notification of any alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, the administrator will immediately report to the state agency, but not later than 2 hours after the allegation is made, if the events that caused the allegation involves abuse or results in serious bodily injury, or not later than 24 hours if the events that caused the allegation do not involve abuse and do not result in serious bodily injury. A. Notify the adult protective services agency, the local Ombudsman, and the appropriate law enforcement authorities, for any incident of patient abuse, mistreatment, neglect or misappropriation of personal property or other reasonable suspicion of a crime. On 12/17/25, the above findings were reviewed with the DON and regional director of clinical services. No additional information was provided. 2. For Resident #40, who was assaulted by Resident #26, the facility staff failed to implement their abuse policy with regard to conducting a thorough investigation. On 12/12/25, during a clinical record review of R26's chart, it was noted in the nursing progress notes that R26 was on one-to-one observation due to a physical assault incident toward another resident. No details of the incident were noted. On 12/12/25, the surveyor asked the facility staff to provide any documentation they had regarding an incident in October 2025, involving R26. The director of nursing (DON) provided the survey

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on resident interviews, staff interviews, clinical record review, and facility documentation review, the facility staff failed to report an allegation of misappropriation to the required agencies in a timely manner involving three residents (Resident #33- R33, Resident #26-R26, and Resident #48-R48), in a survey sample of forty-eight residents. The findings included:1. For Resident #33 (R33), who reported an allegation of misappropriation of property, the facility staff failed to report the allegation to the state survey agency and adult protective services until four days later. On 12/15/25, during a clinical record review, it was noted that R33 had reported missing money. According to a nursing note entry dated 11/20/25, it read, Writer and another nurse went to resident's room to look for his money that he claims is missing. Upon entering resident's room, several other staff members were present with resident. Permission requested and granted to look through resident's nightstand to see if by chance he misplaced it in the drawer.Continued search showed no money found. On 12/15/25, the DON was asked to provide the survey team with any information she had regarding R33's report of missing money. On 12/15/25, the DON provided the survey team with what she stated was the investigation file for R33's report of missing money. According to the incident summary dated 11/20/25, it noted, Resident reported to writer that someone stole his 150 dollars from his bedside drawer that he last seen in September. Writer stated it was in his old bedside drawer in his room. Investigation initiated. The fax confirmation noted that the allegation was not reported to the state survey agency, adult protective services, or the ombudsman until 11/24/25 at 9:54 PM. On 12/16/25 at approximately 11 AM, an interview was conducted with R33. R33 reported that he was in a room on a different unit and was told they were going to re-model the room, so he was moved to his current room. He reported that in the chest of drawers he had cash totaling $150-$200. R33 reported he had a visitor who is like a brother that comes to see him and when he looked in the drawer, he is the one that noticed the money was gone. The resident reported he was moved in September and had not seen the money since then. R33 reported frustration with trusting these people with the move. 2. For resident #26 (R26) and Resident #48 (R48), who had an incident of physical abuse, the facility staff failed to report the incident within the two-hour time frame. On 12/12/25 during a clinical record review of R26's chart, it was noted that he had an altercation with another resident. According to a nursing note entry dated 10/25/25 at 1 AM, which read, Writer was called to the unit by the charge nurse to assess Resident [R26's name redacted] who hit another resident also threaten and accuse the charge nurse of not given him his medication and loud verbalization causing peers to be alarmed/frighten. Resident was not able to be deescalated for some time frame for at least 30 to 45 minutes so 911, DON [director of nursing] and Provider was called. 911 team responded, felt that he should go to the hospital because if he was to have a repeat episode other resident or staff may be harmed since he could not be restrained. Resident [R26's name redacted] R/P (responsible party) was called no answer message left for her to call the facility Resident was sent out to hospital to be evaluated since this was the second incident within last 12 hours Resident [R26's name redacted] have a DX. [diagnosis] TTAUMATIC [sic] brain injury which could be worsening [sic]. According to hospital records within R26's chart it noted that R26 admit date and time to the hospital was 10/25/25 at 1:57 AM. According to the facility submitted investigation file, the incident summary was not sent to the state survey agency, adult protective services, or the ombudsman until 9:13 AM on 10/25/25, which was outside of the 2-hour reporting requirement for allegations of abuse. On 12/17/25 at 2:09 PM, an interview was conducted with the facility's director of nursing. The facility administrator was not present during the survey and was not available for interview. The DON confirmed that the facility administrator is the abuse coordinator but in her absence the DON serves in that capacity. When asked about the process when an allegation is made the DON explained that they report all allegations to the state survey agency, adult protective services and the ombudsman within 24 hours of the allegation. The facility policy titled, Patient Protection with an effective date of 10/17/23, was received and reviewed. The policy read in part, . 3. All employees are responsible for immediately (no later than two hours after the allegation is made if the incident involves abuse or bodily injury, no later than 24 hours if the incident does not involve abuse or bodily injury) reporting to the Administrator, or in their absence, the Director of Nursing, or their immediate supervisor any and all suspected or witnessed incidents of patient abuse, neglect, theft, exploitation and/or mistreatment of a patient as well as any reasonable suspicion of a crime against a patient. 4. Any and all suspected or witnessed incidents of patient/ patient abuse, neglect, theft, and/or exploitation or any reasonable suspicion

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. (continued on next page)

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F 0610 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 interviews, staff interviews, clinical record review, and facility documentation review, the facility staff failed to conduct a thorough investigation into allegations of abuse and misappropriation involving four residents (Resident #26- R26, Resident #40- R40, Resident #48- R48, and Resident #33- R33), in a survey sample of forty-eight residents. The findings included:1. For an incident of physical assault by Resident #26 (R26) toward Resident #40 (R40), who sustained injury, the facility staff failed to conduct a thorough investigation of the incident. On 12/12/25, during a clinical record review of R26's chart, it was noted in the nursing progress notes that R26 was on one-to-one observation due to a physical assault incident toward another resident. No details of the incident were noted. On 12/12/25, the surveyor asked the facility staff to provide any documentation they had regarding an incident in October 2025, involving R26. The director of nursing (DON) provided the survey team with a file that she indicated was the entire investigation. Included was a facility incident summary, facility synopsis, fax confirmations, one witness statement from another resident (resident #44), and excerpts of the clinical record of R26 and R40. According to the incident summary, the incident was witnessed by a certified nursing assistant, but the investigation file did not indicate who the staff member was, nor did it include a statement from any witnesses other than resident #44 (R44). The written statement from R44 read, I was sitting smoking when I heard [R26 name redacted] shouting profanity at another resident, next he wheeled over to him, grabbed him in the collar, and pulled him to the ground and proceeded to hit him with both fist about the head and face. I yelled several times for him to stop. He finally stopped after punching him four or five times. At this point the nurse [registered nurse #1-RN #1 name redacted] arrived. On 12/12/25 at 10:30 AM, an interview was conducted with R44. When asked about the incident R44 stated that they [multiple residents] were all in the smoking area. R44 identified that resident #41 (R41) and R40 were at a table talking. Resident #26 thought [R40's name redacted] said something to R41, but R40 had not opened his mouth. R26 then went over to R40 cursing at him. Everyone keep saying stop. R44 then stated that R26 grabbed R40 by the collar, pulled him to the ground and started punching him in the face. I rolled up and yelled at [R26's name redacted] to stop it! R44 went on to state that R40 sustained a cut on his head. R44 reported that no staff were present, and another resident came inside the facility to get help and [RN #1's name redacted] came. R44 explained that normally a staff member is present but I think the lady [employee scheduled to supervise smoking] was sick. R44 recalled there were about seven or eight residents in the smoking area but couldn't recall who the other residents were. When asked if R44 had seen R26 with behavior before, R44 said, Constantly. He is always cursing and fighting. When asked if R44 was afraid of R26, the resident said, I'm not, but a lot of people are. On 12/12/25 at 10:45 AM, an attempt was made to interview R41, but the resident was not available. On 12/12/25 at 11:52 AM, an interview was conducted with RN #1. RN #1 reported that the incident occurred a little before 4:30 PM. RN #1 said, One resident said a resident needed help. When I got out there, we got [R40's name redacted] back in the chair and blood was coming from the top of the scalp. They said [R26's name redacted] pulled him out of the chair and was hitting him. They were in the smoking area [enclosed courtyard] at the table and chairs designated for smokers. We brought [R40's name redacted] inside, cleaned the wound and called the nursing supervisor. When asked about R26's behaviors, RN #1 reported, he has a TBI [traumatic brain injury] and starts yelling and getting angry over nothing. RN #1 went on to report that the doctor wanted to send R40 to the hospital, but the resident refused. When asked if a staff member was present or witnessed the incident, RN #1 reported it was not a staff member present and that another resident had come to get him to state that help was needed. On 12/16/25 at 12:40 PM, an interview was conducted with R40. When asked about incident in smoking courtyard where another resident hit him, he said, I don't remember anything about it. 2. For Resident #48 (R48), who was the subject of a physical assault by Resident #26 (R26), the facility staff failed to conduct a complete and thorough investigation. On 12/15/25-12/16/25, during a clinical record review of R26's chart, it was noted that on 10/18/25, R26 assaulted another resident and was placed on one-to-one observations. According to a nursing note entry dated 10/25/25 at 1 AM, which read, Writer was called to the unit by the charge nurse to assess Resident [R26's name redacted] who hit another resident also threaten and accuse the charge nurse of not given him his medication and loud verbalization causing peers to be alarmed/frighten. Resident was not able to be deescalated for some time frame for at least 30 to 45 minutes so 911, DON [director of nursing] and Provider was called, 911 team

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident and staff interviews, clinical record review, and facility documentation review, the facility staff failed to develop a comprehensive person-centered care plan for one (1) resident (Resident #27) in a survey sample of 48 residents.The findings included: For Resident #27, the facility staff failed to develop a comprehensive person-centered care plan to address his multiple food and drug allergies.Resident #27 was admitted to the facility on [DATE] with diagnoses to include but not limited to chest pain, muscle weakness, syncope and collapse, atrial septal defect, ventricular septal defect, coarctation of aorta, calculus of kidney, hypertension, anxiety, iron deficiency anemia, hydronephrosis with renal and ureteral calculous, obstruction, morbid obesity, asthma, mast cell activation, type 2 diabetes mellitus, post-traumatic stress disorder. Resident #27's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 9/14/25 coded the resident as having a BIMS (Brief Interview of Mental Status) score of 15 out of a possible 15 indicating no cognitive impairment. Section GG coded the resident as being independent in turning and repositioning, lying to sitting, sitting to standing, chair/bed to chair transfer, and toileting. He uses a rollator for ambulation.On 12/9/25 at 2:55 PM, an interview was conducted with Resident #27, and according to him, he has numerous food and drug allergies, including fish and seafood products. He said, it was one day last week (he could not remember that exact day, maybe it was Wednesday or Thursday but maybe Friday) he had a bad reaction and they, the nurse I mean, had to give me an EpiPen (a pocket-sized spring-loaded syringe with a pre-measured dose of epinephrine for the emergency treatment of a severe allergic reaction) and lots of Benadryl cause I was real bad off. My lips were swelling and turning red and my mouth felt funny. According to Resident #27, he had gone to the dining room for lunch and was served fish at which time he reminded the kitchen staff that he was allergic to fish so they took his plate back, removed the fish but did not give him a clean new plate so the fish oil was still on the plate and he thinks that is what caused his reaction. On 12/10/25 at 9:40 AM, an interview was conducted with the Unit Manager LPN #4 and according to her she was aware of the event as LPN#1 had notified her. She said she was told by the nurse that he said his mouth was swelling and felt funny, but she had assessed him, and he appeared fine. She said he presented with no swelling of his lips, no redness and was talking just fine but LPN#1 said she notified the nurse practitioner due to his multiple allergies, and he was complaining of not feeling just right. Per the Unit Manager LPN#4, she said LPN#! told her the nurse practitioner gave a (1) one time order for Benadryl by mouth. The Unit Manager LPN#4 was asked to provide a copy of the physician's order for Benadryl and a copy of the nurses' assessment. After reviewing Resident #27's electronic medical record she replied, She (LPN#1) did not write a note, and I can't find the order or where she gave it. She should have written an order, she should have documented her assessment and that she notified the nurse practitioner in the progress notes and recorded that she gave the Benadryl on the MARs (Medication Administration Record). When asked how did staff know if a resident had any allergies, the Unit Manager LPN#4 replied, allergies are listed on the resident's meal ticket for dietary staff and for the C.N.A's (Certified Nursing Assistants) to see and is under tasks for the C.N.A's to see and on the MARs (Medication Administration Record) and dashboard for the nurses and other staff to see. When asked if allergies are noted in the resident's care plan she responded, Yes, I believe they are. After reviewing Resident #27's care plan she said he did not have a care plan to address his allergies.On 12/10/25 at 10:15 AM an interview was conducted with the (NP) Nurse Practitioner (OTHER #3). Per the NP (OTHER #3), she said, Yes, I remember the nurse notified me, and I gave her a one-time order to give him Benadryl 25 mg. The nurse said she saw no visual signs of distress, but he was very anxious, and so, out of caution, I gave an order for one dose of Benadryl 25 mg by mouth. He has a long list of allergies. I have been here since the event last week and have seen him in the hallway, and he appears fine.A review of Resident #27's clinical record revealed he has multiple drug and food allergies including: fish and seafood, beets, berries, cinnamon, honey, nutmeg oil, onions, raspberry, azithromycin, benzonatate, cephalexin, ciprofloxacin, clindamycin, cyclobenzaprine, doxycycline, erythromycin, fluticasone, ketorolac, levofloxacin, lidocaine, linezolid, lisinopril, oxycodone, phenazopyridine, prednisone, tamsulosin, tramadol, vancomycin, iodinated contrast media, NSAIDs, penicillins, sulfa antibiotics, rebus fruticose leaf extract, bee venom, latex, wasp venom, vaccinium angustifolium.A review of the clinical record did not show any evidence of a care plan to address his multiple food and drug allergies, no physician orders or evidence of the administration of Benadryl or EpiPen, and no evidence of an

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. (continued on next page)

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on staff interview, facility document review, and clinical record review, the facility staff failed to review and/or revise the care plan for two (2) of 48 residents in the survey sample, Residents #32 and #7. The findings include:1. For Resident #32 (R32), the facility staff failed to review the effectiveness of care plan interventions after a resident to resident altercation on 9/25/25.A review of a facility synopsis of events dated 9/24/25 revealed, in part: [Resident #12] reported to Activities Director that [R32] punched him in the face. [R12] asked the resident to 'come on by and move' so that he could pass through. [R32] stated that he felt he was being 'offended and didn't like it and he swung on him and didn't miss.' Residents were separated upon initial report and [R32] placed on 1:1. [R12] was assessed for further injuries with 5 small abrasions noted around the left cheek bone and left orbital (sic) of the eye. Neurochecks initiated.Further review of R32's clinical record revealed the following progress note dated 9/25/25: Per nurse aide ran to nursing station to report that resident had punched another resident [Resident #12] in the face twice. Residents were separated and assessed for injuries. [R32] was questioned regarding the reason for the incident and what upset him to cause him to hit the other resident.[R32] was placed on 1:1 supervision. There was no evidence in the record that R12 required a provider's assessment or new orders immediately following this altercation. A review of R32's care plan initiated 3/14/23 revealed, in part: [R32] has behaviors r/t (related to) TBI (traumatic brain injury) with cognition impairment, restlessness, agitation, mood d/o (disorder), physical aggression with a peer.verbal and physical aggression towards staff/other residents. This review failed to reveal any evidence that the interventions to address R32's behaviors were reviewed for effectiveness and/or revised following the resident-to-resident altercation on 9/25/25.On 12/16/25 at 10:37 a.m., LPN (licensed practical nurse) #9 was interviewed. She stated that the purpose of a care plan is to direct staff and tell them what a resident needs. She stated that all the resident's needs mentioned on the care plan should be addressed. She explained that a resident's care plan interventions should be reviewed and updated if the resident experiences a physical altercation with another resident. She stated that these updates help provide for the safety of all the residents in the facility.On 12/17/25 at 11:30 a.m., LPN #4, a unit manager, was interviewed. She stated if a resident is involved in an altercation with another resident, the resident's care plan should be reviewed to see which interventions are working and which ones are not. She explained that the care plan gives staff members the basic information needed to meet the resident's needs. She stated that staff members have to read the care plan to find out things about the residents and the best way to approach the residents in certain situations.On 12/16/25 at 3:52 p.m., ASM #2 and ASM #3, the regional director of clinical services, were informed of these concerns. A review of the facility policy, Care Planning, revealed, in part: A licensed nurse, in coordination with the interdisciplinary team, develops and implements an individualized care plan for each patient in order to provide effective, person-centered care, and the necessary health-related care and services to attain or maintain the highest practical physical, mental, and psychosocial well-being of the patient.Care plans will be updated on an ongoing basis as changes in the patient occur, and reviewed quarterly with the quarterly assessment.No additional information was provided prior to exit.2. For Resident #7 (R7), the facility staff failed to review the effectiveness of care plan interventions after a resident-to-resident altercation on 10/5/25.A review of a facility synopsis of events dated 10/5/25 revealed, in part: [Resident #39] was trying to go into Family Parlor while [R7] was sitting in the entrance. When trying to pass by, [R7] struck [R39] in the chest. Staff was informed of incident.Staff immediately separated both residents. [R7] was placed on 1:1.A review of R7's clinical record revealed the following progress note dated 10/5/25: Resident who received physical aggression informed this nurse that this resident hit her with a closed fist in her chest for no apparent reason as she was attempting to wheel herself into the family pallor (sic) room. This resident was positioned at the entrance of the family pallor (sic) room sitting in her wheelchair. Two residents were present at the time of the incident. Residents immediately separated for safety, aggressor placed on 1:1.A review of R7's care plan initiated 11/9/23 revealed, in part: The resident has behaviors related to dementia, hoards, aggressive hitting other residents.physically aggressive toward others.striking out at residents. R7's care plan revealed no evidence of review or revision of current interventions following the altercation on 10/5/25 with R39.On 12/16 25 at 10:37 a.m., LPN (licensed practical nurse) #9 was interviewed. She stated the purpose of a care plan is to direct and tell the staff what a resident needs. She stated that all the resident's needs mentioned on the care plan should be addressed. She explained that a resident's care plan interventions should be reviewed and updated if the

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident and staff interviews, clinical record review and facility documentation review, the facility staff failed to ensure resident care and services were provided in accordance with accepted standards of care for five of 48 residents in the survey sample, (Residents #27, # 21, 32, 12, and #24)The findings included:1. For Resident #27, the facility staff failed to transcribe a physician's order for Benadryl and failed to document assessment of his allergic reaction from the fish served to him at lunch on 12/3/25. Resident #27 was admitted to the facility on [DATE] with diagnoses to include but not limited to hypertension, anxiety, iron deficiency anemia, asthma, type 2 diabetes mellitus and post-traumatic stress disorder. Resident #27's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 9/14/25 coded the resident as having a BIMS (Brief Interview of Mental Status) score of 15 out of a possible 15 indicating no cognitive impairment. On 12/9/25 at 2:55 PM, an interview was conducted with Resident #27 who stated that he had numerous food and drug allergies including fish and seafood products and had an allergic reaction the previous week He said, it was one day last week (he could not remember that exact day, maybe it was Wednesday or Thursday but maybe Friday) I had a bad reaction and they, the nurse I mean, had to give me an EpiPen (a pocket-sized spring-loaded syringe with a pre-measured dose of epinephrine for the emergency treatment of a severe allergic reaction) and lots of Benadryl cause I was real bad off. My lips were swelling and turning red and my mouth felt funny. According to Resident #27, he had gone to the dining room for lunch and was served fish at which time he reminded the kitchen staff that he was allergic to fish so they took his plate back, removed the fish but did not give him a clean plate so the fish oil was still on the plate and he thinks that is what caused his reaction. On 12/10/25 at 9:40 AM, an interview was conducted with the Unit Manager (Licensed Practical Nurse#4) and according to her she was aware of the event as LPN#1 had informed her of the event. She said she was told by LPN#1 that he said his mouth was swelling and felt funny, but she had assessed him, and he appeared fine. She said he presented with no swelling of his lips, no redness and was talking just fine but the nurse notified the Nurse Practitioner (Other #3) due to his multiple allergies, and he was complaining of not feeling just right. Per the Unit Manager LPN#4, she said that LPN#! told her that she had notified the Nurse Practitioner who gave a (1) one time order for Benadryl by mouth. The Unit Manager was asked to provide a copy of the physician's order for Benadryl and a copy of the nurses' assessment. After reviewing Resident #27's electronic medical record she replied, She (LPN#!) did not write a note, and I can't find the order or where she gave it. She should have written an order, documented her assessment and that she notified the Nurse Practitioner in the progress notes and recorded that she gave the Benadryl on the MARs (Medication Administration Record). When asked how did staff know if a resident had any allergies, the Unit Manager LPN#4 replied, allergies are listed on the resident's meal ticket for dietary staff and the C.N.A's (Certified Nursing Assistants) to see and tasks for the C.N.A's to see and on the MARs (Medication Administration Record) and dashboard for the nurses and other staff to see. When asked if allergies are noted in the resident's care plan she responded, Yes, I believe they are. After reviewing Resident #27's care plan she said he did not have a care plan to address his allergies. (continued on next page)

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #27's clinical record revealed he has multiple drug and food allergies including: fish and seafood, beets, berries, cinnamon, honey, nutmeg oil, onions, raspberry, azithromycin, benzonatate, cephalexin, ciprofloxacin, clindamycin, cyclobenzaprine, doxycycline, erythromycin, fluticasone, ketorolac, levofloxacin, lidocaine, linezolid, lisinopril, oxycodone, phenazopyridine, prednisone, tamsulosin, tramadol, vancomycin, iodinated contrast media, NSAIDs, penicillins, sulfa antibiotics, rubus fruticosus leaf extract, bee venom, latex, wasp venom, vaccinium angustifolium. A review of the clinical record did not show any evidence of physician orders or the administration of Benadryl or EpiPen and no evidence of an assessment or follow-up by LPN#1 and no care plan to address his multiple food and drug allergies. On 12/10/25 at approximately 9:30 AM, Resident #27 wanted to share that his friend, Resident #47 was at the dining room table when he had the allergic reaction last week and had asked him, Are you wearing lipstick today your lips are turning red. He said it was then he started feeling a bit funny and my lips felt numb, so I wheeled back to the nurse's station, and they started working on me. I was sorta out of it. I think it was an agency nurse I don't really remember; it was some time last week middle to end of last week. On 12/10/25 at approximately 10:00 AM, an interview was conducted with Resident #27's friend, Resident #47 and according to her He was having some type of reaction because I saw the edge of his lip turning pinkish red and puffing up a little. He was talking ok, but he was touching his lip in a funny way. Then he got up and wheeled on back down the hall to the nurse's station. When asked if she could recall when this occurred last week, she was unable to confirm a day but stated it was some time the middle of last week or later. On 12/10/25 at 10:15 AM, an interview was conducted with the (NP) Nurse Practitioner (Other #3). Per the NP (Other#3) she said, Yes, I remember the nurse notified me, and I gave her a (1) one time order to give him Benadryl 25 mg by mouth. The nurse said she saw no visual signs of distress, but he was very anxious and out of caution due to his multiple allergies I gave a one-time order for Benadryl 25mg by mouth. He has a long list of allergies. I have been here since the event last week and have seen him in the hallway and he appears fine. On 12/11/25, during the end of the day the Director of Nursing and the Corporate Nurse (ADM#3) were notified of the concerns, and the Director of Nursing provided a copy of facility's policy on nursing documentation. On 12/15/25, the Director of Nursing provided a typed statement signed by the nurse (LPN# 1) of her recollection of the event on Resident #27's allergic reaction. According to the nurse's statement, Resident #27 was observed on 12/3/25 after lunch with a red lip and complaining of some burning on the lip. She stated she assessed him, and he presented with no other symptoms, and his vital signs were normal. The nurse stated she informed the Nurse Practitioner (Other #3) who was on-site and was given an order to administer one (1) dose of Benadryl 25 mg by mouth. No further concerns were voiced by Resident #27. A review of the facility's policy titled Mosby'sTextbook, Chapter 4 Documentation and Informatics; Procedural Guidelines 4.2 Adverse Events Reporting (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Steps 1. When you witness an adverse event, assess the extent of any injury to the patient including the patient's subjective report and objective physical examination findings. Clinical Documentation a. Document time of event and describe in chronological order exactly what occurred or was observed, using objective findings and observations. Document condition of patients when discovered or observed, and observation of factors that possibly contributed to incident (e.g., in the case of a fall, presence of wet floor, extension cord). b. Describe measures taken by any caregivers at time of the event. c. Document patient's interpretation of the event using quotes and documenting the events of the incident in the patient's chart. On 12/17/25 during the end of the day meeting with the Director of Nursing and Corporate Nurse, an opportunity was offered to the facility staff to present additional information. They had no further comments or additional information to provide regarding the above concern. 2. For resident #21 (R21), the facility staff failed to follow professional nursing standards by administering medication outside of the scheduled time frame on multiple instances in October, November, and December 2025. A review of R21's clinical record revealed the following orders:2/26/25 Midodrine (to treat low blood pressure) 10 mg (milligrams) Give 1 tablet by mouth three times a day.Hold for SBP (systolic blood pressure) greater than 120. The medication was scheduled for administration at 9:00 a.m., 2:00 p.m., and 9:00 p.m. 1/26/24 Sennosides-Docusate Sodium (a stool softener) 8.6-50 mg Give 2 tablets by mouth every morning and at bedtime for bowel management. The medication was scheduled for administration at 9:00 a.m. and 9:00 p.m. 4/10/25 Carbamazepine (to prevent seizures) 100 mg Give 1 tablet by mouth every morning and at bedtime. This medication was scheduled for administration at 9:00 a.m. and 9:00 p.m. 1/26/24 Pregabalin (to treat nerve pain) 300 mg by mouth every morning and at bedtime. The medication was scheduled for administration at 9:00 a.m. and 9:00 p.m. A review of R21's October, November, and December 2025 MARs (medication administration records revealed administration on the following dates and times: Midodrine on 10/4/24 at 11:13 a.m. and 10:22 p.m.; Sennosides-Docusate Sodium on 11/27/25 at 11:06 p.m. and 12/6/25 at 10:26 p.m.; Carbamazepine on 11/27/25 at 11:06 p.m. and 12/6/25 at 10:23 p.m.; and Pregabalin on 11/27/25 at 11:06 p.m. and 12/6/25 at 10:31 p.m. (continued on next page)

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/16/25 at 10:37 a.m., LPN (licensed practical nurse) # 9 was interviewed. She stated that nurses have a two hour window to safely administer a scheduled medication. She added that this included one hour before and one hour after the medication is due. She stated: We learn that in nursing school. She explained that the time frame is for resident safety and to maintain a stable amount of the medication in the resident's system. On 12/16/25 at 3:52 p.m., ASM (administrative staff member) #2, the director of nursing, and ASM #3, the regional director of clinical services, were informed of these concerns. No additional information was provided prior to exit. 3. For Resident #32 (R32), the facility staff failed to follow professional nursing standards of documentation following a resident to resident altercation on 7/30/25. A review of a facility synopsis of events dated 7/30/25 revealed, in part: Resident [#32] brought Resident [#43] to Nurse.[R32] reported that [R43] was bleeding on his bed. [R43] reported 'Why do y'all let him keep beating me?' Residents were separated due to being roommates and [R32] moved and placed on 1:1.[R43 was assessed with noted injuries to face and general discomfort was expressed. Resident was sent out to hospital for eval (evaluation) and treat.[R43] only resident noted with injuries and discomfort.911 called. R32's progress notes revealed no documentation regarding the description of this incident. On 12/16/25 at 10:37 a.m., LPN (licensed practical nurse) # 9 was interviewed. She stated if two residents engage in an altercation, the nurse in charge needs to document the event in the progress notes of both residents. On 12/16/25 at 1:26 p.m., LPN #3, a unit manager, was interviewed. She stated if a resident is involved in an altercation with another resident, the nurse should make a risk management entry in the clinical record for both residents. She stated the risk management entry should also generate a progress note for the resident. She stated a progress note gives a description of what happened for other facility staff members to review. She stated that documenting a resident to resident altercation in the clinical record is basic nursing practice that learned by all nurses in nursing school. On 12/16/25 at 2:19 p.m., ASM (administrative staff member) #2, the director of nursing, was interviewed. She stated if a resident to resident altercation occurs, there should be a progress note documenting exactly what happened between the residents, what steps the nurse took to keep the residents safe, and who was notified about the event. She stated it is basic nursing practice to document all of these items, and to include assessment results for each resident. On 12/16/25 at 3:52 p.m., ASM #2 and ASM #3, the regional director of clinical services, were informed of these concerns. No additional information was provided prior to exit. 4. For Resident #12 (R12), the facility staff failed to follow professional nursing standards of documentation following a resident to resident altercation on 9/24/25. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of a facility synopsis of events dated 9/24/25 revealed, in part: [Resident #12] reported to Activities Director that [R32] punched him in the face. [R12] asked the resident to 'come on by and move' so that he could pass through. [R32] stated that he felt he was being 'offended and didn't like it and he swung on him and didn't miss.' Residents were separated upon initial report and [R32] placed on 1:1. [R12] was assessed for further injuries with 5 small abrasions noted around the left cheek bone and left orbital (sic) of the eye. Neurochecks initiated. A review of R12's clinical record failed to reveal any note describing the altercation between R12 and R32. On 12/16/25 at 10:37 a.m., LPN (licensed practical nurse) # 9 was interviewed. She stated if two residents engage in an altercation, the nurse in charge needs to document the event in the progress notes of both residents. On 12/16/25 at 1:26 p.m., LPN #3, a unit manager, was interviewed. She stated if a resident is involved in an altercation with another resident, the nurse should make a risk management entry in the clinical record for both residents. She stated the risk management entry should also generate a progress note for the resident. She stated a progress note gives a description of what happened for other facility staff members to review. She stated that documenting a resident to resident altercation in the clinical record is basic nursing practice that learned by all nurses in nursing school. On 12/16/25 at 2:19 p.m., ASM (administrative staff member) #2, the director of nursing, was interviewed. She stated if a resident to resident altercation occurs, there should be a progress note documenting exactly what happened between the residents, what steps the nurse took to keep the residents safe, and who was notified about the event. She stated it is basic nursing practice to document all of these items, and to include assessment results for each resident. On 12/16/25 at 3:52 p.m., ASM #2 and ASM #3, the regional director of clinical services, were informed of these concerns. No additional information was provided prior to exit. 5. For Resident #24 (R24), the facility staff failed to follow professional nursing standards of documentation following a resident to resident altercation on 11/28/25. A review of a facility synopsis of events dated 11/28/25 revealed, in part: [R24] reported that upon rolling in his room [Resident #42] was in his belongings and he bumped into his wheelchair. [R24] reported that when he bumped his wheelchair, [R42] struck him in the right arm and [R24] struck [R42] back in the right jaw. No pain or skin concerns noted upon assessments. A review of R24's clinical record revealed no progress note describing the incident on 11/28/25. On 12/16/25 at 10:37 a.m., LPN (licensed practical nurse) # 9 was interviewed. She stated if two residents engage in an altercation, the nurse in charge needs to document the event in the progress notes of both residents. (continued on next page)

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/16/25 at 1:26 p.m., LPN #3, a unit manager, was interviewed. She stated if a resident is involved in an altercation with another resident, the nurse should make a risk management entry in the clinical record for both residents. She stated the risk management entry should also generate a progress note for the resident. She stated a progress note gives a description of what happened for other facility staff members to review. She stated that documenting a resident to resident altercation in the clinical record is basic nursing practice that learned by all nurses in nursing school. On 12/16/25 at 2:19 p.m., ASM (administrative staff member) #2, the director of nursing, was interviewed. She stated if a resident to resident altercation occurs, there should be a progress note documenting exactly what happened between the residents, what steps the nurse took to keep the residents safe, and who was notified about the event. She stated it is basic nursing practice to document all of these items, and to include assessment results for each resident. On 12/16/25 at 3:52 p.m., ASM #2 and ASM #3, the regional director of clinical services, were informed of these concerns. No additional information was provided prior to exit.

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	495097	A. Building B. Wing	12/17/2025

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

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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. (continued on next page)

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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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interviews, clinical record review, and facility document review, the facility staff failed to ensure a resident received ADL (activity of daily living) assistance for one (1) resident (Resident #31) in a survey sample of 48 Residents.The findings include: The facility staff failed to provide ADL (activities of daily living) for incontinence care and repositioning for Resident #31 for a period of at least 5 continuous hours on 12/11/25.Resident #31 was admitted to the facility on [DATE] with diagnoses that included but not limited to intracerebral hemorrhage, hemiplegia and hemiparesis (paralysis affecting his left side), aphasia (a language disorder that makes it difficult to communicate affecting the residents speech) chronic respiratory failure, asthma, chronic obstructive pulmonary disease, anxiety, seizures, hyperlipidemia, muscle weakness, history of transient ischemic attacks (a brief interruption of the brain's blood flow causing stroke-like symptoms), depression, and hypertension.Resident #31's most recent MDS (Minimum Data Set) a Quarterly assessment with ARD (assessment reference date) of 9/15/25, Section C: Cognitive Pattern was coded as 99 indicating Resident #31 was unable to complete the interview. Section GG was coded as resident being dependent for toileting, shower/bathing, dressing, personal hygiene, roll side to side, sit to lying and sit to stand. Section H0300 Bladder Incontinence and H0400 Bowel Incontinence were coded as 3. Always Incontinent.On 12/11/25 at 8:25 AM, Resident #31 was observed in his bed lying on his back with head of the bed elevated. At 8:37AM, the nurse (LPN#5) was observed to enter room to hang his enteral (through the gastrointestinal tract) feed and water at which time the resident started shaking his left hand very rapidly towards the nurse, the nurse said. I am not familiar with this resident because this is my first time on this cart, so I am going to get the other nurse to help me. At 9:15AM the nurse returned and proceeded to administer Resident #31's medications via tube in his abdomen.From 9:30 AM to 1:29 PM no other staff were observed to enter room [ROOM NUMBER]C to check on Resident #31 to see if he needed incontinence care or repositioning At 1:29 PM Resident #31 was observed in bed, in low position on his back with hand rolls (rolled washcloths) in both hands due to contractures, arms resting on his chest. Two (2) nursing staff members entered (C.N.A #2 and RN ADM #4) entered room [ROOM NUMBER]C and C.N.A #2 stated they had come in to re-position him and provide afternoon care. When questioned on what that meant, C.N.A #2 said, we do morning and afternoon rounds usually every 2 hours. RN ADM #4 was called away to another room. C.N.A #1 and LPN#5 enter the room, dons gown and gloves. C.N.A #1 prepares water and soap and explained to the resident that they were going to wash him up and turn him. Nurse LPN#5 disconnected his tube feeding and left the room. C.N.A #1 and #2 proceeded to give Resident #31 a bed bath. The incontinent brief was removed, brief was noted to be wet with a small bowel movement noted on brief and resident's sacral area. A small area, approximate size and shape of a dime, pink in color was observed. C.N.A #1 left the room to notify the nurse. When asked what she was doing, C.N.A #1 stated she had not seen this area before and she was getting the nurse to look at the residents bottom. At 2:31 PM, an interview was conducted with the Director of Nursing and Regional Director of Clinical Services on their expectations of providing incontinence care to residents who could not call or ask for assistance. According to the Director of Nursing, she said I would expect us to follow standards of practice for making rounds like every 2 hours, some residents may require a little more checking, like hourly. When questioned on what the longest amount of time she would deem acceptable for when residents are checked for repositioning and incontinence care, she replied, no more than 4 hours. When shared with her that we had observed Resident #31 go from 8:25AM to 1:29PM (5 hours continuous) without being checked for incontinence or for repositioning she replied, that is not acceptable I would be concerned about the potential for skin breakdown. She was informed of the small dime size pink area, skin intact observed on his sacral that C.N.A #1 stated she had not seen before. She was also informed that per clinical review, Resident #31's skin was noted as intact 2 days prior.The Director of Nursing presented a document entitled Mosby's Textbook for Long-Term Care Nursing Assistants, 8th edition, Chapter 22 Urinary Elimination, Urinary Incontinence, pages 323 -326. Review of the document did not reveal frequency for incontinence care.On 12/17/25 during the end of the day meeting with the Director of Nursing and Regional Director of Clinical Services, an opportunity was offered to the facility staff to present additional information. They had no further comments or information regarding the above concern.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to appropriately assess and monitor a resident following a fall with injury for one resident (Resident #20-R20) in a survey sample of forty-eight residents. The findings included:For Resident #20, who had a fall and sustained a hematoma to her forehead, the facility staff failed to monitor for latent injuries by conducting neurological checks (neuro checks). On 12/8/25-12/9/25, a closed record review was conducted of R20's chart. According to the nursing progress notes, on 8/3/24 R20 fell. The note read, Description of the fall/V/S/injuries if any: : Time: about 0630-0635. unwitnessed. While doing the med pass facing the wall, overheard a thud, turning this writer's head to the left and observed resident lying on the floor face down, she is alert and responsive. she suffered a bump (hematoma) on her forehead, no other What Interventions were in place at the time of the fall? : initial check to see if okay, and help onto a chair, applied a pack of ice, on-call MD was notified, family notified What are the risk factors that could have contributed to the fall? : resident stated that she was trying to chase a bug and lose [sic] her balance and fell What new Interventions were implemented in response to the fall? : apply a pack of ice, initial neuro check started, on-call MD notified. Review of the Neurological Checklist with an effective date of 8/3/24, revealed that the vital signs of temperature and respirations were recorded and dated 7/21/24. The pulse and blood pressure readings were dated 7/16/24. The neurological assessment of R20 was grossly incomplete, as evidenced by numerous instances of the resident assessment not being completed. On 12/9/25 at 12:34 PM, an interview was conducted with licensed practical nurse #10 (LPN #10). When asked to explain the process/protocol when a resident sustains a fall, LPN #10 explained that, If they have a hematoma I am going to send out because you don't know the extent of their injuries. I am going to do neuro checks, we start the initial at the time of the fall and every 15 minutes for an hour, then every 30 minutes for an hour and then every 4 hours. They [the neuro checks] are in the computer. It includes vital signs, make sure they can move all extremities, check their pupils. When asked why neuro checks are important, LPN #10 explained that It [the fall] can lead to another major injury like a concussion or head trauma. On 12/9/25 at 12:37 PM, an interview was conducted with LPN #11. LPN #11 explained that following a fall she does the following: Assess the resident, obtain vital signs, check range of motion, check to see if they hit their head, if they hit their head they get sent out immediately. Neuro checks are done if it is an unwitnessed fall and we don't know if they hit their head. When asked why neuro checks are done, LPN #11 explained, in case anything changes we want to make sure we continue to monitor. We check their pupils, get full vital signs. They [neuro checks] start every 15 minutes x 1 hour, every 30 minutes x 2 hours, and so on. On 12/9/25, in the afternoon, an interview was conducted with the director of nursing (DON). The DON confirmed that following a resident having a fall with a head injury, neuro checks are to be completed to monitor for latent injuries. Review of the facility policy titled, Neurological Assessment with an effective date of 1/29/24, was conducted. The policy read, A neurological assessment will be completed by a licensed nurse in order to detect potential early signs of brain injury. 1. Explain to the patient why neurological assessment is being performed. 2. Complete the Neurological Checklist Assessment in the medical record. Assess: a. Vital signs. B. Orientation. C. Level of Consciousness. D. Pupillary response. E. Verbal response. F. Pain. G. Movement and sensation of extremities. 3. Complete assessment every 15 minutes for the first hours, every 30 minutes for the next two hours, and every hour for the next four hours. 4. Notify the provider and responsible party of any abnormal findings. Document in the medical record and follow provider recommendations. On 12/9/25, in the afternoon, the above findings were reviewed with the DON.No additional information was provided.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to provide care, services, and supervision for resident safety for six of 48 residents in the survey sample, Residents #32, #7, #40, and #26, resulting in the identification of immediate jeopardy; and for Residents #48, and #45. The findings include:1. For Resident #32 (R32), on three occasions in 2025, the resident physically assaulted other residents, despite being known to have had previous aggressive behaviors, and, in one instance, being under a provider's orders for 1:1 supervision. The lack of supervision of R32 resulted in harm to two victims, Residents #43 and #37. On 7/30/25, Resident #32 punched Resident #43 in the face, resulting in Resident #43 being transferred to the hospital for a trauma evaluation for bruising and facial lacerations. On 9/25/25, Resident #32 punched Resident #12 in the face twice, which resulted in five small abrasions on the cheek bone. On 12/8/25, Resident #32, who had orders for 1:1 supervision, punched Resident #37 in the head and face, requiring a provider's order for treatment of R#37's injuries. On the quarterly MDS (minimum data set) with an ARD (assessment reference date) of 8/21/25, R32 was coded as being moderately cognitively impaired, having scored nine out of 15 on the BIMS (brief interview for mental status). His diagnoses include TBI (traumatic brain injury) and intellectual disability. A review of R32's clinical record revealed facility concerns regarding his aggressive behaviors and orders for close supervision dating back to 5/24/25. This review revealed orders for 1:1 supervision on 5/4/25 and 6/3/25, as well as supervision sight checks every 30 minutes on multiple days in June 2025.A review of a facility synopsis of events dated 7/30/25 revealed, in part: Resident [#32] brought Resident [#43] to Nurse.[R32] reported that [R43] was bleeding on his bed. [R43] reported 'Why do y'all let him keep beating me?' Residents were separated due to being roommates and [R32] moved and placed on 1:1.[R43 was assessed with noted injuries to face and general discomfort was expressed. Resident was sent out to hospital for eval (evaluation) and treat.[R43] only resident noted with injuries and discomfort.911 called.R32's progress notes revealed no documentation regarding the description of this incident.A review of R32's care plan, initiated 3/14/23 and updated 5/27/25 revealed, in part: [R32 has behaviors r/t (related to) TBI with cognition impairment.physical aggression with a peer.verbal and physical aggression towards staff/other residents.physically aggressive with another resident. Continue to redirect from other residents when restless, agitated, aggressive to prevent altercations (5/27/25). R32's care plan revealed no evidence of review or revision of current interventions following the altercation on 7/30/25 with R43.A review of a facility synopsis of events dated 9/24/25 revealed, in part: [Resident #12] reported to Activities Director that [R32] punched him in the face. [R12] asked the resident to 'come on by and move' so that he could pass through. [R32] stated that he felt he was being 'offended and didn't like it and he swung on him and didn't miss.' Residents were separated upon initial report and [R32] placed on 1:1. [R12] was assessed for further injuries with 5 small abrasions noted around the left cheek bone and left orbital (sic) of the eye. Neurochecks initiated.Further review of R32's clinical record revealed the following progress note dated 9/25/25: Per nurse aide ran to nursing station to report that resident had punched another resident [Resident #12] in the face twice. Residents were separated and assessed for injuries. [R32] was questioned regarding the reason for the incident and what upset him to cause him to hit the other resident.[R32] was placed on 1:1 supervision. There was no evidence in the record that R12 required a provider's assessment or new orders immediately following this altercation.A review of R32's care plan initiated 3/114/23 revealed, in part: [R32] has behaviors r/t (related to) TBI (traumatic brain injury) with cognition impairment, restlessness, agitation, mood d/o (disorder), physical aggression with a peer.verbal and physical aggression towards staff/other residents. R32's care plan revealed no evidence of review or revision of current interventions following the altercation on 9/25/25 with R12.A review of R32's provider's orders revealed the following order dated 11/11/25 with no end date: 1:1 observation (during wake [sic] hours).A review of a facility synopsis of events dated 12/8/25 revealed, in part: Staff reported that while in the Dining room [R32] got up and struck [Resident #37] in the face related to saying something to him that he couldn't recall when questioned by staff. Residents separated.First aide (sic) provided to [R37] and [R32] will continue with 1:1 services.Further review of R32's clinical record revealed the following progress note dated 12/8/25: Behavior Note.Resident was sitting in dining room. While 1:1 sitter and another staff member was (sic) passing dinner trays, [R32] thought another resident said something to him. [R32] started punching the other resident on the head and face. Residents were immediately separated. When asked, [R32] could only

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Based on staff interviews and facility document review, it was determined that the facility staff failed to complete annual performance evaluations for two of the five C.N.A.s (certified nursing assistants) records. The findings include: For C.N.A #11, date of hire 7/22/1986, and for C.N.A #12, date of hire 11/29/22, no annual performance review has been completed.Five C.N.A records were reviewed to determine compliance with the requirement for annual performance reviews. When the facility provided the requested documents, C. N.A #11 and C.N.A #12 did not have evidence that an annual performance evaluation had been completed. On 12/16/25, an interview was conducted with the Director of Nursing and according to her she is responsible for ensuring the clinical staff performance evaluations are completed annually. When asked about C.N.A #11 and C.N.A#12, she stated: I do not have an annual performance evaluation done for them, I gave you the evaluations for the other three 3 C.N.A's you requested. She acknowledged she is aware that performance evaluations are due annually.On 12/16/25, the Director of Nursing was asked to provide a copy of the facility's policy on staff training and performance evaluations. As of 12/17/25, no policy was presented. On 12/17/25 during the end of the day meeting with the Director of Nursing and Regional Director of Clinical Services, an opportunity was offered to the facility staff to present additional information. They had no further comments or additional information to provide regarding the above concern.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interview, and facility document review, the facility staff failed to prepare and serve food in a sanitary manner in one of one facility kitchen.The findings include:Based on observation, staff interview, and facility document review, the facility staff failed to prepare and serve food in a sanitary manner in one of one facility kitchen.The findings include:The facility dietary staff failed to wear beard guards while preparing dinner, failed to take holding temperatures of food prior to serving it from the steam table, failed to use utensils to serve baked fish and rolls, and failed to handle serving utensils in a sanitary manner at the dinner observation on 12/9/25.On 12/9/25 at 4:27 p.m., the dietary staff members were observed preparing dinner in the facility kitchen. ASM (administrative staff member) #7, the dietary director, OSM (other staff member) #9, a cook, and OSM #10, a cook, worked in the food preparation area. Each of these staff members had facial hair, but none wore a beard guard. At 4:32 p.m., all food items were removed from the stove and/or convection cooker and placed on the steam table. At no time prior to serving this food did any staff member obtain a holding temperature for any item on the steam table. At 4:36 p.m., ASM #7, OSM #9, and OSM #10 began taking turns serving individual resident place from the steam table line. Each of these staff members wore gloves, and each staff member wore these same gloves as they served multiple plates. As they served, these three staff members touched the steam table surface with gloved hands, then utilized serving utensils on the steam table, contaminating the handle of each and every serving utensil prior to the next staff member's use of the utensil. Additionally, while the contaminating of serving utensils and glove surfaces was ongoing, each of these three staff members used their same gloved hands to pick up both the baked fish and rolls; no serving utensils were used for either of these items. OSM #11 was observed to wear gloves to scoop rice onto serving plates, put the scoop back in the rice, touch the steam table surface, then use the same gloved hands to press the rice into a circular shape. Three different plates containing visible water droplets on their surfaces were filled with food and served to residents.On 12/10/25 at 2:53 p.m., ASM #7 was interviewed. He stated he was aware that the staff needed to be wearing beard guards, but none had come from the supplier yet. He stated he was unaware until the previous week that beard guards were needed. He stated he now understood the beard guards were needed to prevent facial hair from dropping into residents' food. He stated that having multiple staff members handle serving utensils, touch the steam table surface, and then handle food directly with the same gloved hands is a risk of cross contamination of the food. He stated food should never be placed on a plate that had water droplets because the standing water has the potential to grow bacteria. He stated all dishes should be completely dry before being stacked and served. OSM #9 stated that the staff takes the temperature of each hot food item when it is initially removed from the steamer, stove, or convection cooker. He stated once the temperature is taken, the hot food is then placed in the steam table pans or in the warmer.On 12/16/25 at 3:52 p.m., ASM #2, the director of nursing, and ASM #3, the regional director of clinical services, were informed of these concerns.A review of the facility policy, Staff Attire, revealed, in part: The Dining Services Director insures that all staff members have their hair off the shoulders, confined in a hair net or cap, and facial hair properly restrained.A review of the facility policy, Food Preparation, revealed, in part: The Dining Services Director insures that all staff practice proper hand washing technique and practice proper glove use.The Cook(s) insures that all foods are held at appropriate temperatures.for hot holding.and for cold food holding. Temperature for Time/Temperature Control for Safety foods recorded at time of service and monitored periodically during meal service periods as indicated.All staff will use serving utensils appropriately to prevent cross contamination.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident and staff interviews, clinical record review, and facility document review, the facility failed to ensure a complete and accurate medical record in accordance with accepted professional standards for 2 (two) of 48 residents in the survey sample (Resident #27, #26).Findings included: 1.For Resident #27, the facility staff failed to transcribe a physician's order for Benadryl and failed to document assessment of his allergic reaction from the fish served to him at lunch on 12/3/25. Resident #27 was admitted to the facility on [DATE] with diagnoses to include but not limited to chest pain, unspecified, muscle weakness, syncope and collapse, atrial septal defect, ventricular septal defect, coarctation of aorta, calculus of kidney, hypertension, anxiety, iron deficiency anemia, hydronephrosis with renal and ureteral calculous, obstruction, morbid obesity, asthma, mast cell activation, type 2 diabetes mellitus, post-traumatic stress disorder. Resident #27's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 9/14/25 coded the resident as having a BIMS (Brief Interview of Mental Status) score of 15 out of a possible 15 indicating no cognitive impairment. Section GG was coded as Resident #27 being independent in turning and repositioning, lying to sitting, sit to stand, chair/bed to chair transfer, toileting. He uses a rollator for ambulation. On 12/9/25 at 2:55PM, an interview was conducted with Resident #27 and according to him he has numerous food and drug allergies including fish and seafood products. He said, it was one day last week (he could not remember that exact day, maybe it was Wednesday or Thursday but maybe Friday) he had a bad reaction and they, the nurse I mean, had to give me an EpiPen (a pocket-sized spring-loaded syringe with a pre-measured dose of epinephrine for the emergency treatment of a severe allergic reaction) and lots of Benadryl cause I was real bad off. My lips were swelling and turning red and my mouth felt funny. According to Resident #27, he had gone to the dining room for lunch and was served fish at which time he reminded the kitchen staff that he was allergic to fish so they took his plate back, removed the fish but did not give him a clean new plate so the fish oil was still on the plate and he thinks that is what caused his reaction. On 12/10/25 at 9:40AM, an interview was conducted with the Unit Manager LPN #4 and according to her Nurse (LPN#1) had informed her of the event. She said she was told by the nurse that he said his mouth was swelling and felt funny, but she had assessed him, and he appeared fine. She said he presented with no swelling of his lips, no redness and was talking just fine, but that she notified the Nurse Practitioner (OTHER #3) due to his multiple allergies, and he was complaining of not feeling just right. Per the Unit Manager LPN#4, she said the Nurse Practitioner (OTHER#3) gave a (1) one-time order for Benadryl by mouth. The Unit Manager LPN#4 was asked to provide a copy of the physician's order for Benadryl and a copy of the nurses' assessment. After reviewing Resident #27's electronic medical record she replied, She (LPN#1) did not write a note, and I can't find the order or where she gave it. She should have written an order, documented her assessment and that she notified the Nurse Practitioner in the progress notes and recorded that she gave the Benadryl on the MARs (Medication Administration Record). (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #27's clinical record revealed he has multiple drug and food allergies including: fish and seafood, beets, berries, cinnamon, honey, nutmeg oil, onions, raspberry, azithromycin, benzonatate, cephalexin, ciprofloxacin, clindamycin, cyclobenzaprine, doxycycline, erythromycin, fluticasone, ketorolac, levofloxacin, lidocaine, linezolid, lisinopril, oxycodone, phenazopyridine, prednisone, tamsulosin, tramadol, vancomycin, iodinated contrast media, NSAIDs, penicillins, sulfa antibiotics, rubus fruticosus leaf extract, bee venom, latex, wasp venom, vaccinium angustifolium. A review of the clinical record did not show any evidence of physician orders or the administration of Benadryl or EpiPen and no evidence of an assessment or follow-up from the nurse or a care plan to address his multiple allergies and no care plan to address his multiple food and drug allergies. On 12/10/25 at approximately 9:30AM Resident #27 wanted to share that his friend, Resident #47 was at the dining room table when he had the allergic reaction last week and had asked him, Are you wearing lipstick today your lips are turning red. He said it was then he started feeling a bit funny and my lips felt numb, so I wheeled back to the nurse's station, and they started working on me. I was sorta out of it. I think it was an agency nurse I don't really remember; it was some time last week middle to end of last week. On 12/10/25 at approximately 10:00AM, an interview was conducted with Resident #27's friend, Resident #47 and according to her He was having some type of reaction because I saw edge of his lip turning pinkish red and puffing up a little. He was talking ok, but he was touching his lip in a funny way. Then he got up and wheeled on back down the hall to the nurse's station. When asked if she could recall when this occurred last week, she was unable to confirm a day but stated it was some time the middle of last week or later. Resident #47's most recent MDS (Minimum Data Set) assessment with an ARD (Assessment Reference Date) of 11/7/25 coded the resident as having a BIMS (Brief Interview of Mental Status) score of 15 out of a possible 15 indicating cognition is intact (normal thinking and memory. On 12/10/25 at 10:15AM an interview was conducted with the NP Nurse Practitioner (OTHER #3) and she said, Yes, I remember the nurse notified me, and I gave her a (1) one-time order for Benadryl 25 mg by mouth. The nurse said she saw no visual signs of distress, but he was very anxious and out of caution I gave the one-time order for Benadryl by mouth. He has a long list of allergies. I have been here since the event last week and have seen him in the hallway and he appears fine. On 12/11/25, during the end of the day the Director of Nursing, Divisional Director of Nursing Services and the Regional Director of Nursing Services were notified of the concerns, and the Director of Nursing provided a copy of facility's policy on nursing documentation. On 12/15/25, the Director of Nursing provided a typed statement signed by the nurse (LPN# 1) of her recollection of the event on Resident #27's allergic reaction. According to the nurse's statement, Resident #27 was observed on 12/3/25 after lunch with a red lip and complaining of some burning on the lip. She stated she assessed him, and he presented with no other symptoms, and his vital signs were normal. The nurse stated she informed the Nurse Practitioner (OTHER#3) who was on-site and was given an order to administer a one-time dose of Benadryl 25 mg by mouth. No further concerns were voiced by Resident #27. (continued on next page)

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

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy Chapter 4 Documentation and Informatics; Procedural Guidelines 4.2 Adverse Events Reporting Steps 1. When you witness an adverse event, assess the extent of any injury to the patient including the patient's subjective report and objective physical examination findings. Clinical Documentation a. Document time of event and describe in chronological order exactly what occurred or was observed, using objective findings and observations. Document condition of patients when discovered or observed, and observation of factors that possibly contributed to incident (e.g., in the case of a fall, presence of wet floor, extension cord). b. Describe measures taken by any caregivers at time of the event. c. Document patient's interpretation of the event using quotes and documenting the events of the incident in the patient's chart. On 12/17/25 during the end of the day meeting with the Director of Nursing and Regional Director of Clinical Services, an opportunity was offered to the facility staff to present additional information. They had no further comments or additional information to provide regarding the above concern. . For Resident #26 (R26) the facility staff failed to maintain a complete and accurate clinical record to include documentation of an incident where R26 assaulted another resident. On 12/12/25 during a clinical record review of R26's chart, it was noted that he had an altercation with another resident. According to a nursing progress note dated 10/19/25 it read, Resident remains on 1:1 for physical assault. No behaviors observed or reported. In the week prior there was no documentation regarding details of an assault. There were progress notes after 10/18/25 that noted an incident of physical assault towards another resident, but no details of the incident were included in R26's progress notes. On 12/12/25, the facility's director of nursing (DON) was asked to provide any information regarding an incident involving R26 in October. According to a facility incident summary dated 10/18/25, it noted R26 and R40 and read, CAN [sic] (certified nursing assistant) observed resident [name redacted] punch resident [R40's name redacted] in the face. Residents were immediately separated. Non-emergency services called treatment initiated. Resident [name redacted of another resident listed whose name was inaccurately noted in report] placed on 1:1. RP [responsible party], provider and police notified. Skin assessments and pain assessments were conducted for both residents. Resident [R40 name redacted] noted with abrasion to head. Investigation initiated. On 12/12/25, upon receipt of the facility documentation regarding the incident involving R26 and R40, the DON was asked about another resident identified in the incident summary. The DON acknowledged that the wrong resident had been noted in the report, and it should have been R26, who was the aggressor. The DON was asked about the incident and reported that it took place out front and stated it was in front of the facility. The DON could not give any further details about the incident. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility provided in their documents a statement written by Resident #44 (R44). The statement read, I was sitting smoking when I heard [R26 name redacted] shouting profanity at another resident, next he wheeled over to him, grabbed him in the collar, and pulled him to the ground and proceeded to hit him with both fist about the head and face. I yelled several times for him to stop. He finally stopped after punching him four or five times. At this point the nurse [registered nurse #1- RN #1 name redacted] arrived. On 12/12/25 at 10:30 AM, an interview was conducted with R44. When asked about the incident R44 stated that they [multiple residents] were all in the smoking area. R44 identified that resident #41 (R41) and R40 were at a table talking. Resident #26 thought [R40's name redacted] said something to R41, but R40 had not opened his mouth. R26 then went over to R40 cursing at him. Everyone keep saying stop. R44 then stated that R26 grabbed R40 by the collar, pulled him to the ground and started punching him in the face. I rolled up and yelled at [R26's name redacted] to stop it! R44 went on to state that R40 sustained a cut on his head. R44 reported that no staff were present, and another resident came inside the facility to get help and [RN #1's name redacted] came. R44 explained that normally a staff member is present but I think the lady [employee scheduled to supervise smoking] was sick. R44 recalled there were about seven or eight residents in the smoking area but couldn't recall who the other residents were. When asked if R44 had seen R26 with behavior before, R44 said, Constantly. He is always cursing and fighting. When asked if R44 was afraid of R26, the resident said, I'm not, but a lot of people are. On 12/12/25 at 10:45 AM, an attempt was made to interview R41, but the resident was not available. On 12/12/25 at 11:52 AM, an interview was conducted with RN #1. RN #1 reported that the incident occurred a little before 4:30 PM. RN #1 said, One resident said a resident needed help. When I got out there, we got [R40's name redacted] back in the chair and blood was coming from the top of the scalp. They said [R26's name redacted] pulled him out of the chair and was hitting him. They were in the smoking area [enclosed courtyard] at the table and chairs designated for smokers. We brought [R40's name redacted] inside, cleaned the wound and called the nursing supervisor. When asked about R26's behaviors, RN #1 reported, he has a TBI [traumatic brain injury] and starts yelling and getting angry over nothing. RN #1 went on to report that the doctor wanted to send R40 to the hospital, but the resident refused. On 12/16/25, during an end of day meeting, the facility's director of nursing and regional director of clinical services were made aware of the above findings. No additional information was provided.

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F 0850 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Hire a qualified full-time social worker in a facility with more than 120 beds. Based on staff interviews and facility document review, the facility staff failed to provide a full-time, qualified social services worker to meet the resident's individual needs whenever needed.The findings include:The facility staff failed to employ a full-time social services director.On 12/16/25 at 10:16 a.m., OSM (other staff member) #5, the social services assistant, was interviewed. She stated that her title is social services assistant and that she does not yet have the qualifications to be named the social services director. She stated the facility's social services director works remotely now, and does not come into the facility anymore. On 12/16/25 at 3:52 p.m., ASM (administrative staff member) #2, the director of nursing, and ASM #3, the regional director of clinical services, were interviewed. They stated that the current social services director works remotely, mostly in the evenings and on the weekends.On 12/17/25 at 9:26 a.m., OSM #8, the social services director, was interviewed. She stated that she is still the facility's social services director, but that she does not work full-time. She reported that as of 10/27/25, she has been employed full-time in another job, but that she had agreed to promise to continue working at the facility as needed part-time to make sure things are completed and for compliance. She stated that prior to her resignation from full time work with the facility, she was responsible for completing trauma screenings and psychosocial assessments, MDS (minimum data set) assessment reviews and completion, meeting with residents regarding any psychosocial or discharge needs, and generally working with residents and families to help make sure they received all services they needed. She stated that she also supervised the social services assistant. She explained that now that she is not employed full time at the facility, she does audits, makes sure things have been completed, and checks for compliance. On 12/17/25 at 2:45 p.m., ASM #2 and ASM #3 were informed of these concerns.No additional information was provided prior to exit.

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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 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based on observations, resident and staff interviews, clinical record review, and facility documentation review, the facility staff failed to maintain an effective quality assurance program with a focus on the outcomes of care, quality of life, and to correct quality deficiencies, which resulted in multiple residents residing on three of three units being victims of abuse. The findings included:During a survey conducted with a survey completion date of 4/28/25, the facility was cited for multiple areas of deficient practice involving abuse. Seven residents were identified as having been abused by facility staff and/or other residents, failure to report allegations, investigation of allegations, and failure to investigate, prevent, and correct abuse of residents. During the April 2025 survey, the identification of deficiencies for a safe environment was identified. The facility's quality assurance program was involved in the development of a plan of correction and ongoing monitoring to ensure ongoing compliance to sustain compliance. During this survey in December 2025, the survey team identified nine residents who were victims of abuse and where the facility staff failed to report, investigate, and provide adequate supervision to provide for a safe environment, which resulted in the identification of deficiencies in the areas of abuse and quality of care. Therefore, the facility's Quality Assurance and Performance Improvement actions were ineffective in sustaining ongoing compliance. During a survey ending 4/28/25, the facility was cited for failure to protect residents from abuse, failure to report, investigate and correct repeated willful abuse of residents. The facility's quality assurance program developed a plan of corrective. According to the plan of correction, the facility conducted audits to identify other residents at risk of being affected/abused. All facility staff received education on the facility's abuse policy, audits were conducted and the facility alleged compliance as of 6/12/25. Audits were going to be conducted weekly x 4 weeks, then monthly x 2 months to maintain ongoing compliance, all of which was going to be reported to the Quality Assurance and Performance Improvement Committee for review and recommendations. During the current survey, the survey team identified eleven residents who had been victims of abuse and resulted in the identification of immediate jeopardy for the facility's failure to protect the residents' right to be free from abuse. In multiple instances the facility failed to report the allegations timely, failed to conduct thorough investigations and failed to implement their abuse policy, all of which was previously cited. Instances of non-compliance were identified to have begun July 30, 2025, which was seven weeks after the facility had alleged compliance from the prior citations in April 2025. The facility's quality assurance program failed to implement the following interventions as stated in their plan of correction to prevent further abuse of residents, which resulted in the ongoing abuse of residents and was indicative of systemic failure: 1:1 [one-on-one] supervision, psychiatric services for behavioral management . to prevent the recurrence of verbal/physical abuse toward other residents, corrected with interventions to protect, prevent abuse or recurrence of abuse to resident or other residents, facility reported incident submitted timely with state agencies and APS [adult protective services] as applicable, investigation completed with accuracy of findings based on investigation, and education with all staff regarding the abuse and neglect policy and procedures to ensure ongoing compliance. On 12/17/25 at 2:09 PM, an interview was conducted with the facility's director of nursing (DON). When asked about the Quality Assurance (QA) program of the facility, the DON explained that QA was involved in the development of their plan of correction, monitoring for ongoing compliance and self-identification of areas of concern and development of a system to correct the identified non-compliance. When the above findings were discussed, the DON just stated that she understood that there was a lack of evidence that their QA program was effective and said, We need to do better. A review of the facility's policy titled, QAPI with an effective date of 9/23/24, was conducted. The policy read, The Administrator is responsible for directing the Center's Quality Assurance/Performance Improvement Program and for implementing a Quality Assurance/Performance Improvement (QAPI) Plan that focuses on Center specific indicators that measure quality of care, quality of life and patient choice. The QAPI Plan will systematically identify actual or potential areas of risk or deficiency and will proactively pursue ongoing performance improvement.The facility administrator was not present during this survey and, therefore, was not available for an interview. On 12/17/25, the DON was made aware of the above findings and stated that the quality assurance committee was involved in the plan of correction and ongoing compliance to ensure residents were free from abuse and the facility maintained a safe environment.No additional information was provided.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on staff interviews and facility document review, the facility staff failed to ensure the Quality Assessment and Performance Improvement Committee consisted of the minimum required members for three of five meetings (1/9/25, 7/29/25, and 11/25/25; no meeting sign-in sheet for April 2025).Findings include: On 12/16/25, the Regional Director of Clinical Services and Director of Nursing were asked to provide the facility's Quality Assessment and Performance Improvement Committee (QAPI) meeting attendance/sign-in sheets for 2025. The Director of Nursing provided copies of four QAPI meeting attendance/sign-in sheets for 2025 dated 1/9/25, 7/29/25, 9/26/25 and 11/25/25. Review of the attendance/sign-in sheets revealed that 1/9/25, 7/29/25 and 11/25/25 meeting sign-in sheets did not show evidence that the Infection Preventionist attended the meetings. No evidence of sign-in sheet for the month of April 2025.On 2/16/25 at 2:09 PM, an interview was conducted with the Director of Nursing regarding the facility's QAPI committee. When asked who attended the facility's QAPI committee meeting she responded, Business Office Manager, Human Resources, MDS (Minimum Data Set Nurse), the Director of Nursing, Pharmacy and Rehab plus the Medical Director and Administrator. The Administrator runs the meetings. When asked if she was aware that the Infection Preventionist is required to attend the QAPI meetings she responded, No I am aware of that. We may be on the cart sometimes and can't always attend the meetings but if she is not there, I can go over her information with the group.Per review of the facility's policy entitled QAPI Policy #310 Procedure 2. The Administrator serves as Chairperson to the QAPI committee to oversee committee activities. The committee membership includes the Administrator, Director of Nursing, Medical Director, Infection Preventionist, and at least two other Center designated employees.On 12/17/25 during the end of the day meeting with the Director of Nursing and Regional Director of Clinical Services, an opportunity was offered to the facility staff to present additional information. They had no further comments or information regarding the above concern.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview, staff interview, and facility documentation review, the facility staff failed to maintain an operational call bell system and in instances of repeated outages of their call system, the facility staff failed to ensure residents had a means to call for assistance from the bedside and bathroom where the call would go directly to a staff member or central location for residents, affecting multiple residents on one of three units at various times. During the survey, a resident on the central unit did not have an operational call bell and the resident had no alternate means to call for assistance. The findings included:On 12/9/25 at 2:15 PM, an interview was conducted with the Regional Director of Clinical Services (RDCS) and Director of Nursing (DON). The RDCS and DON were asked what the facility policy was on emergency responses for call bell malfunction. The response was we have hand bells that are distributed to all who can use them and more frequent rounding on those that cannot use the hand bells, we don't have a policy on call bell procedures for nursing staff, other than contacting the maintenance director to fix it. The facility was comprised of three units able to house 60 residents each. On 12/9/25 at 1:30 P.M. A search of the entire facility plant was conducted, including all three nursing units, medication and supply storage rooms, the central supply room, and the maintenance office and storage areas to reveal a total of 5 hand bells available to staff for resident use in the entire facility. On 12/9/25 at 1:30 PM, interviews were conducted during observations and a tour of all areas of the facility. Those interviews included four LPN's (Licensed Practical Nurses #1, # 2, 3, and #4), one RN (Registered Nurse #1), The Director of Nursing (DON), The Corporate RN, Central supply staff (other #1), and the maintenance staff (other #2). The interviews were conducted at, and including, nursing stations, medication and supply storage rooms, the maintenance room, central supply, and all three resident nursing units. None of the staff listed were able to find more than 5 hand bells/tap bells in the entire facility and did not know where to find more. They further stated that they knew of no policy that reflected a contingency procedure on when or where to access hand or tap bells in an emergency when the emergency nurse call bell system was inoperable, and where those bells could be found. On 12/9/25 at 3:00 PM, the maintenance representative (Other 2) entered the conference room with 58 more bells found in a box in the maintenance room which was locked at night for a total of 63 hand bells in the facility for use by 180 potential Residents and their bathrooms. Resident interviews were conducted by various survey team members as indicated below: On 12/9/25 at 2:53 p.m., Resident #28 was interviewed. He stated that about two weeks ago, he rang his call bell, and no staff came to answer. He discovered that the call bell indicator did not light up in his room and was broken. He stated he guessed the nursing staff reported this to maintenance, and maintenance fixed it when they got around to it after two or three days. The facility staff did not offer him any type of hand bell while the call bell system was down. He further stated the whole call bell system completely failed a while back. The staff distributed hand bells for the bedside, but not for the bathrooms. He stated two separate staff members told him the hand bell could not be heard outside of the room. He stated when he was less mobile it was very scary not to know if anyone could hear his call bell. On 12/09/25 at 2:55PM an interview was conducted with Resident #27 regarding call bell response. According to Resident #27 his call bell is answered timely, except for night shift a bit slower. Stated sometimes it may be 30 - 40 minutes for them to answer my call bell, 1 time I was on the toilet for over an hour. We have one aid usually for night shift to tend to all of us, that is too many. There has been a shortage of call bells in past few weeks. It has happened twice in past few weeks, lasting 4 days each time, last weekend started on Friday and fixed on Tuesday. Maintenance came on Monday to check it out and it was fixed on Tuesday. We plugged our heater in, and it triggered a shutdown of the call bell system from what we have been told. Only thing working in here was my refrigerator here in the corner and the overbed light. Resident #27 continued to state that it affected the whole hall he thought but was not sure if it affected the entire facility. This happened last weekend and the weekend before that. I am not aware of anything before that, but this is when we started using our heater. When questioned on how he would know if call bell not working or not being answered her replied I would know if I press the call light and did not see the red light on the wall unit but not every resident can look around like that.When questioned on did they ask why they call lights were not answered last weekend he said the staff said I didn't see any lights on. On 12/9/25 at 3:07 PM, an interview was conducted with Resident #24 (R24). When asked about the call bell system R24 stated, It stopped working last week, they gave us little bells to ring. It was out at least three weeks. R24 reported he has had

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interview, observation, staff interview, and facility document review, the facility staff failed to provide a clean environment in four of 88 resident rooms, rooms 77, 13, 11, 53, and 58.The findings include:On 12/11/25 at 3:23 p.m., the resident in room [ROOM NUMBER] (identified as Resident #5 [R5]) was interviewed in his room. R5 stated that he had requested housekeeping services in his room three times that day and the housekeepers had not shown up. Observations of R5's room revealed trash on the floor. The floor was dirty and did not appear to have been cleaned. Upon exiting the room, two nursing staff members were notified of the resident's request. On 12/12/25 at 8:52 a.m., R5 room revealed R5's room remained unkempt, and trash was on the floor. The room and floors did not appear to have been cleaned. On 12/12/25 at 10:06 a.m., ASM (administrative staff member) #9, the environmental services manager, was interviewed. He stated that each resident's room is cleaned once daily by housekeeping. This daily cleaning occurs for all horizontal surfaces in the room such as the top of bedside and overbed tables, sinks, shelves, and windowsill bases. He explained that in the bathrooms, the toilet seat, toilet, side of the toilet, floors, walls, and handrails are cleaned each day. He reported that the floor in the bedroom area as well as the floor in the bathroom is mopped each day for each resident. He stated the housekeepers' shifts are from 7:00 a.m. until 3:00 p.m. for some, and for others the shifts are 8:00 a.m. until 4:00 p.m. He stated the facility staffs four housekeepers each day to clean 88 resident rooms and public spaces.On 12/12/25 at 10:23 a.m., OSM #9 joined the surveyor in the resident room observations. In room [ROOM NUMBER], there were dark stained areas along all four walls, the middle of the floor, and on the bathroom floor. The toilet had a dark area around the base. OSM #9 stated: This toilet needs to be re-caulked. He explained that the floors are not going to get clean with just the daily mopping and that they needed to be stripped and waxed. He stated that his company had been working on a schedule to strip and wax all the rooms, but he had recently been told to stop this process. He stated the rooms with the stained floors were not completely clean. An inspection of room [ROOM NUMBER] revealed that the bathroom tiles smelled strongly of urine. OSM #9 stated that those tiles were beyond cleaning by stripping and waxing and that the tiles needed to be replaced. In this room, the area under the heater was stained dark brown. OSM #9 reported that these tiles also needed to be replaced in order to be completely clean. An observation in room [ROOM NUMBER] revealed the same types of areas of dark brown stains all around the room. An observation of room [ROOM NUMBER] revealed that over 75% of the bathroom tiles were dark and discolored, with an orange tint. OSM #9 reported that these bathroom tiles were beyond repair and needed to be replaced. An observation of room [ROOM NUMBER] revealed similar concerns with dark areas discoloring scattered areas of the floor tiles.On 12/15/25 at 11:52 a.m., OSM #9 provided a record of rooms at the facility that had been stripped and waxed since October 2025. None of the rooms observed earlier were included on that list.On 12/16/25 at 3:52 p.m., ASM #2, the director of nursing, and ASM #3, the regional director of clinical services, were informed of these concerns.No additional information was provided prior to exit.

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	495097	A. Building B. Wing	12/17/2025

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

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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 0942 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that staff members are educated on resident rights and facility responsibilities to properly care for its residents. Based on staff interviews and facility document review, the facility staff failed to provide the required Resident's Rights training for one employee in a survey sample of six employee records. The findings include: The facility staff failed to provide credible evidence of Resident's Rights training for a dietary aide, OSM#9 (Other Staff Member #9).On 12/16/25, a sample of six employees was selected for review of training requirements as part of the extended survey. The list of employees was given to the facility's Director of Nursing, and she was asked to provide evidence of the staff training to include the area of Resident's Rights. On 12/17/25, the employee records were reviewed and revealed no credible evidence to support that OSM#9 who was hired 8/26/25 had completed the required Resident's Rights training.On 12/17/25 at 2:09 PM, the Director of Nursing (DON) was interviewed on her expectations of training for staff. According to the DON, she said she focused on the clinical staff's training primarily. When asked what her expectations for new employee training was, she replied they get training on the the basics and leadership during orientation. When asked what basics implied she said, resident's rights, abuse, things like that. When asked would she expect a dietary staff member to get training on infection control, abuse, kitchen safety, quality assurance and compliance and ethics and resident rights prior to working his kitchen duties, she replied they most definitely should.On 12/17/25 at approximately 4:40 PM, the DON and Regional Director of Nursing (RDCS) produced a document entitled Skills Competency Validation Record signed by OSM#9 and dated 3/17/25 which is a date prior to his date of hire at the facility. According to the DON and RDCS, OSM#9 had worked at a coffee shop (vendor name redacted) and a nursing home prior to his employment with them on 8/26/25. OSM#9 presented his phone app revealing transcript of training since employment which revealed no credible evidence of Resident Rights training. The RDCS confirmed that all employees were expected to have completed training on Resident's Rights. On 12/17/25 the Director of Nursing was asked to provide a copy of the facility's policy on staff training, no policy was presented.On 12/17/25 during the end of the day meeting with the Director of Nursing and Regional Director of Clinical Services, an opportunity was offered to the facility staff to present additional information. They had no further comments or additional information to provide regarding the above concern.

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. Based on staff interviews and facility document review, the facility staff failed to provide required abuse training for one employee in a survey sample of six employee records.The findings include: The facility staff failed to have credible evidence of abuse training for a dietary aide, OSM#9 (Other Staff Member #9).On 12/16/25, a sample of six employees was selected for review of training requirements as part of the extended survey. The list of employees was given to the facility's Director of Nursing, and she was asked to provide evidence of the staff training to include the area of abuse and neglect training.On 12/17/25, the employee records were reviewed and revealed no credible evidence to support that OSM#9 who was hired 8/26/25 had completed the required abuse and neglect training.On 12/17/25 at 2:09 PM the Director of Nursing (DON) was interviewed on her expectations of training for staff. According to the DON, she said she focused on the clinical staff's training primarily. When asked what her expectations for new employee training was, she replied they get training on the the basics and leadership during orientation. When asked what basics implied she said, resident rights, abuse, things like that. When asked, would she expect a dietary staff member to get training on infection control, abuse, kitchen safety, quality assurance, compliance, ethics, and resident rights prior to working their kitchen duties, she replied, They most definitely should.On 12/17/25 at approximately 4:40 PM, the DON and Regional Director of Nursing (RDCS) produced a document entitled Skills Competency Validation Record signed by OSM#9 and dated 3/17/25 which is a date prior to his date of hire at the facility. According to the DON and RDCS, OSM#9 had worked at a coffee shop (vendor name redacted) and a nursing home prior to his employment with them on 8/26/25. OSM#9 presented his phone app revealing transcript of training since employment which revealed no credible evidence of abuse and neglect training. The RDCS confirmed that all employees were expected to have completed training on abuse and neglect.On 12/17/25 the Director of Nursing was asked to provide a copy of the facility's policy on staff training, no policy was presented.On 12/17/25 during the end of the day meeting with the Director of Nursing and Regional Director of Clinical Services, an opportunity was offered to the facility staff to present additional information. They had no further comments or additional information to provide regarding the above concern.

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. Based on staff interviews and facility document review, the facility staff failed to provide the required Quality Assurance and Performance Improvement training for one employee in a survey sample of six employee records reviewed. The findings include: The facility staff failed to have credible evidence of Quality Assurance and Performance Improvement training for a dietary aide, OSM#9.On 12/16/25, a sample of six employees was selected for review of training requirements as part of the extended survey. The list of employees was given to the facility's Director of Nursing, and she was asked to provide evidence of the staff training to include the area of Quality Assurance and Performance Improvement.On 12/17/25, the employee records were reviewed and revealed no credible evidence to support that OSM#9 who was hired 8/26/25 had completed the required Quality Assurance and Performance Improvement.On 12/17/25 at 2:09 PM the Director of Nursing (DON) was interviewed on her expectations of training for staff. According to the DON, she said she focused on the clinical staff's training primarily. When asked what her expectations for new employee training was, she replied they get training on the the basics and leadership during orientation. When asked what basics implied she said, resident rights, abuse, things like that. When asked would she expect a dietary staff member to get training on infection control, abuse, kitchen safety, quality assurance and compliance and ethics and resident rights prior to working his kitchen duties, she replied they most definitely should.On 12/17/25 at approximately 4:40 PM, the DON and Regional Director of Nursing (RDCS) produced a document entitled Skills Competency Validation Record signed by OSM#9 and dated 3/17/25 which is a date prior to his date of hire at the facility. According to the DON and RDCS, OSM#9 had worked at a coffee shop (vendor name redacted) and a nursing home prior to his employment with them on 8/26/25. OSM#9 presented his phone app revealing transcript of training since employment which revealed no credible evidence of Quality Assurance and Performance Improvement training. The RDCS confirmed that all employees were expected to have completed training on Quality Assurance and Performance Improvement. On 12/17/25 the Director of Nursing was asked to provide a copy of the facility's policy on staff training, no policy was presented.On 12/17/25 during the end of the day meeting with the Director of Nursing and Regional Director of Clinical Services, an opportunity was offered to the facility staff to present additional information. They had no further comments or additional information to provide regarding the above concern.

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F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program. Based on staff interviews and facility document review, the facility staff failed to provide required infection control training for one employee in a survey sample of six employee records. The findings include: The facility staff failed to have credible evidence of infection control training for a dietary aide, OSM#9.On 12/16/25, a sample of six employees was selected for review of training requirements as part of the extended survey. The list of employees was given to the facility Director of Nursing, and they were asked to provide evidence of the staff training to include the area of infection control.On 12/17/25, the employee records were reviewed and revealed no credible evidence to support that OSM#9 who was hired 8/26/25 had completed the required infection control training.On 12/17/25 at 2:09 PM the Director of Nursing (DON) was interviewed on her expectations of training for staff. According to the DON, she said she focused on the clinical staff's training primarily. When asked what her expectations for new employee training was, she replied they get training on the the basics and leadership during orientation. When asked what basics implied she said, resident rights, abuse, things like that. When asked would she expect a dietary staff member to get training on infection control, abuse, kitchen safety, quality assurance and compliance and ethics and resident rights prior to working his kitchen duties, she replied they most definitely should.On 12/17/25 at approximately 4:40 PM, the DON and Regional Director of Nursing (RDCS) produced a document entitled Skills Competency Validation Record signed by OSM#9 and dated 3/17/25 which is a date prior to his date of hire at the facility. According to the DON and RDCS, OSM#9 had worked at a coffee shop (name redacted) and a nursing home before that prior to employment with them on 8/26/25. OSM#9 presented his phone app revealing transcript of training since employment which revealed no credible evidence of infection control training. The RDCS confirmed that all employees were expected to have completed infection control training.On 12/17/25 the Director of Nursing was asked to provide a copy of the facility's policy on staff training, no policy was presented.On 12/17/25 during the end of the day meeting with the Director of Nursing and Regional Director of Clinical Services an opportunity was offered to the facility staff to present additional information. They had no further comments or information to provide regarding the above concern.

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F 0946 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide training in compliance and ethics. Based on staff interviews and facility document review, the facility staff failed to provide the required compliance and ethics training for one employee in a survey sample of six employee records. The findings include: The facility staff failed to have credible evidence of compliance and ethics training for a dietary aide, OSM#9On 12/16/25, a sample of six employees was selected for review of training requirements as part of the extended survey. The list of employees was given to the facility Director of Nursing, and they were asked to provide evidence of the staff training to include the area of compliance and ethics.On 12/17/25, the employee records were reviewed and revealed no credible evidence to support that OSM#9 who was hired 8/26/25 had completed the required compliance and ethics training.On 12/17/25 at 2:09 PM, the Director of Nursing (DON) was interviewed on her expectations of training for staff. According to the DON, she said she focused on the clinical staff's training primarily. When asked what her expectations for new employee training was, she replied they get training on the the basics and leadership during orientation. When asked what basics implied, she said, resident rights, abuse, things like that. When asked, would she expect a dietary staff member to get training on infection control, abuse, kitchen safety, quality assurance, compliance, ethics, and resident rights prior to working their kitchen duties, she replied, They most definitely should.On 12/17/25 at approximately 4:40 PM, the DON and Regional Director of Nursing (RDCS) produced a document entitled Skills Competency Validation Record signed by OSM#9 and dated 3/17/25, which is a date prior to his date of hire at the facility. According to the DON and RDCS, OSM#9 had worked at a coffee shop (name redacted) and a nursing home before employment with them on 8/26/25. OSM#9 presented his phone app, which showed a transcript of training since employment, indicating no credible evidence of compliance and ethics training. The RDCS confirmed that all employees were expected to have completed compliance and ethics training.On 12/17/25, the Director of Nursing was asked to provide a copy of the facility's staff training policy; none was provided.On 12/17/25, during the end-of-day meeting with the Director of Nursing and the Regional Director of Clinical Services, an opportunity was offered to the facility staff to present additional information. They didn't have any more comments or information about the above concern.