

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495097	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/28/2025
NAME OF PROVIDER OR SUPPLIER Parham Health Care & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</p> <p>2. Resident #41 was originally admitted to the facility [DATE]. The resident's current diagnoses included blindness, chronic back pain and migraines.</p> <p>The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of [DATE] coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #41's cognitive abilities for daily decision making were intact.</p> <p>Resident #41's had a care plan problem with a revision date of [DATE] which stated he had an ADL self-care performance deficit related to blindness, and chronic health conditions. The goal stated the resident would maintain his current level of functioning through the review date, [DATE]. The interventions included requires minimal assistance with bathing/showers, and requires set up/supervision with dressing.</p> <p>On [DATE] at 12:21 PM Licensed Practical Nurse (LPN) O asked that the surveyor move away from grab bars along the wall leading to the service hall where maintenance and and environmental services are located. LPN O stated that the resident travels along the hallway to the shower room. Resident #41 was observed leaving his room, heading towards the nurse's station and turn the wheel chair towards the service hall using the wall grab bars as a guide. LPN O stated this was the resident's normal method of getting to the shower and she did not appear to understand his attire was not appropriate for being outside of his room.</p> <p>As Resident #41 was observed traveling to the shower room, he was observed with a short hospital gown on, which stopped midway his thighs and his entire back was visible, for the hospital gown ties were not tied.</p> <p>On [DATE] at approximately 4:00 PM, a final interview was conducted with the Administrator, Director of Nursing, [NAME] President of Operations and a Regional Nurse Consultant. They offered no comments and voiced no concerns regarding the above information.</p> <p>Based on observation, interview, clinical record review and facility documentation the facility staff failed to ensure the right to a dignified existence for two (2) Residents (#151, and #41) in a survey sample of 57 Residents.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The findings included:</p> <p>1. For Resident # 151, the facility staff failed to ensure the resident was treated with dignity and respect after she expired. They did not ensure Resident # 151 was prepared for viewing if the family wanted visitation.</p> <p>Resident # 151 was admitted to the facility on [DATE], hospitalized on [DATE] and readmitted on [DATE]. Diagnoses included but were not limited to: Diabetes, Cerebral Infarction, Gastrointestinal hemorrhage, Chronic Kidney Disease, Hypertension, Congestive Heart Failure, Respiratory Heart Failure and history of Polysubstance Abuse.</p> <p>Resident #151's MDS (Minimum Data Set) coded as an admission Assessment with an ARD (Assessment Reference Date) of [DATE] coded Resident #151 as having a BIMS (Brief Interview of Mental Status) score of 14/15 indicating no cognitive impairment. Resident #151 was coded as requiring assistance with Activities of Daily Living.</p> <p>Review of the clinical record was conducted on [DATE]-[DATE].</p> <p>On [DATE] at approximately 3:00 p.m., four (4) staff members were observed pushing a bed in the hallway. The bed was in a low position and the staff were trying to maneuver the bed around the doorway. They appeared to be struggling to push the bed. At first glance, it appeared that the staff members were pushing an unoccupied bed. Upon further observation, it was noted that a resident was in the bed. There was a gray colored blanket completely covering the resident. The entire body including the head and face were wrapped in the blanket. The staff members were having difficulty steering the bed. The staff members pushed the bed with Resident # 151 in it into an empty room at the end of the hallway close to the lobby area. There were residents near the Nurses station and at the other end of the hallway on the Central Unit.</p> <p>The staff members walked back down the hall toward the nursing station, talking amongst themselves. They stated one of the wheels on the bed was locked. The roommate of Resident # 151 was sitting at the corner of the hallway near the nurses station. One of the staff members stopped and talked to the roommate of Resident # 151.</p> <p>One of the staff members who identified herself as Registered Nurse B was asked if that was a resident in the bed who had expired. Registered Nurse-B replied yes and identified the resident as Resident # 151. Registered Nurse-B did not say anything else and walked toward the nurses station. She did not offer any explanation of why Resident # 151 was completely wrapped in the blanket, was moved to another room and the bed was pushed in the room in a cater cornered position.</p> <p>A review of the clinical record revealed that Resident # 151 expired on [DATE]. Resident # 151 had a Do Not Resuscitate Order. The Director of Nursing pronounced the death at 10:20 a.m.</p> <p>There was progress note dated [DATE] at 10:30 written by the Director of Nursing which stated Resident was provided postmortem care by aides at this time resident was observed with no chest rise or fall no noted stimulation to tactile or verbal stimuli. Resident pronounced at 1020.</p> <p>(continued on next page)</p>

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Three surveyors opened the door to the room where Resident # 151 had been taken. The bed was pushed cater cornered in the room close to the door. The blanket was still completely covering the entire body of Resident # 151. The blanket was wrapped around the resident's head. When the blanket was lowered to uncover the face, it was observed that Resident # 151's mouth was open, lips appeared dry, and hair was tousled.</p> <p>It did not appear that post mortem care had been provided. Resident # 151's mouth was open, lips appeared dry and hair was not combed.</p> <p>On [DATE] at 10 a.m., an interview was conducted with the Director of Nursing and two Corporate Nurse Consultants. The Director of Nursing stated the facility staff was trying to move the deceased resident into another room. The Director of Nursing stated she came to the room to pronounce the resident and observed the staff providing post mortem care. She stated the expectation was for post mortem care to be provided to residents when they expire. When asked if it was expected for the staff to completely wrap the resident in a blanket, transport them to another room and place cater cornered in the room, the Director of Nursing replied no. The room where Resident # 151 was transported had been empty and had a bed and other extra supplies stored in there. She was not placed behind a curtain nor in a manner that would have been presentable for the family to view.</p> <p>The Corporate Nurse Consultant (Employee C) stated it was not expected for residents who expired to be pushed into an unoccupied room where another bed and other supplies were stored. She stated that it is a dignity issue.</p> <p>On [DATE] during the end of day debriefing, the Administrator, Director Nursing, [NAME] President of Operations and Corporate Nurse Consultants (Employee C and D) were informed of the findings. They stated it was important to ensure residents were treated with dignity and respect. A copy of the postmortem care policy was requested.</p> <p>Review of the facility's policy and procedure on Post Mortem care entitled Nursing Care and Services, Effective [DATE] from Mosby's Textbook for Long-Term Care Assistants by [NAME] and [NAME] and [NAME], page 616, Chapter 6, End of Life Care revealed the following excerpt:</p> <p>Postmortem care is done to maintain a good appearance of the body. Discoloration and skin damage are prevented. Valuables and personal items are gathered for the family. The right to privacy and the right to be treated with dignity and respect apply after death.</p> <p>On [DATE] at approximately 10:45 a.m., an interview was conducted with Certified Nursing Assistant-G who stated the staff members were transporting the deceased resident to another room while waiting for the family to come view the body. Certified Nursing Assistant-G stated he worked for the Agency.</p> <p>On [DATE] during the end of day debriefing, the Administrator, Director Nursing, [NAME] President of Operations and Corporate Nurse Consultants were informed of the findings. They stated it was important to ensure residents were treated with dignity and respect.</p> <p>No further information was provided.</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, Resident interview, staff interview and clinical record review, the facility staff failed to provide services in the facility with reasonable accommodation of resident needs and preferences, for 1 Resident (Resident # 56) in a survey sample of 57 Residents.</p> <p>For Resident # 56, the facility staff failed to provide a bed that was an adequate size for someone 74 inches tall.</p> <p>The findings included:</p> <p>Resident # 56 was readmitted to the facility on [DATE]. Diagnoses included but were not limited to: Septic Shock, Hypertension, Acute Metabolic Encephalopathy, Chronic Kidney Disease-Stage 3, Acute Embolism and Thrombosis of deep veins of right lower extremity, peripheral vascular disease and non-pressure chronic ulcer of right calf.</p> <p>The most recent Minimum Data Set (MDS) assessment was a Significant Change Assessment with an assessment reference date (ARD) of 4/10/2025. Resident #56 was coded with a Brief Interview of Mental Status score of 15 out of 15 indicating no cognitive impairment. Resident # 56 required extensive assistance on staff for activities of daily living.</p> <p>Review of the clinical record was conducted 4/16/2025-4/28/2025.</p> <p>On 4/16/2025 at 2:42 p.m., Resident # 56 was observed lying in bed with his legs bent at the knee and feet touching the footboard. Resident # 56 stated he was over 6 feet tall. He stated the bed was too short for him.</p> <p>On 4/17/2025 at 10:27 a.m., Resident # 56 was observed sitting up in bed, knees bent, and feet touching the footboard.</p> <p>On 4/18/2025 at 2:10 p.m., Resident # 56 was observed lying in bed. His feet were touching the footboard and his knees were bent.</p> <p>Review of the Care plan revealed no documentation of concerns about the size or length of Resident # 56's bed.</p> <p>Review of the Progress Notes revealed no documentation of concerns about the size of Resident # 56's bed.</p> <p>On 4/22/2025 at 11:10 a.m., an interview was conducted with the Licensed Practical Nurse-P who stated residents should have beds that fit them. Licensed Practical Nurse-P stated it was important for many reasons including comfort and proper positioning.</p> <p>During the end of day debriefing on 4/25/2025, the Facility Administrator, two Regional Nurse Consultants (Employees C and D) and the Director of Nursing were informed of the findings that Resident # 56's bed was too short for him. They stated the size or length of the bed should accommodate the needs of residents.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>No further information was provided.</p>

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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, Resident interview, staff interview and clinical record review, the facility staff failed to promote self determination through support of choice for one (1) Resident (Resident # 75) in a survey sample of 57 Residents.</p> <p>The findings included:</p> <p>For Resident # 75, the facility staff failed to provide a cup of coffee in the mornings prior to breakfast being served as per her choice.</p> <p>Resident # 75 was readmitted to the facility on [DATE]. Diagnoses included but were not limited to: Diabetes, Seizure Disorder, Hypertension and Stroke.</p> <p>The most recent Minimum Data Set (MDS) assessment was an Annual assessment with an assessment reference date (ARD) of 3/19/2025. Resident # 75 was coded with a Brief Interview of Mental Status score 15 out of 15 indicating no cognitive impairment. Resident # 75 required assistance for activities of daily living.</p> <p>Review of the clinical record was conducted 4/16/2025-4/28/2025.</p> <p>On 04/24/25 at 11:06 a.m.- Resident # 75 stated she wanted coffee in the mornings but cannot get any until breakfast is served.</p> <p>Resident # 75 stated we can't get coffee until breakfast but I would like a cup before breakfast. They all know I like my coffee.</p> <p>She then stated, I have to buy it from the store if I want it early in the morning.</p> <p>On 4/23/2025 at 8:51 a.m., Resident # 75 was observed standing in her room near the door to her room. She stated she was waiting for the breakfast trays to come to the floor.</p> <p>Resident # 75 stated she wanted some coffee. When asked if she could get coffee prior to the trays being served, she stated no. We have to wait until the trays come. Resident # 75 also stated that the staff know I love my coffee. She stated the only way she can get coffee prior to breakfast being served is if she buys it. When asked what that meant, she stated she would have to ask the staff to go out to a store to buy some for her.</p> <p>Resident # 75 was observed walking back and forth to the door of her room and later in the hallway asking dietary staff members what time they were going to deliver the breakfast trays to the unit where she resided. Resident # 75's room was located on the East wing perpendicular to the hall where the door to the kitchen was located. Resident # 75 could stand in the doorway to her room and see the carts being transported out of the kitchen.</p> <p>On 4/23/2025 at 9 a.m., observed Resident # 75 walking in the hall and questioning staff members if the dietary cart was going to be delivered soon.</p> <p>(continued on next page)</p>		

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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/23/2025 at 9:18 a.m., observed the dietary staff delivering the trays for the East unit where Resident # 75 resided, The nursing staff delivered the tray to Resident # 75 at 9:21 a.m. Resident # 75 immediately started preparing her coffee. She stated she loved coffee.</p> <p>On 4/24/2025 at 3:03 p.m., an interview was conducted with the Dietary Manager who stated she would discuss the request for coffee prior to breakfast with Resident # 75 and the facility staff.</p> <p>During the end of day debriefing on 4/24/2025, the Administrator, Director Nursing, [NAME] President of Operations and Corporate Nurse Consultants were informed of the findings.</p> <p>No further information was provided.</p>		

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<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to organize and participate in resident/family groups in the facility.</p> <p>Based on resident interview, staff interview, and review of facility documentation, the facility's staff failed to act promptly upon the grievances and recommendations of the group concerning issues of resident care and life in the facility reported in three out of three months.</p> <p>The findings included:</p> <p>An interview was conducted on 4/17/2025 at 1 p.m. with the Activities Director who stated Resident Council meetings were conducted monthly. He stated the Council president kept minutes of each meeting. The Activities Director stated he would encourage alert and oriented residents to attend the meeting with the surveyor.</p> <p>On 4/18/2025 at 1 p.m., an interview was conducted with the Resident Council President who stated the residents had meetings every month. She stated she wrote the minutes for the meetings. She stated that the facility did not respond to the concerns of the group. She stated they complained every month about the food, the temperature in the facility, lack of staffing and pests in the facility. She stated there was a serious problem with those issues.</p> <p>The Resident Council Meeting was conducted on 4/21/2025 at 2:00 p.m. in the small dining room. Ten alert and oriented residents attended the meeting. There were representatives from all three units of the facility. During the Resident council meeting, the residents who attended complained that they did not get offered bedtime snacks and did not receive snacks on a regular basis. The attendees represented all three units. The residents stated that it was rare to receive snacks at bedtime. They all stated they would like a snack at bedtime.</p> <p>The residents further stated that they had witnessed the dietary staff bring snacks to the unit occasionally, and left them at the nursing station desk. Some of the residents stated they were Diabetic and did not get a snack on a regular basis. They stated the nursing staff left the snacks at the nursing desk, which allowed ambulatory residents who could get to the desk to get a snack but the residents who could not ambulate, often did not get a snack. They all stated they had observed nursing staff eating the snacks that were supposed to be given to residents.</p> <p>The residents complained that the foods were salty and starchy foods for each meal. They also stated the only fresh fruit allowed were bananas. They stated they are served canned fruit which tastes old.</p> <p>An interview was conducted with the Dietary Manager on 4/18/2025 at approximately 4:15 p.m. The Dietary Manager stated that the only bedtime snacks that were provided were for the Diabetics on the units. She stated that was what was included in the Dietary contract. The Dietary Manager stated she provided nursing staff with the snacks for Residents diagnosed with Diabetes. She stated the snacks provided were labeled with the names of the Residents with Diabetes. The nursing staff was responsible for distributing the snacks. The Dietary Manager stated she did not provide snacks for the other residents due to the contract with the facility.</p> <p>(continued on next page)</p>		

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<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An interview was conducted with the facility's Activities Assistant on 4/23/2025 at 3:20 p.m. She stated that she could not submit copies of the last six months of Council minutes because only the Activities Director could do that and he was not in the office. The Activities Assistant stated she would inform the Activities Director of the request to send a copy of the Resident Council minutes for the previous 6 months to the surveyor.</p> <p>The minutes from January, February and March 2025 were provided to the surveyor by the Director of Nursing who stated she would contact the Activities Director to send the minutes from October to December 2024. The Director of Nursing stated the only notes she could access in the system at the time of the request were the ones for the current year 2025. She stated the Activities Director would have to access the minutes from 2024.</p> <p>Review of the facility documentation revealed no documentation of written responses to the concerns expressed during the Resident Council meetings.</p> <p>The facility's policy titled Resident's Rights, undated reads, Residents have a right to form or participate in a resident group to discuss issues and concerns about the facilities policies and operations such as resident council.</p> <p>On 4/24/2025 during the end of day debriefing, the findings were shared with the Executive Director (Administrator), Director of Nursing, Regional [NAME] President of Operations, and Corporate Nurse Consultants (Employees C and D). They stated it was important to respond to the grievances promptly.</p> <p>No additional information was provided.</p> <p>The requested minutes from October to December 2024 were not submitted to the surveyor prior to the completion of this report.</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, and a clinical record review, the facility staff failed to notify the Physician and/or Designee of refusals of care and services for two (2) of 57 residents (Resident #43 and 116), in the survey sample.</p> <p>The findings included:</p> <p>1. The facility staff failed to notify the Psychiatric-Mental Health Nurse Practitioner (PMHNP) that Resident #43 refused his medications most days.</p> <p>Resident #43 was originally admitted to the facility 11/14/2024 after an acute care hospital stay. The current diagnoses included Parkinson's disease, heart failure and dementia with depression and anxiety. The quarterly MDS with an assessment reference date (ARD) of 2/21/25 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 11 out of a possible 15. This indicated Resident #43's cognitive abilities for daily decision making were moderately impaired.</p> <p>A care plan problem dated 12/23/24 stated the resident has behaviors (refuses medications, ADL care, and weights) related to dementia, and a depressive disorder. The goal read the resident's behaviors will not cause him or other resident's distress thru the review period, 5/22/25. The interventions included administer medications as ordered, and assign staff members that are familiar or preferred by the resident whenever possible.</p> <p>On 4/23/25 at 12:02 PM an interview was conducted with the Psychiatric-Mental Health Nurse Practitioner (PMHNP) regarding Resident #43. The PMHNP stated he was considering increasing the resident's medications he was receiving, Remeron and Exelon for dementia and depression. The PMHNP was informed that the resident was currently nonadherent with the ordered medications and had not adhered for an extended period therefore, what would warrant increasing the dosages. The PMHNP stated he had never been notified that Resident #43 was nonadherent with the ordered psychiatric medications.</p> <p>The PMHNP stated at 12:13 PM when the resident was visited earlier that day he was exhibiting paranoia (he believed that the staff was giving him the wrong medications) and the cognitive screening revealed significant dementia (a score of 4 out of 10). The PMHNP further stated the resident talked about holding the wheelchair foot pedals to threaten staff because they were trying to harm him. The PMHNP stated he educated the staff on methods to achieve the resident's compliance and communicated to the staff the importance of nursing services keeping him informed of the resident's adherence to the prescribed medications.</p> <p>On 4/28/25 at approximately 4:00 PM, a final interview was conducted with the Administrator, Director of Nursing, [NAME] President of Operations and a Regional Nurse Consultant. They offered no comments and voiced no concerns regarding the above information.</p> <p>2. Resident #116 was admitted to the facility on [DATE] with diagnoses of but not limited to muscle weakness, major depressive disorder, left artificial hip, seizures and fibromyalgia.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The most recent Minimum Data Set (MDS) was a Quarterly Assessment with an Assessment Reference Date (ARD) of 03/18/25. Resident # 116's BIMS (Brief Interview for Mental Status) Score was a 15 out of 15, indicating no cognitive impairment. Resident #116 required assistance with Activities of Daily Living.</p> <p>On 4/14/2025 during the initial tour, Resident #116's room had a strong smell of urine. The bed was soiled, the incontinent pad appeared brown in color and soaked with urine. Resident #116 stated she did not want to have her bed changed or be assisted with ADL (Activities of Daily Living) and incontinent care by the CNA (Certified Nursing Assistant) assigned.</p> <p>A review of a Nursing note dated 04/22/2024 revealed that Resident #116 refused ADL care and that it was reported to the physician and Residents family member.</p> <p>On 04/24/2025, at 1:40 p.m., an interview was conducted with the LPN #B who stated that Resident #116 refuses care often, and that her refusal had been care-planned but that the resident still refuses often. When asked if the physician was notified LPN#B stated most times the physician is notified. She went on to say that Resident #116's aunt could usually assist with getting resident #116 to allow ADL and incontinent care.</p> <p>On 04/24/2025, an interview was conducted with the Facility's Nurse Practioner. When asked if she was notified when Resident #116 refused care, she stated no not every time but that she is aware that Resident #116 refuses ADL and incontinent care almost daily. She went on to say that she has had Psychiatry to evaluate the resident and has added this behavior to the care plan.</p> <p>On 4/25/25 at approximately 6:00 PM, during the end of day meeting the Interim Administrator, DON (Director of Nursing) and two Regional Consultants were informed of the concerns. The DON stated the family member that they would contact to assist with the communicating with the resident has informed that she washes her hands with Resident #116 and the staff will be working with the Resident, physician, behavioral health and social work to develop a new plan of care. No additional information was provided.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495097	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/28/2025
NAME OF PROVIDER OR SUPPLIER Parham Health Care & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 4. Comfortable and safe temperature on the Central Unit:</p> <p>a. Resident #43 complained of not being comfortable because of coldness on 4/17/25.</p> <p>Resident #43 was originally admitted to the facility 11/14/2024 after an acute care hospital stay. The current diagnoses included Parkinson's disease, heart failure and dementia with depression and anxiety. The quarterly MDS with an assessment reference date (ARD) of 2/21/25 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 11 out of a possible 15. This indicated Resident #43's cognitive abilities for daily decision making were moderately impaired.</p> <p>On 4/17/25 at 11:35 AM an interview was conducted with Resident #43. He was observed lying on his bed complaining of a toothache and wrapped in a robe. The only linens on the resident's bed was sheets and a light bedspread. Resident #43 stated that it's was too cold and that's why he had a robe wrapped around him. The resident further stated that he is accustomed to the cold because lived in Buffalo, New York for years and the coldness was why he left Buffalo. The resident also stated he had been cold seven day out of the last seven and it was too cold in the facility for elders. The resident stated a blanket could help but a better form of heat would be better.</p> <p>Nurses were observed distributing blankets later in the day on 4/17/25 at approximately 1:15 PM but Resident #43 did not receive one. Also on 4/17/25 at approximately 3:20 PM the Maintenance Director stated the Corporate office instructed him not to turn the heating system back on because over the coming weekend the temperature was supposed to rise significantly.</p> <p>On 4/28/25 at approximately 4:00 PM, a final interview was conducted with the Administrator, Director of Nursing, [NAME] President of Operations and a Regional Nurse Consultant. They offered no comments and voiced no concerns regarding the above information.</p> <p>5. Comfortable and safe temperature on the Central Unit:</p> <p>Resident #45 complained of feeling cold on 4/17/25.</p> <p>Resident #45 was originally admitted to the facility on [DATE] and had not been discharged from the facility. The resident's diagnoses included dementia and coronary artery disease. The annual MDS with an assessment reference date (ARD) of 1/18/25 coded the resident as not completing the Brief Interview for Mental Status (BIMS). The staff interview coded the resident as having long term and short tem memory problems and severely impaired decision making abilities.</p> <p>On 4/17/25 at 11:37 AM an interview was conducted with Resident #45. Resident #45 complained of freezing and stated that was why she needed her foot covered. She further stated she had been freezing for the last 3 out of seven days.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Nurses were observed distributing blankets later in the day on 4/17/25 at approximately 1:15 PM and Resident #43 received one. Also on 4/17/25 at approximately 3:20 PM the Maintenance Director stated the Corporate office instructed him not to turn the heating system back on because over the coming weekend the temperature was supposed to rise significantly.</p> <p>On 4/28/25 at approximately 4:00 PM, a final interview was conducted with the Administrator, Director of Nursing, [NAME] President of Operations and a Regional Nurse Consultant. They offered no comments and voiced no concerns regarding the above information.</p> <p>6. Comfortable and safe temperature on the Central Unit:</p> <p>Resident #85's husband stated the resident was often cold on 4/17/25.</p> <p>Resident #85 was originally admitted to the facility 8/22/2023. The resident's current diagnoses included adult failure to thrive, dementia and dysphagia. The significant change MDS with an assessment reference date (ARD) of 1/18/25 coded the resident as not completing the Brief Interview for Mental Status (BIMS). The staff interview coded the resident as having long term and short tem memory problems and moderately impaired decision making abilities.</p> <p>On 4/17/25 at approximately 11:39 AM Resident #85 was observed seated in her room with a blanket wrapped around her. An interview was conducted with Resident #85's husband who was seated beside her, assisting her to consume food he had brought in. The husband stated the resident is often cold therefore he keeps personal blankets on her bed. The husband stated over the last week it had been colder but he was aware that the heat had been turned off for the season.</p> <p>On 4/17/25 at approximately 3:20 PM the Maintenance Director stated the Corporate office instructed him not to turn the heating system back on because over the coming weekend the temperature was supposed to rise significantly.</p> <p>On 4/28/25 at approximately 4:00 PM, a final interview was conducted with the Administrator, Director of Nursing, [NAME] President of Operations and a Regional Nurse Consultant. They offered no comments and voiced no concerns regarding the above information.</p> <p>7. Comfortable and safe temperature on the Central Unit:</p> <p>Resident #38 complained about it being too cold in her room on 4/17/25.</p> <p>Resident #38 was originally admitted to the facility 11/20/2023. The current diagnoses included Parkinson's disease and diabetes. The quarterly MDS with an assessment reference date (ARD) of 2/20/25 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 13 out of a possible 15. This indicated Resident #38's cognitive abilities for daily decision making were intact.</p> <p>On 4/17/25 at 11:49 AM Resident #38 was observed in bed with 3 additional throw blankets on and wearing a burgundy wool hat. During the interview with Resident #38 she stated it was too cold and she had put on and gotten out everything out she could to keep warm and it was not helping. The resident stated the heated needed to be turned up.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Nurses were observed distributing blankets later in the day on 4/17/25 at approximately 1:15 PM but Resident #43 did not receive one. Also on 4/17/25 at approximately 3:20 PM the Maintenance Director stated the Corporate office instructed him not to turn the heating system back on because over the coming weekend the temperature was supposed to rise significantly.</p> <p>On 4/28/25 at approximately 4:00 PM, a final interview was conducted with the Administrator, Director of Nursing, [NAME] President of Operations and a Regional Nurse Consultant. They offered no comments and voiced no concerns regarding the above information.</p> <p>Sanitary Issues:</p> <p>On 4/18/25 at approximately 12:04 PM, an interview was conducted with Licensed Practical Nurse (LPN) H, at the medication cart. A medium size roach was first observed crawling around on the top of the medication cart near the drawers, then as LPN H attempted to get rid of it, the roach ran across the cart near the applesauce container and then quickly beneath the towel absorbing the water from the water pitcher. LPN H removed the towel, exposing the roach and was observed swatting the roach to the floor and killing it. LPN H stated she has seen roaches before in the facility but not on the medication cart.</p> <p>On 4/28/25 at approximately 4:00 PM, a final interview was conducted with the Administrator, Director of Nursing, [NAME] President of Operations and a Regional Nurse Consultant. They offered no comments and voiced no concerns regarding the above information.</p> <p>2. For the facility, the facility staff failed to ensure a clean and comfortable homelike environment and the [NAME] and East units.</p> <p>For Resident # 56 residing on [NAME] Unit, the facility staff failed to ensure ensure a clean, comfortable homelike environment due to deep scratches on the unpainted walls and the presence of roaches.</p> <p>Resident # 56 was readmitted to the facility on [DATE]. Diagnoses included but were not limited to: Septic Shock, Hypertension, Acute Metabolic Encephalopathy, Chronic Kidney Disease-Stage 3, Acute Embolism and Thrombosis of deep veins of right lower extremity, peripheral vascular disease and non-pressure chronic ulcer of right calf.</p> <p>The most recent Minimum Data Set (MDS) assessment was a Significant Change Assessment with an assessment reference date (ARD) of 4/10/2025. Resident #56 was coded with a Brief Interview of Mental Status score of 15 out of 15 indicating no cognitive impairment. Resident # 56 required extensive assistance on staff for activities of daily living.</p> <p>Review of the clinical record was conducted 4/16/2025-4/28/2025.</p> <p>During rounds on 4/16/2025 at 3:15 p.m., Resident # 56 was observed lying in bed and watching television. The walls were noted to have large white colored areas and deep scratches. The walls were in need of painting. When asked if there were any other problems, he stated there were a lot of roaches in the facility.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Resident # 56 stated roaches were everywhere. He stated they were in the residents' rooms and in the hallways. He also stated he had seen roaches in the facility several times.</p> <p>Resident # 56 stated the room needed some work.</p> <p>On 4/17/2025 at 1:20 p.m., there were observations of debris under the Resident # 56's bed and in the corners of the room.</p> <p>On 4/18/2025 at approximately 11:30 a.m., an interview was conducted with the Housekeeping Director. He stated the housekeeping department was responsible for cleaning the rooms. He stated the staff did clean each room each day. The Housekeeping Director stated the facility was in the process of getting the walls painted.</p> <p>On 4/18/2025 at approximately 11:45 a.m., an interview was conducted with the Maintenance Director who stated the facility had a pest control contract. He stated the exterminator should be notified of persistent problems with pests. He also stated the facility was being painted in the hallways. There were observations of painters painting in the hallways on each unit.</p> <p>On 4/18/2025 during the end of day debriefing, the Administrator, [NAME] President of Operations, Corporate Nurse Consultant (Employee C) and Director of Nursing were informed of the findings of failure to provide a clean, comfortable, homelike environment.</p> <p>On 4/23/2025 at 3:15 p.m., an interview was conducted with Licensed Practical Nurse-B who stated it was important for the residents' rooms to be comfortable and homelike. She stated some of the rooms did not look homelike.</p> <p>During the end of day debriefing on 4/23/2025, the Facility Administrator, two Corporate Nurse Consultants (Employees C and D) and Director of Nursing were informed of the findings. They stated the rooms should be comfortable and homelike and that some were in need of repair.</p> <p>No further information was provided.</p> <p>3. On the East Unit, the facility staff failed to ensure a clean, comfortable homelike environment including but not limited to: foul odors, patchwork on unpainted walls and the presence of roaches.</p> <p>During tour of the facility on 4/16/2025, there were several observations of areas where the facility failed to ensure a clean, comfortable, homelike environment. There were odors of urine and feces noted while touring the unit.</p> <p>During tour of the Shower room on the East short hall, there were roaches observed in the shower stall.</p> <p>In the room where residents # 9 and # 75 resided, there were white patches on the walls and a hole in the plaster. The bathroom had patches on the walls. Both residents who resided in the room were alert and oriented with BIMS (Brief Interview for Mental Status) scores of 15 indicating no cognitive impairment.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Both residents were interviewed on 4/16/2025 at approximately 2:30 p.m. They stated the room looked like that for a while. Resident # 75 stated there was a problem with roaches in their room and other areas in the facility. Their room was located two doors down and perpendicular to the hall to the facility's kitchen area.</p> <p>Throughout the days of the survey, there were observations of odors occasionally on the East Unit. The odors were more pungent in the mornings prior to 11 a.m.</p> <p>On 4/18/2025 at 12:30 p.m., an interview was conducted with CNA (Certified Nursing Assistant)-B who stated that sometimes roaches were observed in the facility. She also stated sometimes there were odors in the facility. She stated the nursing staff was expected to perform incontinence care every two hours and after every incontinent episode. She stated there were some residents who refused care and that contributed to the odors. She stated the staff was expected to inform the supervisor of any refusal of care and Housekeeping staff of any rooms that needed cleaning.</p> <p>On 4/18/2025 at 1:10 p.m., an interview was conducted with Licensed Practical Nurse-D who stated there were issues with roaches and ants in the facility. She stated sometimes there were odors also. Licensed Practical Nurse-D stated she made rounds to ensure incontinence care was being provided regularly. She stated if residents had clutter or items that might attract pests, she encouraged them to keep the items covered and clean.</p> <p>During the end of day debriefing on 4/23/2025, the Facility Administrator, two Regional Nurse Consultants and Director of Nursing were informed of the findings. The Facility Administrator stated it was important for the facility to be clean, comfortable and homelike.</p> <p>No further information was provided.</p> <p>Based on observation, interview, clinical record review and facility documentation the facility staff failed to ensure the Residents' right to a safe, clean, comfortable homelike environment for the entire facility and seven (7) Residents (#s56, 75, 43, 45, 85, 38, and #116) in a survey sample of 57 Residents.</p> <p>The findings included:</p> <p>1. For the facility, the residents complained of being either too cold or too hot, the dishwasher was not working, the oven was not working, the rooms were dirty, there were strong odors of urine on all hallways, the shower rooms were dirty, and (one)1 shower needed repair.</p> <p>4/15/25 10:00 a.m.- Walking on to the Central Unit there was a strong odor of urine all the way down to the shower room. Central unit shower room strong urine odor, toilet was dirty and not flushed, stains at base of toilet near floor yellow and brown. Three (3) used wash cloths on the floor, shower chair has brown stains on it.</p> <p>4/15/25 10.10 a.m.- East unit shower room shower curtain has brown stains, also mold at base of curtain, shower room smells of urine, shower stalls not clean, resident clothing in room.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>4/15/25 10:15 a.m. - [NAME] unit shower room shower stall at end of room is running, staff attempt but unable to turn it off. shower chair has dirty linen on it, paper towels on floor and in sink. Odor of Urine in hallways.</p> <p>On 4/15/25 - 11:00 a.m. an interview was conducted with the housekeeping supervisor who stated that they usually clean the shower rooms in the morning, but they didn't have a chance because the CNA's were giving showers all morning. Stated his usual deep clean day is Wednesday for shower rooms.</p> <p>4/16/25 - 9:00 a.m. shower curtains had not been changed or washed with the same mold and brown stains observed on the shower curtains. This was observed by the housekeeping supervisor and Employee D; the housekeeping supervisor stated the facility does not have any new curtains to replace them with. When asked if an attempt been made to wash the curtains currently hanging and he stated that he did not know.</p> <p>4/15/25 - 4/16/25 observations were made of all meals being served on styrofoam trays. On 4/26/25 at 3:00 p.m. an interview conducted with the Dietary Manager revealed the dishwasher had not been working. When asked how long the dishwasher had been down, she stated that she would have to check the work orders.</p> <p>Review of facility documentation from the dishwasher repair technician revealed the following:</p> <p>3/26/25 - Customer complaint was unit not washing at all, found 214VAC on the T1,2 and 3 of 3CON [Motor Part numbers], diagnosed as bad wash pump, putting in estimate for repair.</p> <p>4/10/25 - When removing the bottom panel found roaches running throughout the entire unit, found roaches and roach excrement inside of the old motor, advising customer to get an exterminator out before replacing the unit to prevent the motor going bad again after I replace it as well as, so I don't take any roaches home, a majority of them had egg sacs attached to their body.</p> <p>4/15/25 -Customer wanted me to come out today to remove the panels of the warewasher to verify if infestation had been stopped, we found together that there were a reduced number of bugs but still persistent, customer wants to reschedule to Friday to have exterminator out one more time to prevent bugs from breaking a new motor.</p> <p>4/18/25 - Arrived onsite and replaced motor it was filled with roaches, after replacing the motor unit is working and functioning normally.</p> <p>A review of the work orders revealed that the oven had also been out of service, excerpts are as follows:</p> <p>4/9/25 - Oven not heating. Troubleshoot the problem found need to replace fan motor. Blower spacer and mounting screws. Parts ordered.</p> <p>4/15/25 - Received part. Removed the old blower and motor. Installed new blower and motor. Oven working at normal function.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>4/17/25 - Residents on three (3) of three (3) units complained about the temperature being cold in the facility. The overnight temperature in Henrico County was 41 degrees. The facility maintenance director escorted Surveyors E and F to each unit and the temps were as follows:</p> <p>Central Unit - room [ROOM NUMBER] - 65 degrees</p> <p>East Unit - room [ROOM NUMBER] - 65 degrees</p> <p>West Unit - room [ROOM NUMBER]- 68 degrees</p> <p>West Unit hallway 72 degrees</p> <p>The Maintenance Director was asked why the heat was not on he stated, This time of year in Virginia it is sometimes cold at night and hot during the day, and it is not good for the system to keep turning on and off the heat and air. He stated that this is an old system and cannot keep up with the demands of this building. The Maintenance Director also informed surveyors that the chiller they have now is from another building and is not functioning properly.</p> <p>The surveyors requested repair and service information for the heating and air conditioning for the past year below are excerpts from the emails between the Regional Director of Physical Plant and Corporate offices regarding the repairs:</p> <p>5/21/24 - This chiller was working when it was turned off last year at [facility name redacted]. [Company name redacted] moved it for us, it was vandalized sitting in [Facility name redacted] parking lot overnight. Since it was installed a few months ago in the mechanical room, a large circulating pump has ruptured spraying all over the mechanical room. The control board is ruined and has to be built and programmed for this particular chiller . Given the issues last year with the state, I think we need to move on this asap.</p> <p>4/1/25 - The chiller project at [Facility name redacted] which began in 2023, remains unresolved despite a significant financial investment. The original chiller was relocated and installed, only to find the control board was nonfunctional. We then incurred additional costs to bring in a temporary chiller while awaiting a new control board. We were told installation would proceed in the spring, but that was followed by further delays. We've now been informed that the system is still not operational and are told guidance is pending from [Company name redacted]. This has gone on for far too long. We are now at risk of the state shutting down the building if the issue is not resolved immediately.</p> <p>On 4/21/25 at 4 p.m. a large trash can was observed in the hallway on the [NAME] Unit. Water was dripping from the ceiling into the trash can. An interview with the Maintenance Director revealed that the temperature had gone up to 81 degrees that afternoon the a/c was turned on. The air conditioning unit was leaking, condensation from the rooftop unit. The [NAME] Unit has a separate air conditioning system, and the Maintenance Director stated the technician said there was Three and a half (3-1/2) inches of ice built up on the coils that had to melt before any repairs could be done.</p> <p>A review of the facility policy entitled Timely Repairs dated 1/22/24 revealed the following:</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>1. Verify identified repairs are completed within two (2) business days from the date the work order was generated in the preventative maintenance electronic record unless the repairs require the acquisition of outside resources.</p> <p>2. For repairs that require the acquisition of outside resources, and/or parts that must be ordered which will delay and extend repair time past ten (10) working days, document in the preventative maintenance electronic record the parts ordered, P.O. number(s), contractor, and/or anticipated date for repairs.</p> <p>8. For Resident #116 residing on the Central Unit, the facility staff failed to maintain a clean comfortable and homelike environment. 1. During the Survey 04/14/2025-04/28/2025, The wall behind Resident #116's bed and the wall behind the television was soiled, with what appeared to be dried dark brown liquid splashes from the middle of the wall down to the floor. 2. Ensure the Resident Room was free of pests. 3. The floor tile under Resident #116's sink is missing, and the one that was pulled up has jagged edges throughout the entire survey.</p> <p>Resident #116 was admitted to the facility on [DATE] with the diagnoses of, but not limited to, muscle weakness, major depressive disorder, left artificial hip, seizures, and fibromyalgia.</p> <p>The most recent Minimum Data Set (MDS) was a Quarterly Assessment with an Assessment Reference Date (ARD) of 03/18/25. Resident # 116's BIMS (Brief Interview for Mental Status) Score was a 15 out of 15, indicating no cognitive impairment. Resident #116 required assistance with Activities of Daily Living.</p> <p>On April 14, 2025, during the initial tour, Resident #116's room was devoid of any homelike decorations. The room possessed a strong smell of urine. Some of the tiles under the sink were missing, and one of the remaining tiles had jagged edges. The wall behind Resident #116's bed and the wall behind the television had what appeared to be dark brown liquid splashes to the floor.</p> <p>On 4/22/25, at approximately 1:00 PM, a dead mouse was observed in a sticky trap behind Resident #116's door in the room.</p> <p>On 04/23/25 at 12:40 p.m., an interview was conducted with the LPN #B, who stated that pests/bugs/insects should not be in residents' rooms.</p> <p>On 04/23/25 an interview was conducted with the DON (Director of Nursing), who stated that Angel Rounds are done every morning after the Morning Stand up and are conducted by all department heads and unit managers. She also indicated that pests, bugs, and insects should not be in residents' rooms.</p> <p>On 04/24/25, an interview was conducted with the housekeeping staff, who stated that resident rooms are checked, mopped, and cleaned daily, as well as when requested or needed.</p> <p>Review of the facility policy entitled Patient Room Inspections, implemented 05/01/2022, revealed a policy statement which included the following excerpts:</p> <ol style="list-style-type: none"> 1. Identify room locations. 2. Inspect room environment including but not limited to sprinkler heads, lights, globes, privacy <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>curtains and tracks, wallpaper, walls, floor tile, carpet, baseboards, door, door hardware, bumper stops, and frames, ceiling tiles, toilet seats, towel bars, grab bars, furniture, windows, blinds, and all electrical appliances and/or equipment including medical devices to verify items are safe and properly maintained.</p> <p>6. Check for insects/pests.</p> <p>11. Replace cracked or broken wall/floor tile. Re-caulk around tile and bath fixtures as necessary.</p> <p>Apply new grout as necessary.</p> <p>17. Inspect flooring and repair as needed.</p> <p>On April 24, 2025, during the end-of-day meeting, the Administrator, Director of Nursing, Housekeeping, and Maintenance staff were informed of the findings regarding the failure to provide a clean, comfortable, and homelike environment. There was no additional documentation was provided.</p>

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Observation, staff interviews, Resident interviews, clinical record reviews, and facility documentation review, the facility staff failed to prevent repeated willful abuse at the hands of Residents, and staff members. The facility further failed to report the abuse to the state agency accurately and timely, failed to fully investigate the abuse, failed to protect new victims from abuse, and further failed to implement their abuse and neglect policies for multiple known Residents who were abused, (Residents #167, Male 1, Male 2, and Female 1, #77, #50, and #56) in a survey sample size of 57 residents.</p> <p>The findings included:</p> <p>1. The facility failures described above resulted in the willful abuse of Resident #167 and 3 other Resident victims who collectively were abused by Resident #86 on 5 occasions, (one Resident twice).</p> <p>Resident #167 (victim 1) was admitted to the facility on [DATE]. Diagnoses included: Motor vehicle accident with traumatic brain injury, vertebral fractures, dissection of the carotid artery, tracheostomy with status post ventilator support, seizures, atrial fibrillation, dysphagia with gastrostomy tube for feeding, weakness, and diabetes type 2.</p> <p>Resident #167's most recent Minimum Data Set with an Assessment Reference Date of 4-9-25 was coded as an admission assessment. The Brief Interview for Mental Status was coded as 3 out of a possible 15 points which indicates severe cognitive impairment. The Resident was dependent on staff members for all activities of daily living including hygiene and bathing. The Resident had no aberrant behaviors documented.</p> <p>Resident #86 (abuser) was admitted to the facility on [DATE]. Diagnoses included : Chronic obstructive pulmonary disease (COPD) and was a current smoker, HIV, chronic Hepatitis C, homelessness, chronic pain syndrome, alcoholic hepatitis with current alcohol consumption, anxiety, schizophrenia, bipolar disorder, mood disorder, malnutrition, and diabetes type 2.</p> <p>Resident #86's most recent Minimum Data Set with an Assessment Reference Date of 3-12-25 was coded as an annual assessment. The Brief Interview for Mental Status was coded as 15 out of a possible 15 points which indicates no cognitive impairment. The Resident was cognitively intact, and his own responsible party. The Resident was documented as no change in mental status, and no physical or verbal behaviors directed at others even though he had 3 occurrences of abuse toward others prior to this (3-12-25) assessment in which police reports were made. The Resident required set up help for most activities of daily living with only minimal assistance from one staff member for bathing. The document was not signed as completed until 4-17-25 during survey as data entry errors were noted, and the Resident had no aberrant behaviors documented, even though 5 abuses (two others occurred on 3-19-25, and 4-3-25) were known to have taken place as perpetrated by this Resident by this date (4-17-25).</p> <p>The 3 other Resident's abused by Resident #86 were one female (abuse female 1) who refused to be mentioned in the sample for fear of retaliation, and 2 males. The first male (abuse male 1) who was abused twice refused to be mentioned in the sample for fear of retaliation, and a second male (abuse male 2) who was discharged and could not be located for interview.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>While on continued tour of the facility from 4-14-25 through 4-28-25 Resident #86 was interviewed multiple times, and found to be hiding half smoked cigarettes in his room, and the room smelled of burnt tobacco. The Resident admitted that he and his room mate had been caught smoking in their room that very week. The window sill by Resident #86's bed was full of the following:</p> <p>Two (2) half eaten Styrofoam box containers of take out food sandwiches which were covered in black and green mold, a clear plastic take out food container with moisture condensation on the closed lid with half eaten black pizza inside. Room temperature opened milk in a pint carton box which looked like cottage cheese, a name brand red plastic zip lock bag of green molded Swiss cheese, cups of cereal soggy and room temperature with milk in them, and assorted other food items too numerous to mention all spoiled and being saved by the Resident. Upon entering Resident #86 was found on his room mate's side of the room looking inside the room mate's things. This was discovered as his side of the room was approached and he said hey! that's my stuff leave it alone or I'll mess you up!</p> <p>The facility Administration was asked for all allegations of abuse involving Resident #86 to include; investigations, reports to the state agency, and all staff statements for surveyor review. Five document packages were received. Those documents included initial reports to state agencies, and 5 day follow up reports as required by regulation. 4 of the 5 packages also included fax copies showing each report successfully sent to each state agency.</p> <p>No investigations, no witness or staff statements, no planning to curb behaviors nor protect other Residents from abuse were included. When the Administrative staff were asked for those, they stated that this was all that could be found as the former administrator had recently resigned and they could not find any other information. The 5 instances of actually reported abuses perpetrated by Resident #86 are described below in chronological order;</p> <ol style="list-style-type: none"> 1. 5-14-24 - (abuse male 2) - was rolling down the hallway in his wheel chair and as he passed Resident #86's door he was hit by Resident #86 on the right side of his neck. Resident #86 stated he would not hit this man again, and additional rounding was done, and the matter was closed according to the 5 day follow up report. No description of rounding was given. No initial report to the state agency could ever be found. 2. 6-12-24 - (abuse male 1) - first occurrence was going down the hallway in his wheel chair as he passed Resident #86's door he was hit by Resident #86 for no reason with a reacher (defined as a grabber device on a long handle). The facility had no five day follow up report faxed to the state agency, however, the initial report lists on the 6-12-24 documents unfounded for abuse. 3. 11-12-24 - (abuse male 1) - second occurrence - while abuse male 1 (name) tried to go round Resident #86 who was sitting in the front of the hall, abuse male 1 bumped the wheel chair of Resident #86 and hit Resident #86's arm who then struck abuse male 1 in the face. No report to the state agency was made until 3 days after this second occurrence, which was a five day follow up, with no decision to substantiate abuse ever made via the 5 day follow up report, and no initial report was ever made. <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>4. 3-19-25 - (sexual abuse female 1) - Resident stated she was standing in her door and Resident #86 was in the hallway in front of her door sitting in his wheel chair and reached up and touched her breast. She wanted to press charges and police were called, and the allegation was substantiated. The police arrived and arrested the Resident for an outstanding warrant in an unrelated matter. The Resident was incarcerated from 3-19-25 until his return on 3-25-25. The Resident had a history of incarceration and marked all of his clothing items with his inmate number.</p> <p>5. 4-3-25 - (abuse Resident #167) - 9 days after Resident #86 returned from incarceration, Resident #167 was admitted (4-3-25) as his room mate, and the same day was assaulted by Resident #86. Resident #75 was in the hallway walking past the room shared by Resident #167, and #86, and stated she heard Resident #86 yelling at Resident #167 and she heard Resident #86 hit Resident #167 making him fall. Staff immediately entered the room as they were in the hallway and heard the altercation as well, and found Resident #167 on the floor on Resident #86's side of the room. No 5 day follow up report was submitted to the state agency until six days later, on 4-11-25 (late), and stated that no abuse occurred (unsubstantiated).</p> <p>Resident #75, with a Bims score of 15 out of 15 possible points, and her own responsible party was found to be an excellent historian. She was interviewed on 4-17-25 and stated that was exactly what happened and she felt sorry for Resident #167. She stated that everyone knew Resident #86 was violent and they had to avoid him, however, she stated that Resident #167 had just arrived and had no idea his room mate was dangerous. She stated Resident #86 said after the incident to the nurse in the room, he's ok, I didn't really hit him hard or hurt him bad, and he don't want to move rooms. She further stated that staff did move Resident #167, and that was good, because he is so gentle and has a bad head injury from a car wreck and can't protect himself. Staff stated that her recollection was correct.</p> <p>In review of all 5 ongoing allegations of abuse made by 4 different Residents about Resident #86 none were substantiated by the facility, even though there was overwhelming evidence to support it. Only when police became involved was the allegation substantiated for abuse and resulted in the Resident being arrested for an unrelated outstanding warrant, which resulted in his incarceration from 3-19-25 to 3-25-25, when he returned to the facility.</p> <p>The care plan for Resident #86 was reviewed and revealed only one entry focus for behaviors in his 13 month stay. That follows below;</p> <p>Focus - created 3-7-24, initiated 4-9-25, revised 4-16-25.</p> <p>The Resident has behaviors. refused assessment, refused vital signs, cursing/yelling at staff, physical aggression towards others, doing own wound care, props leg on any item while sitting, refused skin assessments, inappropriately touching others, wants to store personal items on window ledge.</p> <p>Goal - The resident's behaviors will not cause them or other residents distress through the review period.</p> <p>Interventions - follow by created date;</p> <p>3-7-24 - Physician review of medication as needed, administer medications as ordered, assure Resident they are safe if they become distressed.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>5-14-24 (first known abuse on others)</p> <p>5-14-24 - 1:1 until seen by provider, assign staff members that are familiar or preferred by the resident when possible, diversional activities of interest as needed, provide snacks and drinks that the resident prefers if they become distressed, psyche services referral as needed, take resident to a quiet place if they become overstimulated, redirect resident and other residents from each others personal space as noted to prevent verbal/physical interactions (stopped on 5-17-24) according to progress notes</p> <p>11-12-24 - education provided to ask for assistance from staff with another resident as needed to avoid verbal and physical altercations.</p> <p>3-19-25 - resident encouraged to avoid touching others and respecting their personal space.</p> <p>4-6-25 - 1:1 until seen by provider, 15 minute checks remainder of shift following (stopped in 48 hours) according to progress notes.</p> <p>Physician and nursing progress notes were reviewed and revealed further multiple incidents of serious allegations of abuse not reported nor investigated. Those follow below in chronological order:</p> <p>3-7-24 - 1 day after admission, verbally aggressive to staff.</p> <p>4-19-24 - Smoking at front door of facility refuse to agree to rules.</p> <p>5-6-24 - [NAME] into street/main highway in wheel chair refusing to return to building stated he was rolling straight to hell because he had no money for cigarettes and snacks.</p> <p>5-14-24 - Hit another Resident in the neck for no reason.</p> <p>6-12-24 - Allegations of antagonizing other residents.</p> <p>7-19-24 - Cursing and yelling at staff, told he could be discharged , he stated he didn't give a damn and rolled away.</p> <p>7-22-24 - Smoking at front door of building throwing cigarettes on ground, cursing and yelling at staff.</p> <p>7-23-24 - In hallway making derogatory remarks do not like gay people or want them near me.</p> <p>7-25-24 - Smoking at front door of building and counseled again.</p> <p>7-31-24 - Ripped smoking signage off the courtyard, stating he will smoke wherever he wants to.</p> <p>8-5-24 - Counseled again in regard to smoking and using fire proof ash trays.</p> <p>8-7-24 - Physician reported significant aggressive behavior with increased paranoia and mood dysregulation, and staff stated he does better when he does not have significant interactions with others.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>9-2-24 - Resident smelled of alcohol during medication administration.</p> <p>9-5-24 - Counseled not to share cigarettes with others, and no smoking inside the facility.</p> <p>9-18-24 - Counseled for Resident to Resident incident of intentionally hitting the leg of a Resident.</p> <p>10-22-24 - Counseled for leaving facility at night without telling staff. Given a reflective device for chair.</p> <p>11-12-24 - Hit another Resident.</p> <p>11-13-24 - Counseled for aggressive incident with another Resident.</p> <p>12-1-24 - Resident had knife in the pocket of his wheel chair for protection staff looked and found scissors.</p> <p>12-2-24 - 9:30 AM argument with room mate blocking room mate from leaving the room trying to punch room mate stated I wish he would die. Resident's room mate helped out of room.</p> <p>12-2-24 - 11:00 AM stealing room mates personal items, threatened room mate with scissors.</p> <p>12-2-24 - 1:00 PM drinking alcohol in front of building, cursed at nurse who confiscated it and lashed out punching and charging in wheel chair at nurse</p> <p>12-2-24 - 3:30 PM punching and kicking staff, room mate removed from room after Resident #86 threatened to stab him. Full Vodka bottles found and confiscated.</p> <p>12-3-24 - Resident smells of alcohol/slurred speech.</p> <p>12-14-24 - Resident riding down street in traffic, resident stated he was going to the store and refused to turn around and refused to get out of the road.</p> <p>12-15-24 - Resident room changed due to behaviors, Resident unhappy about room change.</p> <p>12-15-24 - Resident had altercation aggressive screaming with new room mate.</p> <p>12-18-24 - Resident threw medication at staff.</p> <p>1-17-25 - Resident in possession of and sharing alcohol, Resident angry, cursing and using derogatory language to staff.</p> <p>1-21-25 - Arguing with another Resident in hallway.</p> <p>1-23-25 - Asking other residents for money, said he got cigarettes for them and they owed it to him.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2-1-25 - Verbal altercation with room mate as Resident #86 angry when his room mate moved his own personal items away from Res #86, and #86 threatened room mate with his reacher.</p> <p>2-26-25 - Wants to move because he doesn't like his room mate.</p> <p>3-19-25 - Police called after incident with another Resident. Police removed resident who returned on 3-25-25 after incarceration.</p> <p>3-30-25 - Resident taking things from medication cart, caught by staff said he would not do it again. 10 minutes later found doing it again.</p> <p>4-3-25 - Initiated physical aggression on room mate.</p> <p>4-3-25 - Resident room moved again.</p> <p>Nursing staff on the unit where Resident #86 was housed were interviewed and stated they remembered Resident #86, and his aggressive behaviors, however, those working during survey interviews were not present during all of the abuses. They stated they were aware of the incidents, however, most of the staff were from a staffing agency and did not work there every day.</p> <p>During interview and review of the clinical record, it was found that the Social Worker/Discharge Planner (SWDP) was involved with Resident #86 on 18 documented occasions in 13 months. Those instances follow patterns of behaviors exhibited by the Resident including; smoking in disallowed public spaces, smoking in his room, buying cigarettes for other Residents, drinking alcohol in the facility obtained by traveling to a local convenience store independently in his wheel chair using a busy highway to buy it, and giving it to other Residents. Resident #86 was counseled repeatedly due to aggressive acts perpetrated on other Residents, had room changes because of violence against other Residents, theft of other Residents belongings, attempting to get money from other Residents, threatening to stab a room mate with scissors, and assaulting staff. Only on 2 occasions was added supervision used, and the two occasions were a year apart.</p> <p>The facility staff provided a copy of their Abuse policy, and the policy review revealed that all allegations of abuse will be investigated, Residents will be protected and prevented from further abuse, reports will be sent initially to the State agency VDH/OLC (and other agencies) within 24 hours or within 2 hours if serious injury occurs, and a follow up report will be sent in 5 days to include findings and corrections.</p> <p>Residents reported abuse and were told no abuse occurred (unfounded/unsubstantiated) on multiple occasions before staff observed the abuse and moved Resident #86. Resident #86 was only supervised on 2 occasions (5-14-24, and 4-6-25) a year apart, then allowed to independently move around the entire facility inside, and outside without supervision or oversight, and placed with Residents who were not protected and were abused during that year. Resident #86 was known to have room changes on 3 occasions, and each time he abused again and went to a new area without supervision to abuse.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Many of the incidents listed above as documented, were or should have been, allegations of abuse, however, they were not initially reported to the state agency, not investigated, not followed up with a five day report, were reported late, or never reported to the state agency. Residents were not protected from a known abuser. Abuse was not investigated fully, and the facility policy was not implemented for the protections of Residents from abuse. Further, there was never any ongoing added staff supervision for Resident #86 to prevent the continuing known abuse from occurring.</p> <p>On 4-20-25 at approximately 5:00 p.m., the facility Administrator, Corporate Registered Nurse, and Corporate Administrator were notified of the findings. They stated they had no further information or documentation to offer.</p> <p>4. For Resident # 56, the facility staff failed to protect from physical abuse by another resident (Resident # 322). Resident # 322 hit Resident # 56 in the right eye and caused a contusion and evaluation at the hospital.</p> <p>Resident # 56 was a [AGE] year-old readmitted to the facility on [DATE] with diagnoses that included but were not limited to: Septic Shock, Hypertension, Acute Metabolic Encephalopathy, Chronic Kidney Disease-Stage 3, Acute Embolism and Thrombosis of deep veins of right lower extremity, peripheral vascular disease and non-pressure chronic ulcer of right calf.</p> <p>The most recent Minimum Data Set (MDS) assessment was a Significant Change Assessment with an assessment reference date (ARD) of 4/10/2025. Resident #56 was coded with a Brief Interview of Mental Status score of 15 out of 15 indicating no cognitive impairment.</p> <p>Resident # 322 was a [AGE] year-old admitted to the facility on [DATE] with diagnoses that included but were not limited to: metabolic encephalopathy, cirrhosis of the liver, heart failure and altered mental status.</p> <p>The most recent Minimum Data Set (MDS) assessment was a Discharge Assessment with an assessment reference date (ARD) of 3/28/2025. Resident # 322 was coded with a Brief Interview of Mental Status score of 12 out of 15 indicating moderate cognitive impairment. The resident was in the facility for only 9 days and not long enough to complete an admission Assessment.</p> <p>Review of the clinical records was conducted 4/16/2025-4/28/2025.</p> <p>Review of the Progress Notes for Resident # 56 revealed that on 3/22/2025, Resident # 322 hit Resident # 56 in the eye. The note stated that Resident # 56 was possibly assaulted by his new roommate. Residents have a swollen right eye. POA (Power of Attorney) called no answer/ left message for a return call. Resident have been moved to west wing transferred to another unit in the facility.</p> <p>The next note written on 3/23/2025 at 1:14 a.m. stated that Resident # 56 was sent to the hospital's ER (Emergency Room) for evaluation. The note read: Nursing observations, evaluation, and recommendations are: Resident observed with intermittent confusion. Resident observed with swelling to right eye.</p> <p>Primary Care Provider Feedback : Primary Care Provider responded with the following feedback:</p> <p>A. Recommendations: Send to ER for further eval and treatment</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Further review of the clinical record revealed that Resident # 56 returned to the facility on 3/23/2025 at 9:30 a. m. when the following note stated:</p> <p>Resident returned from ER for evaluation and treatment s/p assaulted by another resident. Multiple X-rays were taken at ER with no abnormalities reported. Contusion remains to right eye. No complaints of visual disturbances voiced. All scheduled pain medications accepted as scheduled. No complaints of pain or discomfort. Will continue to monitor.</p> <p>The swelling of the right eye continued for several days. On 3/26/2025, Resident # 56 was seen by the eye doctor, and new orders were written for for Prednisolone Acetate Ophthalmic Suspension TID (three times a day) to right eye for 14 Days then twice a day for 14 Days for redness to right eye.</p> <p>Review of Resident # 322's record revealed the following documentation from the Psychiatric nurse practitioner dated 3/26/2025:</p> <p>Patient is a [AGE] year-old male requested by this facility for management of aggressive behavior that has been present since 3/23/2025. Patient has been taking Abilify, trazodone, melatonin before his admission to the facility on 3/19/2025. Patient had significant agitation and psychiatry was consulted in the hospital and recommended Abilify for mood stabilization and psychosis management and recommended Haldol 7.5 mg as needed for breakthrough agitation.</p> <p>The note also stated: Per medical record patient recently punched another male resident in the face on 3/23/2025. His aggression was so severe that it caused the other resident to need to go to the hospital for evaluation. Staff reports patient having significant irritability however has not been noted to attack any of the staff. Today when this provider saw patient he was quite irritable and sneered at this provider. He reported 'I am a private person. He did not provide his specific mood however he appeared quite irritable and hostile in the interview. This provider asked how he was adjusting to the facility and he stated that being at the facility 'sucks.' He reported his clothing and shoes being stolen at the facility and states he is ready to go home. Staff is not reported any missing clothing from patient. Patient also stated grandiose statements and he was carrying a load of log books on his lap.</p> <p>The note stated: Resident # 322 stated he was on his way to law school and had only 4 more classes left before he became a lawyer. He denied feeling anxious and excessively worried. He denied having conflicts with staff or other residents. However, when this provider initiated conversation on the physical altercation he had with another male resident he became significantly agitated and repeatedly stating 'who reported this to you!' Patient became increasingly agitated and verbally aggressive with threatening behaviors and this provider decided to end the interview due to safety reasons. Patient refused to answer further interview questions. Cognitive functioning did not appear to have significant increased confusion in the encounter. No suicidal or violent ideations voiced. He denies having retaliatory ideations towards peer. No reported or observed adverse psychotropic medication side effects and patient has been noted to be psychotropic medication adherent.</p> <p>Under Recommendations was written:</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Patient with significant aggressive behaviors with high risk of violence as demonstrated by assaulting patient on 3/23/2025. Abilify does not appear to be fully effective in stabilizing mood or reducing psychosis because patient continues to have grandiose and paranoid delusions. Patient has end-stage renal disease and Haldol may be the best mode of psychosis management which may also reduce patient's aggression. Will augment Abilify with Haldol for psychosis agitation and mood disorder mood dysregulation and impulsive aggression. Haldol is currently being utilized to keep patient in the facility and reduce risk of further violence. Patient currently does not have violent ideations towards other resident at this time who is currently on another unit for safety.</p> <p>The Psychiatric Nurse Practitioner's note also stated there should be followed up in 1-3 weeks. It stated: If pt is to be discharged from facility before this provider is able to re-assess response of psychiatric medication intervention, please follow up with personal outside-facility provider for continued treatment evaluation and psychiatric medication management.</p> <p>On 4/25/2025 at 2:10 p.m., an interview was conducted with Licensed # Practical Nurse-B who stated Resident # 322 hit Resident # 56 at the change of the shifts. Licensed Practical Nurse-B stated Resident # 56 informed the police and facility staff that Resident # 322 hit him. She stated that Resident # 322 was discharged from the facility on 3/28/2025. Licensed Practical Nurse-B stated Resident # 322 had a history of extreme agitation prior to being admitted to the facility.</p> <p>On 4/25/2025 at 4 p.m., an interview was conducted with the Director of Nursing who stated Resident # 322 no longer resided in the facility. He was discharged home. She stated that all of the appropriate agencies were informed of the resident-to-resident altercation. The Director of Nursing stated the staff immediately separated the two residents and that Resident # 56 moved to another unit.</p> <p>Review of the facility's documentation revealed that Resident # 56 yelled out to the nurse that Resident # 322 had punched him in the face. Resident # 56 reported that Resident # 322 punched him after accusing him of stealing his clothes. Resident # 56 denied having any of Resident # 322's clothes.</p> <p>After the incident, the police were notified and completed a report.</p> <p>The doctor and responsible parties for both residents were notified. The facility staff notified all of the appropriate agencies of the altercation.</p> <p>Resident # 322 was placed on 1:1 care for the remainder of the shift.</p> <p>Resident # 56 requested a room change and was moved to another room.</p> <p>Resident # 322 was discharged from the facility on 3/28/2025.</p> <p>Resident # 56 remained upset about being assaulted by his roommate. He told the surveyor it messed me up.</p> <p>On 4/24/2025 at 1:45 a.m., an interview was conducted with Certified Nursing Assistant-C who stated they watch the residents and the way they interact with each other. Certified Nursing Assistant-C stated she would report any issues to the charge nurse or Director of Nursing.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/25/2025 at 2:20 p.m., an interview was conducted with License Practical Nurse-H who stated the staff monitor residents for any signs of aggression or agitation. Licensed Practical Nurse-H stated if residents do have any altercations, they would immediately be separated and protected from further abuse.</p> <p>During the end of day debriefing on 4/25/2025, the Facility Administrator, two Regional Nurse Consultants and Director of Nursing were informed of the findings. Based on the note from the Psychiatric Nurse Practitioner, the facility administration was aware of Resident # 322's significant agitation and need for a Psychiatric consult to in the hospital prior to admission to the facility. During that hospitalization, the Psychiatrist recommended Resident 322 to start taking medications. The medication, Abilify, was prescribed for mood stabilization and psychosis management and another drug, Haldol, was recommended as needed for breakthrough agitation. The facility failed to protect Resident # 56 from abuse by Resident # 322, who was known to have significant agitation and psychosis.</p> <p>Resident # 56 remained upset about being hit in the eye by his roommate (Resident # 322.)</p> <p>No further information was provided.</p> <p>2. For Resident #77 the facility staff failed to keep the Resident free from abuse and neglect.</p> <p>Resident # 77 was admitted to the facility on [DATE] with diagnosis that included chronic embolism and thrombosis, mood disorder, insomnia, dysphasia, muscle, wasting and atrophy, chronic obstructive, pulmonary disease, polyneuropathy, major depressive disorder, chronic kidney disease, fibromyalgia, chronic diastolic heart, failure, hypertension, chronic pain syndrome, and generalized anxiety disorder.</p> <p>Resident # 77's most recent MDS (Minimum Data Set) dated, 4/23/25, scored Resident #77 as having a BIMS (Brief Interview of Mental Status) score of 12 out of 15 indicating mild cognitive impairment. Resident #77 was also coded as requiring extensive assistance with all aspects of ADL (Activities of Daily Living) care except for feeding.</p> <p>On the afternoon of 4/23/25 Resident #77 was interviewed, and she stated that some of the CNA's are rude and rough when providing care. When asked to elaborate she stated that she had a problem with two CNA's and the facility stopped having them care for her. She stated this made the issue worse because now she felt they would just come into the room, turn off the light and tell her they would get someone else to come in but then they never would come. She also stated that now that 2 of the CNA's were upset with her Now they all are. She stated that 2 CNA's came in her room to give her care and brought witness and they Snatched, the blankets, out from under me and lifted my leg to provide care but then they just dropped it back on the bed. When asked if she was injured, she stated that she was not. She further stated, It just made me feel like they just don't care. When asked if she reported the incident, she stated that she told the DON a few days ago. She stated that she waited 12 hours to have incontinent care provided. She stated that she was not changed the entire night shift from 7 p.m. - until 7 a.m.</p> <p>She stated they (the CNAs) sit outside her room and laugh and talk and come in and shut the call light off but never get anyone to come in. When asked how she felt she stated that she felt Helpless, like who is going to protect me? I am bed bound, I cannot get up or defend myself if I have to. Like I am supposed to accept whatever care they choose to provide.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/23/25 at approximately 4:00 p.m., an interview was conducted with the DON who stated that she was aware of the incident and had advised staff to always have someone else in the room to observe when providing care for Resident #77. She stated that she told the resident it was for her as well as the staff. The DON stated that having someone else observed care would safeguard the resident as well as provide the staff with a witness to care provided. When asked if this was considered an allegation of abuse and/or neglect, she stated that it should be.</p> <p>The facility reported the allegation of abuse to the OLC, APS, Ombudsman, and the local authorities on 4/23/25.</p> <p>A review of the clinical record revealed the following excerpt from the physicians progress note:</p> <p>4/23/25 9:30 p.m. -Nursing request for assessment of newly reported bilateral buttocks MASD, skin intact with blanchable redness. Recommend continuing with zinc oxide cream and frequent brief changes to reduce incontinence associated skin breakdown. Facility to manage, provider can reassess if worsening or new area of skin breakdown.</p> <p>A review of the Policy entitled Abuse, Neglect, and Misappropriation effective date, 10/17/23, revealed the following excer[TRUNCATED]</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Observation, staff interviews, Resident interviews, clinical record reviews, and facility documentation review, the facility staff failed to prevent repeated willful abuse at the hands of Residents, and staff members. The facility further failed to report the abuse to the state agency accurately and timely, failed to fully investigate the abuse, failed to protect new victims from abuse, and further failed to implement their abuse and neglect policies for multiple known Residents who were abused. (Residents #167, Male 1, Male 2, and Female 1, and #77) in a survey sample size of 57 residents.</p> <p>The findings included:</p> <p>1. The facility failures described above resulted in the willful abuse of Resident #167 and 3 other Resident victims who collectively were abused by Resident #86 on 5 occasions, (one Resident twice).</p> <p>Resident #167 (victim 1) was admitted to the facility on [DATE]. Diagnoses included: Motor vehicle accident with traumatic brain injury, vertebral fractures, dissection of the carotid artery, tracheostomy with status post ventilator support, seizures, atrial fibrillation, dysphagia with gastrostomy tube for feeding, weakness, and diabetes type 2.</p> <p>Resident #167's most recent Minimum Data Set with an Assessment Reference Date of 4-9-25 was coded as an admission assessment. The Brief Interview for Mental Status was coded as 3 out of a possible 15 points which indicates severe cognitive impairment. The Resident was dependent on staff members for all activities of daily living including hygiene and bathing. The Resident had no aberrant behaviors documented.</p> <p>Resident #86 (abuser) was admitted to the facility on [DATE]. Diagnoses included : Chronic obstructive pulmonary disease (COPD) and was a current smoker, HIV, chronic Hepatitis C, homelessness, chronic pain syndrome, alcoholic hepatitis with current alcohol consumption, anxiety, schizophrenia, bipolar disorder, mood disorder, malnutrition, and diabetes type 2.</p> <p>Resident #86's most recent Minimum Data Set with an Assessment Reference Date of 3-12-25 was coded as an annual assessment. The Brief Interview for Mental Status was coded as 15 out of a possible 15 points which indicates no cognitive impairment. The Resident was cognitively intact, and his own responsible party. The Resident was documented as no change in mental status, and no physical or verbal behaviors directed at others even though he had 3 occurrences of abuse toward others prior to this (3-12-25) assessment in which police reports were made. The Resident required set up help for most activities of daily living with only minimal assistance from one staff member for bathing. The document was not signed as completed until 4-17-25 during survey as data entry errors were noted, and the Resident had no aberrant behaviors documented, even though 5 abuses (two others occurred on 3-19-25, and 4-3-25) were known to have taken place as perpetrated by this Resident by this date (4-17-25).</p> <p>The 3 other Resident's abused by Resident #86 were one female (abuse female 1) who refused to be mentioned in the sample for fear of retaliation, and 2 males. The first male (abuse male 1) who was abused twice refused to be mentioned in the sample for fear of retaliation, and a second male (abuse male 2) who was discharged and could not be located for interview.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>While on continued tour of the facility from 4-14-25 through 4-28-25 Resident #86 was interviewed multiple times, and found to be hiding half smoked cigarettes in his room, and the room smelled of burnt tobacco. The Resident admitted that he and his room mate had been caught smoking in their room that very week. The window sill by Resident #86's bed was full of the following;</p> <p>Two (2) half eaten Styrofoam box containers of take out food sandwiches which were covered in black and green mold, a clear plastic take out food container with moisture condensation on the closed lid with half eaten black pizza inside. Room temperature opened milk in a pint carton box which looked like cottage cheese, a name brand red plastic zip lock bag of green molded Swiss cheese, cups of cereal soggy and room temperature with milk in them, and assorted other food items too numerous to mention all spoiled and being saved by the Resident. Upon entering Resident #86 was found on his room mate's side of the room looking inside the room mate's things. This was discovered as his side of the room was approached and he said hey! that's my stuff leave it alone or I'll mess you up!</p> <p>The facility Administration was asked for all allegations of abuse involving Resident #86 to include; investigations, reports to the state agency, and all staff statements for surveyor review. Five document packages were received. Those documents included initial reports to state agencies, and 5 day follow up reports as required by regulation. 4 of the 5 packages also included fax copies showing each report successfully sent to each state agency.</p> <p>No investigations, no witness or staff statements, no planning to curb behaviors nor protect other Residents from abuse were included. When the Administrative staff were asked for those, they stated that this was all that could be found as the former administrator had recently resigned and they could not find any other information. The 5 instances of actually reported abuses perpetrated by Resident #86 are described below in chronological order;</p> <ol style="list-style-type: none"> 1. 5-14-24 - (abuse male 2) - was rolling down the hallway in his wheel chair and as he passed Resident #86's door he was hit by Resident #86 on the right side of his neck. Resident #86 stated he would not hit this man again, and additional rounding was done, and the matter was closed according to the 5 day follow up report. No description of rounding was given. No initial report to the state agency could ever be found. 2. 6-12-24 - (abuse male 1) - first occurrence was going down the hallway in his wheel chair as he passed Resident #86's door he was hit by Resident #86 for no reason with a reacher (defined as a grabber device on a long handle). The facility had no five day follow up report faxed to the state agency, however, the initial report lists on the 6-12-24 documents unfounded for abuse. 3. 11-12-24 - (abuse male 1) - second occurrence - while abuse male 1 (name) tried to go round Resident #86 who was sitting in the front of the hall, abuse male 1 bumped the wheel chair of Resident #86 and hit Resident #86's arm who then struck abuse male 1 in the face. No report to the state agency was made until 3 days after this second occurrence, which was a five day follow up, with no decision to substantiate abuse ever made via the 5 day follow up report, and no initial report was ever made. <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>4. 3-19-25 - (sexual abuse female 1) - Resident stated she was standing in her door and Resident #86 was in the hallway in front of her door sitting in his wheel chair and reached up and touched her breast. She wanted to press charges and police were called, and the allegation was substantiated. The police arrived and arrested the Resident for an outstanding warrant in an unrelated matter. The Resident was incarcerated from 3-19-25 until his return on 3-25-25. The Resident had a history of incarceration and marked all of his clothing items with his inmate number.</p> <p>5. 4-3-25 - (abuse Resident #167) - 9 days after Resident #86 returned from incarceration, Resident #167 was admitted (4-3-25) as his room mate, and the same day was assaulted by Resident #86. Resident #75 was in the hallway walking past the room shared by Resident #167, and #86, and stated she heard Resident #86 yelling at Resident #167 and she heard Resident #86 hit Resident #167 making him fall. Staff immediately entered the room as they were in the hallway and heard the altercation as well, and found Resident #167 on the floor on Resident #86's side of the room. No 5 day follow up report was submitted to the state agency until six days later, on 4-11-25 (late), and stated that no abuse occurred (unsubstantiated).</p> <p>Resident #75, with a Bims score of 15 out of 15 possible points, and her own responsible party was found to be an excellent historian. She was interviewed on 4-17-25 and stated that was exactly what happened and she felt sorry for Resident #167. She stated that everyone knew Resident #86 was violent and they had to avoid him, however, she stated that Resident #167 had just arrived and had no idea his room mate was dangerous. She stated Resident #86 said after the incident to the nurse in the room, he's ok, I didn't really hit him hard or hurt him bad, and he don't want to move rooms. She further stated that staff did move Resident #167, and that was good, because he is so gentle and has a bad head injury from a car wreck and can't protect himself. Staff stated that her recollection was correct.</p> <p>In review of all 5 ongoing allegations of abuse made by 4 different Residents about Resident #86 none were substantiated by the facility, even though there was overwhelming evidence to support it. Only when police became involved was the allegation substantiated for abuse and resulted in the Resident being arrested for an unrelated outstanding warrant, which resulted in his incarceration from 3-19-25 to 3-25-25, when he returned to the facility.</p> <p>The care plan for Resident #86 was reviewed and revealed only one entry focus for behaviors in his 13 month stay. That follows below;</p> <p>Focus - created 3-7-24, initiated 4-9-25, revised 4-16-25.</p> <p>The Resident has behaviors. refused assessment, refused vital signs, cursing/yelling at staff, physical aggression towards others, doing own wound care, props leg on any item while sitting, refused skin assessments, inappropriately touching others, wants to store personal items on window ledge.</p> <p>Goal - The resident's behaviors will not cause them or other residents distress through the review period.</p> <p>Interventions - follow by created date;</p> <p>3-7-24 - Physician review of medication as needed, administer medications as ordered, assure Resident they are safe if they become distressed.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>5-14-24 (first known abuse on others)</p> <p>5-14-24 - 1:1 until seen by provider, assign staff members that are familiar or preferred by the resident when possible, diversional activities of interest as needed, provide snacks and drinks that the resident prefers if they become distressed, psyche services referral as needed, take resident to a quiet place if they become overstimulated, redirect resident and other residents from each others personal space as noted to prevent verbal/physical interactions (stopped on 5-17-24) according to progress notes</p> <p>11-12-24 - education provided to ask for assistance from staff with another resident as needed to avoid verbal and physical altercations.</p> <p>3-19-25 - resident encouraged to avoid touching others and respecting their personal space.</p> <p>4-6-25 - 1:1 until seen by provider, 15 minute checks remainder of shift following (stopped in 48 hours) according to progress notes.</p> <p>Physician and nursing progress notes were reviewed and revealed further multiple incidents of serious allegations of abuse not reported nor investigated. Those follow below in chronological order:</p> <p>3-7-24 - 1 day after admission, verbally aggressive to staff.</p> <p>4-19-24 - Smoking at front door of facility refuse to agree to rules.</p> <p>5-6-24 - [NAME] into street/main highway in wheel chair refusing to return to building stated he was rolling straight to hell because he had no money for cigarettes and snacks.</p> <p>5-14-24 - Hit another Resident in the neck for no reason.</p> <p>6-12-24 - Allegations of antagonizing other residents.</p> <p>7-19-24 - Cursing and yelling at staff, told he could be discharged , he stated he didn't give a damn and rolled away.</p> <p>7-22-24 - Smoking at front door of building throwing cigarettes on ground, cursing and yelling at staff.</p> <p>7-23-24 - In hallway making derogatory remarks do not like gay people or want them near me.</p> <p>7-25-24 - Smoking at front door of building and counseled again.</p> <p>7-31-24 - Ripped smoking signage off the courtyard, stating he will smoke wherever he wants to.</p> <p>8-5-24 - Counseled again in regard to smoking and using fire proof ash trays.</p> <p>8-7-24 - Physician reported significant aggressive behavior with increased paranoia and mood dysregulation, and staff stated he does better when he does not have significant interactions with others.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>9-2-24 - Resident smelled of alcohol during medication administration.</p> <p>9-5-24 - Counseled not to share cigarettes with others, and no smoking inside the facility.</p> <p>9-18-24 - Counseled for Resident to Resident incident of intentionally hitting the leg of a Resident.</p> <p>10-22-24 - Counseled for leaving facility at night without telling staff. Given a reflective device for chair.</p> <p>11-12-24 - Hit another Resident.</p> <p>11-13-24 - Counseled for aggressive incident with another Resident.</p> <p>12-1-24 - Resident had knife in the pocket of his wheel chair for protection staff looked and found scissors.</p> <p>12-2-24 - 9:30 AM argument with room mate blocking room mate from leaving the room trying to punch room mate stated I wish he would die. Resident's room mate helped out of room.</p> <p>12-2-24 - 11:00 AM stealing room mates personal items, threatened room mate with scissors.</p> <p>12-2-24 - 1:00 PM drinking alcohol in front of building, cursed at nurse who confiscated it and lashed out punching and charging in wheel chair at nurse</p> <p>12-2-24 - 3:30 PM punching and kicking staff, room mate removed from room after Resident #86 threatened to stab him. Full Vodka bottles found and confiscated.</p> <p>12-3-24 - Resident smells of alcohol/slurred speech.</p> <p>12-14-24 - Resident riding down street in traffic, resident stated he was going to the store and refused to turn around and refused to get out of the road.</p> <p>12-15-24 - Resident room changed due to behaviors, Resident unhappy about room change.</p> <p>12-15-24 - Resident had altercation aggressive screaming with new room mate.</p> <p>12-18-24 - Resident threw medication at staff.</p> <p>1-17-25 - Resident in possession of and sharing alcohol, Resident angry, cursing and using derogatory language to staff.</p> <p>1-21-25 - Arguing with another Resident in hallway.</p> <p>1-23-25 - Asking other residents for money, said he got cigarettes for them and they owed it to him.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Parham Health Care & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2-1-25 - Verbal altercation with room mate as Resident #86 angry when his room mate moved his own personal items away from Res #86, and #86 threatened room mate with his reacher.</p> <p>2-26-25 - Wants to move because he doesn't like his room mate.</p> <p>3-19-25 - Police called after incident with another Resident. Police removed resident who returned on 3-25-25 after incarceration.</p> <p>3-30-25 - Resident taking things from medication cart, caught by staff said he would not do it again. 10 minutes later found doing it again.</p> <p>4-3-25 - Initiated physical aggression on room mate.</p> <p>4-3-25 - Resident room moved again.</p> <p>Nursing staff on the unit where Resident #86 was housed were interviewed and stated they remembered Resident #86, and his aggressive behaviors, however, those working during survey interviews were not present during all of the abuses. They stated they were aware of the incidents, however, most of the staff were from a staffing agency and did not work there every day.</p> <p>During interview and review of the clinical record, it was found that the Social Worker/Discharge Planner (SWDP) was involved with Resident #86 on 18 documented occasions in 13 months. Those instances follow patterns of behaviors exhibited by the Resident including; smoking in disallowed public spaces, smoking in his room, buying cigarettes for other Residents, drinking alcohol in the facility obtained by traveling to a local convenience store independently in his wheel chair using a busy highway to buy it, and giving it to other Residents. Resident #86 was counseled repeatedly due to aggressive acts perpetrated on other Residents, had room changes because of violence against other Residents, theft of other Residents belongings, attempting to get money from other Residents, threatening to stab a room mate with scissors, and assaulting staff. Only on 2 occasions was added supervision used, and the two occasions were a year apart.</p> <p>The facility staff provided a copy of their Abuse policy, and the policy review revealed that all allegations of abuse will be investigated, Residents will be protected and prevented from further abuse, reports will be sent initially to the State agency VDH/OLC (and other agencies) within 24 hours or within 2 hours if serious injury occurs, and a follow up report will be sent in 5 days to include findings and corrections.</p> <p>Residents reported abuse and were told no abuse occurred (unfounded/unsubstantiated) on multiple occasions before staff observed the abuse and moved Resident #86. Resident #86 was only supervised on 2 occasions (5-14-24, and 4-6-25) a year apart, then allowed to independently move around the entire facility inside, and outside without supervision or oversight, and placed with Residents who were not protected and were abused during that year. Resident #86 was known to have room changes on 3 occasions, and each time he abused again and went to a new area without supervision to abuse.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Many of the incidents listed above as documented, were or should have been, allegations of abuse, however, they were not initially reported to the state agency, not investigated, not followed up with a five day report, were reported late, or never reported to the state agency. Residents were not protected from a known abuser. Abuse was not investigated fully, and the facility policy was not implemented for the protections of Residents from abuse. Further, there was never any ongoing added staff supervision for Resident #86 to prevent the continuing known abuse from occurring.</p> <p>On 4-20-25 at approximately 5:00 p.m., the facility Administrator, Corporate Registered Nurse, and Corporate Administrator were notified of the findings. They stated they had no further information or documentation to offer.</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, clinical record review and facility documentation, the facility staff failed to implement the abuse policy and report an allegation of abuse for one (1) resident (Resident #77) in a survey sample of 57 Residents.</p> <p>The findings included:</p> <p>For Resident #77 the facility staff failed to report and investigate allegations of abuse in a timely manner.</p> <p>Resident # 77 was admitted to the facility on [DATE] with diagnosis that included chronic embolism and thrombosis, mood disorder, insomnia, dysphasia, muscle, wasting and atrophy, chronic obstructive, pulmonary disease, polyneuropathy, major depressive disorder, chronic kidney disease, fibromyalgia, chronic diastolic heart, failure, hypertension, chronic pain syndrome, and generalized anxiety disorder. Resident # 77's most recent MDS (Minimum Data Set) dated, 4/23/25, scored Resident #77 as having a BIMS (Brief Interview of Mental Status) score of 12 out of 15 indicating mild cognitive impairment. Resident #77 was also coded as requiring extensive assistance with all aspects of ADL (Activities of Daily Living) care except for feeding.</p> <p>On the afternoon of 4/23/25 Resident #77 was interviewed, and she stated that some of the CNA's are rude and rough when providing care. When asked to elaborate she stated that she had a problem with two CNA's and the facility stopped having them care for her. She stated this made the issue worse because now she felt they would just come into the room, turn off the light and tell her they would get someone else to come in but then they never would come. She also stated that now that 2 of the CNA's were upset with her Now they all are She stated that 2 CNA's came in her room to give her care and brought witness and they Snatched, the blankets, out from under me and lifted my leg to provide care but then they just dropped it back on the bed. When asked if she was injured, she stated that she was not. She further stated, It just made me feel like they just don't care. When asked if she reported the incident, she stated that she told the DON a few days ago. She stated that she waited 12 hours to have her incontinent care provided. She stated that she was not changed the entire night shift from 7 p.m. - until 7 a.m.</p> <p>She stated they (the CNAs) sit outside her room and laugh and talk and come in and shut the call light off but never get anyone to come in. When asked how she felt she stated that she felt Helpless, like who is going to protect me? I am bed bound, I cannot get up or defend myself if I have to. Like I am supposed to accept whatever care they choose to provide.</p> <p>On 4/23/25 at approximately 4:00 p.m. An interview was conducted with the DON who stated that she was aware of the incident and had advised staff to always have someone else in the room to observe when providing care for Resident #77. She stated that she told the Resident it was for her as well as the staff. The DON stated that having someone else observed care would safeguard the Resident as well as provide the staff with a witness to care provided. When asked if this was considered an allegation of abuse and/or neglect, she stated that it should be.</p> <p>(continued on next page)</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility reported the allegation of abuse to the OLC, APS, Ombudsman, and the local authorities on 4/23/25.</p> <p>A review of the clinical record revealed the following excerpt from the physicians progress note:</p> <p>4/23/25 9:30 p.m. -Nursing request for assessment of newly reported bilateral buttocks MASD, skin intact with blanchable redness. Recommend continuing with zinc oxide cream and frequent brief changes to reduce incontinence associated skin breakdown. Facility to manage, provider can reassess if worsening or new area of skin breakdown.</p> <p>A review of the Policy entitled Abuse, Neglect, and Misappropriation effective date, 10/17/23, revealed the following excerpts:</p> <p>Page 1.</p> <p>Policy: there is zero tolerance for mistreatment abuse, neglect, misappropriation of property or any crime that is against the patient of a healthcare and rehabilitation center.</p> <p>Procedures:</p> <p>1. Patients of the center have the legal right to be free from verbal, sexual, mental, and physical abuse, corporal punishment, involuntary seclusion, including abuse from facilitated or enabled through the use of technology, and free from chemical and physical restraints, except in an emergency and or as authorized by a physician.</p> <p>4. All employees are responsible for immediately (no later than two hours after an 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 the absence, the Director of nursing, or their immediate supervisor and any, and all suspected witnesses incident of the patient abuse, neglect, theft, exploitation, and or mistreatment of a patient as well as any reasonable succession of a crime against the patient.</p> <p>5. Any and all suspected or witnessed incidents of patient-to-patient abuse, neglect, theft, and or exploitation or the reasonable suspicion of a crime against a patient, patient center brought to the attention of the centers. The administrator will result in internal investigation, appropriate, and timely reporting to the state survey agency, and other legally designated agencies, as well as staff corrective action, suspension, and or termination as necessary.</p> <p>On 4/23/25 the Administrator was made aware of the concerns and no further information was provided.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interviews, Resident interviews, clinical record reviews, and facility documentation review, the facility staff failed to investigate, prevent, and correct repeated willful abuse at the hands of Resident #86. The facility further failed to report the abuse to the state agency accurately and timely, and failed to implement their abuse and neglect policies for multiple known Residents who were abused. (Residents #167, Male 1, Male 2, and Female 1) in a survey sample size of 57 residents.</p> <p>The findings included:</p> <p>The facility failures described above resulted in the willful abuse of Resident #167 and 3 other Resident victims who collectively were abused by Resident #86 on 5 occasions, (one Resident twice).</p> <p>Resident #167 (victim 1) was admitted to the facility on [DATE]. Diagnoses included: Motor vehicle accident with traumatic brain injury, vertebral fractures, dissection of the carotid artery, tracheostomy with status post ventilator support, seizures, atrial fibrillation, dysphagia with gastrostomy tube for feeding, weakness, and diabetes type 2.</p> <p>Resident #167's most recent Minimum Data Set with an Assessment Reference Date of 4-9-25 was coded as an admission assessment. The Brief Interview for Mental Status was coded as 3 out of a possible 15 points which indicates severe cognitive impairment. The Resident was dependent on staff members for all activities of daily living including hygiene and bathing. The Resident had no aberrant behaviors documented.</p> <p>Resident #86 (abuser) was admitted to the facility on [DATE]. Diagnoses included : Chronic obstructive pulmonary disease (COPD) and was a current smoker, HIV, chronic Hepatitis C, homelessness, chronic pain syndrome, alcoholic hepatitis with current alcohol consumption, anxiety, schizophrenia, bipolar disorder, mood disorder, malnutrition, and diabetes type 2.</p> <p>Resident #86's most recent Minimum Data Set with an Assessment Reference Date of 3-12-25 was coded as an annual assessment. The Brief Interview for Mental Status was coded as 15 out of a possible 15 points which indicates no cognitive impairment. The Resident was cognitively intact, and his own responsible party. The Resident was documented as no change in mental status, and no physical or verbal behaviors directed at others even though he had 3 occurrences of abuse toward others prior to this (3-12-25) assessment in which police reports were made. The Resident required set up help for most activities of daily living with only minimal assistance from one staff member for bathing. The document was not signed as completed until 4-17-25 during survey as data entry errors were noted, and the Resident had no aberrant behaviors documented, even though 5 abuses (two others occurred on 3-19-25, and 4-3-25) were known to have taken place as perpetrated by this Resident by this date (4-17-25).</p> <p>The 3 other Resident's abused by Resident #86 were one female (abuse female 1) who refused to be mentioned in the sample for fear of retaliation, and 2 males. The first male (abuse male 1) who was abused twice refused to be mentioned in the sample for fear of retaliation, and a second male (abuse male 2) who was discharged and could not be located for interview.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>While on continued tour of the facility from 4-14-25 through 4-28-25 Resident #86 was interviewed multiple times, and found to be hiding half smoked cigarettes in his room, and the room smelled of burnt tobacco. The Resident admitted that he and his room mate had been caught smoking in their room that very week. The window sill by Resident #86's bed was full of the following;</p> <p>Two (2) half eaten Styrofoam box containers of take out food sandwiches which were covered in black and green mold, a clear plastic take out food container with moisture condensation on the closed lid with half eaten black pizza inside. Room temperature opened milk in a pint carton box which looked like cottage cheese, a name brand red plastic zip lock bag of green molded Swiss cheese, cups of cereal soggy and room temperature with milk in them, and assorted other food items too numerous to mention all spoiled and being saved by the Resident. Upon entering Resident #86 was found on his room mate's side of the room looking inside the room mate's things. This was discovered as his side of the room was approached and he said hey! that's my stuff leave it alone or I'll mess you up!</p> <p>The facility Administration was asked for all allegations of abuse involving Resident #86 to include; investigations, reports to the state agency, and all staff statements for surveyor review. Five document packages were received. Those documents included initial reports to state agencies, and 5 day follow up reports as required by regulation. 4 of the 5 packages also included fax copies showing each report successfully sent to each state agency.</p> <p>No investigations, no witness or staff statements, no planning to curb behaviors nor protect other Residents from abuse were included. When the Administrative staff were asked for those, they stated that this was all that could be found as the former administrator had recently resigned and they could not find any other information. The 5 instances of actually reported abuses perpetrated by Resident #86 are described below in chronological order;</p> <ol style="list-style-type: none"> 1. 5-14-24 - (abuse male 2) - was rolling down the hallway in his wheel chair and as he passed Resident #86's door he was hit by Resident #86 on the right side of his neck. Resident #86 stated he would not hit this man again, and additional rounding was done, and the matter was closed according to the 5 day follow up report. No description of rounding was given. No initial report to the state agency could ever be found. 2. 6-12-24 - (abuse male 1) - first occurrence was going down the hallway in his wheel chair as he passed Resident #86's door he was hit by Resident #86 for no reason with a reacher (defined as a grabber device on a long handle). The facility had no five day follow up report faxed to the state agency, however, the initial report lists on the 6-12-24 documents unfounded for abuse. 3. 11-12-24 - (abuse male 1) - second occurrence - while abuse male 1 (name) tried to go round Resident #86 who was sitting in the front of the hall, abuse male 1 bumped the wheel chair of Resident #86 and hit Resident #86's arm who then struck abuse male 1 in the face. No report to the state agency was made until 3 days after this second occurrence, which was a five day follow up, with no decision to substantiate abuse ever made via the 5 day follow up report, and no initial report was ever made. <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>4. 3-19-25 - (sexual abuse female 1) - Resident stated she was standing in her door and Resident #86 was in the hallway in front of her door sitting in his wheel chair and reached up and touched her breast. She wanted to press charges and police were called, and the allegation was substantiated. The police arrived and arrested the Resident for an outstanding warrant in an unrelated matter. The Resident was incarcerated from 3-19-25 until his return on 3-25-25. The Resident had a history of incarceration and marked all of his clothing items with his inmate number.</p> <p>5. 4-3-25 - (abuse Resident #167) - 9 days after Resident #86 returned from incarceration, Resident #167 was admitted (4-3-25) as his room mate, and the same day was assaulted by Resident #86. Resident #75 was in the hallway walking past the room shared by Resident #167, and #86, and stated she heard Resident #86 yelling at Resident #167 and she heard Resident #86 hit Resident #167 making him fall. Staff immediately entered the room as they were in the hallway and heard the altercation as well, and found Resident #167 on the floor on Resident #86's side of the room. No 5 day follow up report was submitted to the state agency until six days later, on 4-11-25 (late), and stated that no abuse occurred (unsubstantiated).</p> <p>Resident #75, with a Bims score of 15 out of 15 possible points, and her own responsible party was found to be an excellent historian. She was interviewed on 4-17-25 and stated that was exactly what happened and she felt sorry for Resident #167. She stated that everyone knew Resident #86 was violent and they had to avoid him, however, she stated that Resident #167 had just arrived and had no idea his room mate was dangerous. She stated Resident #86 said after the incident to the nurse in the room, he's ok, I didn't really hit him hard or hurt him bad, and he don't want to move rooms. She further stated that staff did move Resident #167, and that was good, because he is so gentle and has a bad head injury from a car wreck and can't protect himself. Staff stated that her recollection was correct.</p> <p>In review of all 5 ongoing allegations of abuse made by 4 different Residents about Resident #86 none were substantiated by the facility, even though there was overwhelming evidence to support it. Only when police became involved was the allegation substantiated for abuse and resulted in the Resident being arrested for an unrelated outstanding warrant, which resulted in his incarceration from 3-19-25 to 3-25-25, when he returned to the facility.</p> <p>The care plan for Resident #86 was reviewed and revealed only one entry focus for behaviors in his 13 month stay. That follows below;</p> <p>Focus - created 3-7-24, initiated 4-9-25, revised 4-16-25.</p> <p>The Resident has behaviors. refused assessment, refused vital signs, cursing/yelling at staff, physical aggression towards others, doing own wound care, props leg on any item while sitting, refused skin assessments, inappropriately touching others, wants to store personal items on window ledge.</p> <p>Goal - The resident's behaviors will not cause them or other residents distress through the review period.</p> <p>Interventions - follow by created date;</p> <p>3-7-24 - Physician review of medication as needed, administer medications as ordered, assure Resident they are safe if they become distressed.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>5-14-24 (first known abuse on others)</p> <p>5-14-24 - 1:1 until seen by provider, assign staff members that are familiar or preferred by the resident when possible, diversional activities of interest as needed, provide snacks and drinks that the resident prefers if they become distressed, psyche services referral as needed, take resident to a quiet place if they become overstimulated, redirect resident and other residents from each others personal space as noted to prevent verbal/physical interactions (stopped on 5-17-24) according to progress notes</p> <p>11-12-24 - education provided to ask for assistance from staff with another resident as needed to avoid verbal and physical altercations.</p> <p>3-19-25 - resident encouraged to avoid touching others and respecting their personal space.</p> <p>4-6-25 - 1:1 until seen by provider, 15 minute checks remainder of shift following (stopped in 48 hours) according to progress notes.</p> <p>Physician and nursing progress notes were reviewed and revealed further multiple incidents of serious allegations of abuse not reported nor investigated. Those follow below in chronological order:</p> <p>3-7-24 - 1 day after admission, verbally aggressive to staff.</p> <p>4-19-24 - Smoking at front door of facility refuse to agree to rules.</p> <p>5-6-24 - [NAME] into street/main highway in wheel chair refusing to return to building stated he was rolling straight to hell because he had no money for cigarettes and snacks.</p> <p>5-14-24 - Hit another Resident in the neck for no reason.</p> <p>6-12-24 - Allegations of antagonizing other residents.</p> <p>7-19-24 - Cursing and yelling at staff, told he could be discharged , he stated he didn't give a damn and rolled away.</p> <p>7-22-24 - Smoking at front door of building throwing cigarettes on ground, cursing and yelling at staff.</p> <p>7-23-24 - In hallway making derogatory remarks do not like gay people or want them near me.</p> <p>7-25-24 - Smoking at front door of building and counseled again.</p> <p>7-31-24 - Ripped smoking signage off the courtyard, stating he will smoke wherever he wants to.</p> <p>8-5-24 - Counseled again in regard to smoking and using fire proof ash trays.</p> <p>8-7-24 - Physician reported significant aggressive behavior with increased paranoia and mood dysregulation, and staff stated he does better when he does not have significant interactions with others.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>9-2-24 - Resident smelled of alcohol during medication administration.</p> <p>9-5-24 - Counseled not to share cigarettes with others, and no smoking inside the facility.</p> <p>9-18-24 - Counseled for Resident to Resident incident of intentionally hitting the leg of a Resident.</p> <p>10-22-24 - Counseled for leaving facility at night without telling staff. Given a reflective device for chair.</p> <p>11-12-24 - Hit another Resident.</p> <p>11-13-24 - Counseled for aggressive incident with another Resident.</p> <p>12-1-24 - Resident had knife in the pocket of his wheel chair for protection staff looked and found scissors.</p> <p>12-2-24 - 9:30 AM argument with room mate blocking room mate from leaving the room trying to punch room mate stated I wish he would die. Resident's room mate helped out of room.</p> <p>12-2-24 - 11:00 AM stealing room mates personal items, threatened room mate with scissors.</p> <p>12-2-24 - 1:00 PM drinking alcohol in front of building, cursed at nurse who confiscated it and lashed out punching and charging in wheel chair at nurse</p> <p>12-2-24 - 3:30 PM punching and kicking staff, room mate removed from room after Resident #86 threatened to stab him. Full Vodka bottles found and confiscated.</p> <p>12-3-24 - Resident smells of alcohol/slurred speech.</p> <p>12-14-24 - Resident riding down street in traffic, resident stated he was going to the store and refused to turn around and refused to get out of the road.</p> <p>12-15-24 - Resident room changed due to behaviors, Resident unhappy about room change.</p> <p>12-15-24 - Resident had altercation aggressive screaming with new room mate.</p> <p>12-18-24 - Resident threw medication at staff.</p> <p>1-17-25 - Resident in possession of and sharing alcohol, Resident angry, cursing and using derogatory language to staff.</p> <p>1-21-25 - Arguing with another Resident in hallway.</p> <p>1-23-25 - Asking other residents for money, said he got cigarettes for them and they owed it to him.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Parham Health Care & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2400 E Parham Road Richmond, VA 23228	
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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2-1-25 - Verbal altercation with room mate as Resident #86 angry when his room mate moved his own personal items away from Res #86, and #86 threatened room mate with his reacher.</p> <p>2-26-25 - Wants to move because he doesn't like his room mate.</p> <p>3-19-25 - Police called after incident with another Resident. Police removed resident who returned on 3-25-25 after incarceration.</p> <p>3-30-25 - Resident taking things from medication cart, caught by staff said he would not do it again. 10 minutes later found doing it again.</p> <p>4-3-25 - Initiated physical aggression on room mate.</p> <p>4-3-25 - Resident room moved again.</p> <p>Nursing staff on the unit where Resident #86 was housed were interviewed and stated they remembered Resident #86, and his aggressive behaviors, however, those working during survey interviews were not present during all of the abuses. They stated they were aware of the incidents, however, most of the staff were from a staffing agency and did not work there every day.</p> <p>During interview and review of the clinical record, it was found that the Social Worker/Discharge Planner (SWDP) was involved with Resident #86 on 18 documented occasions in 13 months. Those instances follow patterns of behaviors exhibited by the Resident including; smoking in disallowed public spaces, smoking in his room, buying cigarettes for other Residents, drinking alcohol in the facility obtained by traveling to a local convenience store independently in his wheel chair using a busy highway to buy it, and giving it to other Residents. Resident #86 was counseled repeatedly due to aggressive acts perpetrated on other Residents, had room changes because of violence against other Residents, theft of other Residents belongings, attempting to get money from other Residents, threatening to stab a room mate with scissors, and assaulting staff. Only on 2 occasions was added supervision used, and the two occasions were a year apart.</p> <p>The facility staff provided a copy of their Abuse policy, and the policy review revealed that all allegations of abuse will be investigated, Residents will be protected and prevented from further abuse, reports will be sent initially to the State agency VDH/OLC (and other agencies) within 24 hours or within 2 hours if serious injury occurs, and a follow up report will be sent in 5 days to include findings and corrections.</p> <p>Residents reported abuse and were told no abuse occurred (unfounded/unsubstantiated) on multiple occasions before staff observed the abuse and moved Resident #86. Resident #86 was only supervised on 2 occasions (5-14-24, and 4-6-25) a year apart, then allowed to independently move around the entire facility inside, and outside without supervision or oversight, and placed with Residents who were not protected and were abused during that year. Resident #86 was known to have room changes on 3 occasions, and each time he abused again and went to a new area without supervision to abuse.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Many of the incidents listed above as documented, were or should have been, allegations of abuse, however, they were not initially reported to the state agency, not investigated, not followed up with a five day report, were reported late, or never reported to the state agency. Residents were not protected from a known abuser. Abuse was not investigated fully, and the facility policy was not implemented for the protections of Residents from abuse. Further, there was never any ongoing added staff supervision for Resident #86 to prevent the continuing known abuse from occurring.</p> <p>On 4-20-25 at approximately 5:00 p.m., the facility Administrator, Corporate Registered Nurse, and Corporate Administrator were notified of the findings. They stated they had no further information or documentation to offer.</p>

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the resident record review, staff interviews and a review of facility documents, the facility staff failed to notify the Office of the State Long-Term Care Ombudsman in writing of a hospital discharge for 1 of 57 residents (Resident #156), in the survey sample.</p> <p>The findings included:</p> <p>Resident #156 was originally admitted to the facility 2/8/2025 and readmitted [DATE] after a right above the knee amputation (RAKA). The resident's current diagnoses included atherosclerosis, diabetes and chronic kidney disease.</p> <p>The 5-day Medicare Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 03/17/2025 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #156's cognitive abilities for daily decision making were intact.</p> <p>In MDS section GG0130. Self-Care the resident was coded as requiring supervision or touching assistance with eating, oral hygiene, rolling from left to right, sitting on side of bed to lying flat, partial/moderate assistance with lower body dressing and chair/bed-to-chair transfers, substantial/maximal assistance with toileting hygiene, shower/baths, and upper body dressing, dependent with putting on/taking off footwear, sit to stand, toilet transfers and wheeling a wheel chair.</p> <p>A nurse's note dated 3/5/25 at 4:28 AM stated the resident was admitted to hospital following a vascular appointment. Another nurse's note 3/5/25 at 8:19 AM stated the Responsible Party stated the resident was admitted for surgery and will be hospitalized for at least a week. The MDS assessment revealed the resident was discharged return anticipated on 3/4/25.</p> <p>An interview was conducted with the Social Services Director (SSD) on 4/25/25 at approximately 12:45 PM. The SSD stated there was no documentation that the Office of the State Long-Term Care Ombudsman was notified of Resident #156's 3/4/25 discharge to the hospital. The SSD stated she was not aware if notification of the State Long-Term Care Ombudsman was her responsibility with this employer. When the SSD reported back, she stated going forward she would be responsible for notifying the State Long-Term Care Ombudsman of facility initiated a transfers/discharges.</p> <p>On 4/28/25 at approximately 4:00 PM, a final interview was conducted with the Administrator, Director of Nursing, [NAME] President of Operations and a Regional Nurse Consultant. They offered no comments and voiced no concerns regarding the above information.</p>

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review and staff interview, the facility staff failed to ensure a Pre-admission Screening and Resident Review (PASARR) was completed prior to admission for two (2) Residents (Residents #86, and #143) in a sample of 57 residents.</p> <p>The Findings included:</p> <p>1. For Resident #86, facility staff failed to ensure a Preadmission Screening and Resident Review (PASARR) was completed correctly prior to admission.</p> <p>Resident #86 was admitted on [DATE] with diagnoses including: Schizophrenia, bipolar disorder, mood disorder, and anxiety disorder.</p> <p>Physicians orders for medications were reviewed and revealed psychotropic medications actively being administered for anxiety, ongoing behaviors to include alcoholism, aggression and nightmares, and abuse to peers.</p> <p>The Resident's only Passar I was completed 3-25-25, one year after his admission and it was coded incorrectly. The Resident had serious mental illness, and the document refuted that. The Resident was an abuser, and his mental illness was being treated with psychotropic medication, he was being followed by psychiatric practitioners, and he was still unstable, abusive, and his poor mental health interfered with his ability to conduct self directed activities successfully and safely. All of these deficits were well documented by this time. The Pasaar II should have been triggered if the Pasaar I had been completed correctly, and completed as well, however, it was never triggered nor completed.</p> <p>On 4-20-25 at approximately 5:00 p.m., the facility Administrator, Corporate Registered Nurse, and Corporate Administrator were notified of the findings. They stated they had no further information or documentation to offer.</p> <p>2. For Resident #143 the facility staff failed to obtain a PASARR (Preadmission Screening and Resident Review) prior to admission on [DATE].</p> <p>Resident #143 was admitted to the facility on [DATE] with diagnoses that included but were not limited to Bipolar Disorder, Metabolic Encephalopathy, Other Psychoactive substance Abuse, and Seizures.</p> <p>Resident #84's most recent MDS (Minimum Data Set) was an admission Assessment, coded the Resident as having a BIMS (Brief Interview of Mental Status) score of 15 out a possible 15 indicating no cognitive impairment.</p> <p>On 04/22/25, a review of Resident 143's clinical record was conducted. No prior to admission PASARR for mental illness or intellectual disability was found in the Electronic Health Record (EHR). The only PASARR found was dated 03/24/2024, that did not document the psychiatric diagnosis, The Facility staff were asked to locate any previous PASARR documents, and they stated none had been completed prior to that date.</p> <p>(continued on next page)</p>

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 04/24/25 an interview was conducted with the Director of Nursing (DON), who stated that the PASARR should have been done prior to admission documenting the listed diagnosis.</p> <p>The Administrator and Director of Nursing were informed of the findings again at the end of day meeting on 04/25/25. No further documents were provided.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interview and facility documentation review, the facility staff failed to develop and implement a comprehensive person-centered care plan consistent with resident needs for one (1) of 57 residents in the survey sample.</p> <p>The findings included:</p> <p>Resident # 56 was readmitted to the facility on [DATE]. Diagnoses included but were not limited to: Septic Shock, Hypertension, Acute Metabolic Encephalopathy, Chronic Kidney Disease-Stage 3, Acute Embolism and Thrombosis of deep veins of right lower extremity, peripheral vascular disease and non-pressure chronic ulcer of right calf.</p> <p>The most recent Minimum Data Set (MDS) assessment was a Significant Change Assessment with an assessment reference date (ARD) of 4/10/2025. Resident #56 was coded with a Brief Interview of Mental Status score of 15 out of 15 indicating no cognitive impairment. Resident # 56 required extensive assistance on staff for activities of daily living.</p> <p>Review of the clinical record was conducted 4/16/2025-4/28/2025.</p> <p>Resident # 56 was interviewed during tour of the facility on 4/16/2025.</p> <p>Resident # 56 stated he had lost a lot of weight. He stated he has had to send out for food to eat because the food in the facility tastes like garbage. Resident # 56 stated he had lost 42 pounds.</p> <p>Review of the Weights Summary revealed the following weights listed:</p> <p>4/3/2025 14:39 166.8 Lbs Wheelchair</p> <p>3/19/2025 23:26 205.0 Lbs Last weight obtained-refusal</p> <p>2/8/2025 09:29 205.0 Lbs Last weight obtained-refusal</p> <p>12/6/2024 12:50 205.0 Lbs Last weight obtained-refusal</p> <p>11/5/2024 12:50 205.0 Lbs Last weight obtained-refusal</p> <p>10/21/2024 15:30 205.0 Lbs Last weight obtained-refusal</p> <p>7/10/2024 17:55 205.0 Lbs Wheelchair</p> <p>6/7/2024 14:16 210.0 Lbs Wheelchair</p> <p>Resident # 56 had an unplanned weight loss of 39 pounds from July 2024 (weight- 205 pounds) to April 2025 (weight 166.8).</p> <p>(continued on next page)</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the clinical record revealed the following excerpts from Resident # 56's care plan:</p> <p>Focus:</p> <p>the resident is at risk for weight loss or malnutrition related to chronic disease, hx (history) non-pressure related chronic wound and hx of HTN (hypertension), wounds, decreased appetite severe malnutrition dx (diagnosis) -supplements for wound healing/nutrition</p> <p>4/3 significant weight loss noted, overall</p> <p>decline in health status</p> <p>dx of GERD (gastroesophageal reflux disease), high cholesterol</p> <p>Date Initiated: 08/02/2023</p> <p>Created on: 08/02/2023</p> <p>Revision on: 04/16/2025</p> <p>GOAL:</p> <p>the resident will have optimal nutrition and hydration status thru review period</p> <p>Date Initiated: 08/02/2023</p> <p>Revision on: 04/16/2025</p> <p>INTERVENTIONS:</p> <p>RD (registered dietitian) consult as needed,</p> <p>Diet-record meal % (percentage) intake</p> <p>review dietary preferences with the resident as needed</p> <p>snacks at bedside for easy access</p> <p>supplements as ordered</p> <p>weekly weights</p> <p>Date Initiated: 08/02/2023</p> <p>Revision on: 04/02/2025</p> <p>The Goal on the care plan was not measurable. The interventions were not implemented. There was no evidence of weekly weights being obtained nor attempted to be obtained.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/22/2025 at approximately 10:30 a.m., an interview was conducted with the Director of Nursing who stated the care planning process was important and should reflect the care for each resident. The Director of Nursing stated care plans should be tailored for each resident and goals should be measurable. She stated interventions should help to attain the goals for the identified concerns.</p> <p>During the end of day debriefing on 4/24/2024, the Executive Director (Administrator), Director of Nursing, Regional [NAME] President of Operations, and Corporate Nurse Consultants were informed of the findings.</p> <p>No additional information was provided.</p>

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>Based on observation, resident interview, staff interviews, and clinical record review, the facility staff failed to ensure medications were administered according to professional standards for 1 of 57 residents (Resident #43), in the survey sample.</p> <p>The findings included:</p> <p>Resident #43 was originally admitted to the facility 11/14/2024 after an acute care hospital stay. The current diagnoses included Parkinson's disease, heart failure and dementia with depression and anxiety. The quarterly MDS with an assessment reference date (ARD) of 2/21/25 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 11 out of a possible 15. This indicated Resident #43's cognitive abilities for daily decision making were moderately impaired.</p> <p>A care plan problem dated 12/23/24 stated the resident has behaviors (refuses medications, ADL care, and weights) related to dementia, and a depressive disorder. The goal read the resident's behaviors will not cause him or other resident's distress thru the review period, 5/22/25. The interventions included administer medications as ordered, and assign staff members that are familiar or preferred by the resident whenever possible.</p> <p>An interview was conducted with Licensed Practical Nurse (LPN) H on 4/18/25 at approximately 11:48 AM regarding Resident #43's statement about his dental procedure, aftercare and ongoing monitoring. LPN H stated she ensured medications for pain were ordered and would be available for administration after the procedure. LPN H reviewed the medication administration record and stated the resident had not received any pain medication since the dental procedure and it was likely because he aggravates the nurses and always refuses his medications.</p> <p>LPN H stated the resident had refused all medication during the morning medication pass but she would ask Resident #43 if he wanted a pain pill to help with his mouth pain but she left without the pain medication. Upon LPN H's return to the medication cart, she stated Resident #43 said he would accept the pain medication for pain rated 7 out of 10. LPN H administered Oxycodone 10 mg to the resident at 12 noon.</p> <p>LPN H stated the nurse's do not pour the resident's medications prior to offering administration because the resident always refuses to accept his medications. LPN H stated they ask the resident at medication pass are you taking your medications and based on his response determines if the medications are removed from the medication cart.</p> <p>On 4/28/25 at approximately 4:00 PM, a final interview was conducted with the Administrator, Director of Nursing, [NAME] President of Operations and a Regional Nurse Consultant. They offered no comments and voiced no concerns regarding the above information.</p> <p>This information was obtained from the internet on 5/12/25: Steps for Oral Medication Administration</p> <p>(continued on next page)</p>

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>When administering medications, patient safety is the top priority. Therefore, considerations must be given throughout the medication process to ensure practices are in place that promote safe medication administration. This includes confirming the medication rights when collecting, preparing, and administering medications.</p> <p>Before administering oral medications, the nurse should assess for contraindications that would prohibit the patient from being able to receive the medication, such as dysphagia, NG tube with gastric suctioning, NPO (nothing passed orally) status, or the inability to sit upright. After determining that oral medications may be safely administered, the nurse should verify the medication administration record (MAR) against the prescribing provider's orders. The nurse should then remove the medications from the medication cabinet, drawer, or automated dispensing cabinet, confirming the medication rights for each medication. The medications should then be prepared, confirming the rights for each medication a second time.</p> <p>After the medications have been prepared, the nurse is then ready to administer the medications. After confirming the rights for each medication for a third time, the nurse should assist the patient into an upright position. If the patient is unable to be placed in the upright position, a side-lying position may be used; however, the nurse should use caution to ensure the patient's ability to swallow in this position. When positioned, the nurse should offer the patient something to drink. Consideration should be given to ensure the liquid offered is not contraindicated with any of the medications the patient is taking, and that the oral intake is accounted for within the medication record. Ask the patient if they prefer to take all medications at once or if they prefer the medications to be placed in the cup one at a time. Remain with the patient to ensure all medications are swallowed before documenting the medication administration. Perform any required post-assessments (e.g., blood pressure checks or pain reassessments) and document the patient's response to the medication. (https://openstax.org/books/clinical-nursing-skills/pages/12-1-administering-oral-medications)</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, clinical record review and facility documentation, the facility staff failed to provide necessary services to maintain good grooming and personal hygiene for 2 Residents (#77, & #147) in a survey sample of 57 Residents.</p> <p>The findings included:</p> <p>1. For Resident #77 the facility staff failed to provide 2 showers per week for Resident who is unable to provide self-care.</p> <p>Resident # 77 was admitted to the facility on [DATE] with diagnosis that included chronic embolism and thrombosis, mood disorder, insomnia, dysphasia, muscle, wasting and atrophy, chronic obstructive, pulmonary disease, polyneuropathy, major depressive disorder, chronic kidney disease, fibromyalgia, chronic diastolic heart, failure, hypertension, chronic pain syndrome, and generalized anxiety disorder. Resident # 77's most recent MDS (Minimum Data Set) dated, 4/23/25, scored Resident #77 as having a BIMS (Brief Interview of Mental Status) score of 12 out of 15 indicating mild cognitive impairment. Resident #77 was also coded as requiring extensive assistance with all aspects of ADL (Activities of Daily Living) care except for feeding.</p> <p>On the afternoon of 4/23/25 an interview was conducted with Resident #77 who stated that she waited 12 hours to have her incontinence care provided. She stated that she was not changed the entire night shift from 7 p.m. - until 7 a.m. She stated they (the CNAs) sat outside her room and laughed and talked and came in and shut the call light off and told her someone would be in to change her, but no one ever came in. When asked if she reported this, she stated that she had reported it to DON. When asked how she felt she stated that she felt Helpless, like who is going to protect me? I am bed bound, I cannot get up or defend myself if I have to. Like I am supposed to accept whatever care they choose to provide. She also stated that she has not had a shower or had her hair washed in months.</p> <p>A review of the clinical record revealed that in the ADL (Activities of Daily Living) POC (Point of Care) documentation, Resident #77 was documented as receiving a bed bath on 17 days in the month of February 2025 and on 15 days in the month of April, however no showers are documented for either month or no record of hair washing were recorded for either month.</p> <p>A review of the clinical record revealed the following excerpt from the physicians progress note:</p> <p>4/23/25 9:30 p.m. -Nursing request for assessment of newly reported bilateral buttocks MASD, skin intact with blanchable redness. Recommend continuing with zinc oxide cream and frequent brief changes to reduce incontinence associated skin breakdown. Facility to manage, provider can reassess if worsening or new area of skin breakdown.</p> <p>A review of the policy, entitled Shift responsibilities for CNA revealed the following excerpts:</p> <p>1. CNA's will report to a designated unit at the beginning of a shift to obtain the shift responsibility/patient assignment as determined by a licensed nurse.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. Obtain patient assignment at the beginning of each shift/with the nurse and nurse. Examples of general report information include, but not limited to the patient's name, room in bed, scheduled appointments, bathing needs, special healthcare needs, etc.</p> <p>3. Provide pertinent patient information for the oncoming shift, such as tasks that are not completed, etc. Number four prefer to perform shift responsibilities/assignments that promote quality of care; make rounds, identify an address any immediate patient needs, promptly respond to call lights, and notify the license starts with any pertinent findings (red skin, etc.).</p> <p>On 4/24/25, during the end of day meeting the Administrator was made aware of the findings and no further information was provided.</p> <p>2. For resident number 147 the facility staff failed to provide 2 showers per week for Resident who is unable to provide self-care.</p> <p>Resident # 147 was admitted to the facility on [DATE] with diagnoses that included, but we're not limited to severe sepsis with shock, diabetes, type two, and Enterocolitis due to C-Difficile, Pneumonitis due to inhalation of food and vomit, malignant neoplasm of oropharynx, respiratory failure with hypoxia, dementia, squamous, cell carcinoma of skin and scalp, generalized anxiety disorder, BPH, gout, mood disorder, and dysphasia. Resident #147's most recent MDS (minimum data) with an ARD parent assessment reference date of 4/9/25 coded resident # 147 as having a Bims (Brief Interview of Mental Status) score of 12 out of 15 indicating mild cognitive impairment Resident #147 requires assistance with all aspects of ADL care and requires the use of a walker/wheelchair.</p> <p>On 4/23/25 at 11:00 a.m. Resident #147 was observed in bed with a white t-shirt on with food stains on the shirt. Resident #147's mouth appeared to have food residue; the blankets had stains brown in color. Resident #147 was interviewed and asked when he had last had a shower, to which he responded, Not since I got here. When asked if he would like a shower, he stated that he would.</p> <p>A review of the clinical record revealed that although, Resident 147 was given bed baths in March and April he had not received a shower or hair washing at the time since admission.</p> <p>On 4/23/25 at 2:00 p.m an interview with CNA C was conducted who stated, Residents are supposed to have 2 showers per week unless they request otherwise.</p> <p>On the afternoon 4/23/25 an interview was conducted with LPN D who stated, CNA's are supposed to shower Residents twice a week including hair washing. If a Resident refuses the CNA should report to the nurse so that this can be documented in the clinical record.</p> <p>A review of the policy, entitled Shift responsibilities for CNA revealed the following excerpts:</p> <p>1. CNA's will report to a designated unit at the beginning of a shift to obtain the shift responsibility/patient assignment as determined by a licensed nurse.</p> <p>2. Obtain patient assignment at the beginning of each shift/with the nurse and nurse. Examples of general report information include, but not limited to the patient's name, room in bed, scheduled appointments, bathing needs, special healthcare needs, etc.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3. Provide pertinent patient information for the oncoming shift, such as tasks that are not completed, etc. Number four prefer to perform shift responsibilities/assignments that promote quality of care; make rounds, identify an address any immediate patient needs, promptly respond to call lights, and notify the license starts with any pertinent findings (red skin, etc.).</p> <p>On 4/23/25 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. The facility's staff failed to identify Resident #156's pressure ulcer prior to progression to a Stage 3 and they failed to provide care and services to promote pressure ulcer healing that resulted in harm.</p> <p>Resident #156 was originally admitted to the facility 2/8/2025 and readmitted [DATE] after a right above the knee amputation (RAKA). The resident's current diagnoses included atherosclerosis, diabetes and chronic kidney disease.</p> <p>The 5-day Medicare Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 03/17/2025 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #156's cognitive abilities for daily decision making were intact.</p> <p>In MDS section GG0130. Self-Care the resident was coded as requiring supervision or touching assistance with eating, oral hygiene, rolling from left to right, sitting on side of bed to lying flat, partial/moderate assistance with lower body dressing and chair/bed-to-chair transfers, substantial/maximal assistance with toileting hygiene, shower/baths, and upper body dressing, dependent with putting on/taking off footwear, sit to stand, toilet transfers and wheeling a wheel chair.</p> <p>A review of the CMS 802 revealed that Resident #156 had a stage 3 pressure ulcer. A further review of the clinical record revealed a full body skin assessment was completed by the wound/skin Nurse Practitioner (NP) on 3/12/25 and the resident presented with a RAKA surgical site and a left heel stage 1 pressure ulcer. The next wound/skin assessment dated [DATE] revealed the resident continued with the left heel stage 1 pressure ulcer and the RAKA surgical site was worsening because it dehisced (opened/split).</p> <p>On 3/28/25 the wound care NP assessed a new wound to Resident #156's right buttock reported by nursing. The wound care NP identified the new right buttock wound as a stage 3 pressure ulcer. The right buttock pressure ulcer measured; length 3.00 centimeters (cm) by width 2.80 cm by depth 0.20 cm. Further assessment of the right buttock pressure ulcer revealed it was with 10% epithelial tissue, 10% granulation tissue, and 80% slough (dead tissue) as well as a moderate amount of light pink, watery drainage.</p> <p>A review of Resident #156's pressure ulcer interventions to promote healing revealed as of 4/28/25 there was not a nutrition assessment or orders for nutritional support to promote healing of the newly identified Stage 3 pressure ulcer. An interview was conducted with the Director of Nursing (DON) on 4/28/25 at approximately 3:30 PM.</p> <p>The DON stated the resident was currently nutritionally supported and provided a copy of the Registered Dietitian progress notes which included an initial assessment conducted at the time of the resident's admission to the facility dated 2/10/25. On 3/13/25 a nutritional review was conducted because the resident was readmitted to the facility after the RAKA. At that time a house supplement 90 ml by mouth, two times a day was ordered for prevention of malnutrition/wound healing of the surgical wound and the stage 1 heel ulcer). On 3/17/25 an adult multivitamin with minerals oral tablet was ordered for daily administration.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>The next nutrition assessment was conducted on 3/26/25 for a significant weight change which was associated with the RAKA. On 4/7/25 another nutritional note addressed a weight change which also was associated with the RAKA. There was not a nutritional assessments which addressed the newly identified Stage 3 pressure ulcer on 3/28/25 and there was no evidence that the resident received additional nutritional support after identification of the Stage 3 pressure ulcer.</p> <p>An interview was conducted with the wound care Nurse Practitioner (NP) on 4/23/25 at 1:40 PM. The wound care NP stated it had been recommended that there be ongoing pressure reduction, including pressure reduction to the heels and all bony prominences, turning/repositioning, incontinence management with application of barrier cream afterwards and use of emollients daily. The wound NP also stated the more interventions the more likely the pressure ulcer would not have complications, but improve and heal.</p> <p>On 4/24/25 at approximately 4:20 PM an observation was made of Resident #156's right buttock pressure ulcer while he was lying in bed with it exposed. The pressure ulcer was clean, with a moderate amount of drainage, absent of odor, and appeared to have approximately 100 percent of granulation tissue.</p> <p>On 4/25/25 at approximately 12:40 PM an interview was conducted with the Licensed Practical Nurse (LPN) C. LPN C stated Resident #156 refused wound care on 4/24/25 but that it was not his normal behavior. LPN C also stated she was not aware of the resident having a Stage 3 pressure ulcer for she was told he had moisture-associated skin damage (MASD). When LPN C returned, she stated the resident did have a Stage 3 pressure ulcer and if she had been aware additional interventions such as more frequent turning/positioning, an air mattress and protein supplements would likely had been discussed and instituted during the weekly Interdisciplinary Team (IDT) meeting.</p> <p>On 4/25/25 at approximately 5:00 PM the DON provided a action plan for pressure ulcers. The plan dated 4/8/25 stated the problem was pressure ulcers Stage 3 or higher and weekly wound measurements not consistently completed and/or documented weekly by the facility nurse or wound NP or clinic staff. The Action Plan was reviewed on 4/28/25.</p> <p>The Immediate response: DON reviewed and identified the areas and initiated an action plan to correct processes and prevent reoccurrences. How to identify other residents that might be impacted: current residents have a potential to be affected. An audit of current residents with pressure ulcers were conducted by the wound nurse or designee to identify pressure ulcers identified at stage 3 or higher had Physician orders, interventions, care plan, physician and responsible party (RP) notifications and to verify weekly wound measurements were completed by the facility nurse, wound NP or wound clinic staff. Findings will be corrected.</p> <p>What measures were put in place to prevent reoccurrence: the Staff Development Coordinator (SDC) or designee would educate the licensed nurses on the wound management process, implement preventative interventions, notifying, obtaining and performing treatment orders per MD with RP notification of wound progress and orders. Weekly skin assessments with wound measurements, if the wound clinic visits are completed, the nurse should verify the wound clinic measurements. If the measurements are not performed by the wound clinic the measurements will be completed and documented weekly on the skin observation tool.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>How to monitor to ensure the problem does not reoccur: the wound nurse or designee will complete weekly audits for 4 weeks on residents with pressure ulcers identified at Stage 3 or higher. Have physician orders, interventions, and care plan updated. MD/RP notification, verify weekly wound measurements were completed by the facility nurse, wound NP or clinic staff. Findings will be corrected. Date of compliance 4/14/25. Quality Assurance (QA): the results will be reported to the monthly QA committee for review and discussion to ensure substantial compliance. Once the QA committee determines the problem no longer exists, the reviews will be completed on a random basis.</p> <p>During the interview conducted with the Director of Nursing (DON) on 4/28/25 at approximately 3:30 PM. The DON stated a support surface (a medical device used to relieve or redistribute pressure) had been added to the resident bed to aid in pressure relief. Observations were made of Resident #156's bed daily from 4/22/25 through 4/25/25 and a standard mattress was identified on the bed.</p> <p>The Director of Nursing (DON) also stated on 4/28/25 at approximately 3:30 PM, that the resident would have ongoing weekly assessments of the pressure ulcer for management. A review of the resident's weekly pressure ulcer assessment revealed the resident's pressure ulcer was not assessed/measured in-house or by the wound care NP between 4/10/25 and 4/22/25. The resident also did not receive a nurse skin observation between 3/29/25 and 4/13/25.</p> <p>On 4/28/25 at approximately 4:00 PM a final interview was conducted with the Administrator, Director of Nursing, [NAME] President of Operations and a Regional Nurse Consultant. The DON and Regional Nurse consultant requested an additional review of their Action Plan although for this resident measures in the action plan had not instituted, after their alleged date of compliance, 4/14/25.</p> <p>In Grade 3 pressure ulcers, skin loss occurs throughout the entire thickness of the skin. The underlying tissue is also damaged, but the underlying muscle and bone are not damaged. The ulcer appears as a deep cavity like wound. The characteristics are: Full thickness skins involving damage to or necrosis of, subcutaneous tissue that may extend down to, but not through, underlying fascia. Presents clinically as a deep crater with or without undermining. (https://pmc.ncbi.nlm.nih.gov/articles/PMC4413488/)</p> <p>Pressure ulcers are considered to be largely preventable via the use of pressure-relieving processes in those considered at risk. Additionally, pressure relief is part of the treatment offered to those with ulceration. Support surfaces are specialized medical devices designed to relieve or redistribute pressure on the body, or both, in order to prevent and treat pressure ulcers. (https://pmc.ncbi.nlm.nih.gov/articles/PMC8407250/)</p> <p>Based on observation, staff interview, resident interview, facility documentation review, and clinical record review the facility staff failed to manage and prevent pressure ulcers for two (2) residents (Resident #50, and Resident #156) in a survey sample of 57 Residents with constituted harm.</p> <p>The findings included:</p> <p>1. The facility staff failed to ensure the necessary services were provided to prevent the development of a pressure ulcer that was identified at an advanced stage, resulting in harm.</p> <p>Resident #50 was originally admitted to the facility on [DATE] after an acute care hospital stay and re-admitted on [DATE]. The current diagnoses included quadriplegia, unspecified.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>The significant Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 12/12/24 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #50 cognitive abilities for daily decision making were intact. Section M Skin Conditions coded the resident as having a stage one or greater unhealed pressure ulcers/injuries. The resident was coded as having one stage 3 pressure ulcer. The number of these stage 3 pressure injuries present on admission/entry was coded as 0.</p> <p>The person-centered care plan dated 9/18/24 read that the resident had a pressure ulcer to the Left Elbow. The resident has a risk for worsening wound(s) or the development of additional wounds related to chronic health conditions Date Initiated: 09/18/2024. The goal for the resident was that the resident's wound will show s/s of healing through the review period. The interventions for Resident #50 was skin assessments as indicated and treatment per Treatment Administration Record (TAR).</p> <p>The Braden Scale was completed on 9/12/24:</p> <p>Resident #50 scored 16 on the Braden Scale which placed the resident at risk for developing pressure ulcers.</p> <p>1. SENSORY PERCEPTION: Ability to respond meaningfully to pressure-related discomfort. No Impairment: Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort.</p> <p>2. MOISTURE: Occasionally Moist: Skin is occasionally moist, requiring an extra linen change approximately once a day.</p> <p>3. ACTIVITY: Degree of physical activity: Chairfast: Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.</p> <p>4. MOBILITY: Very Limited: Changes independently.</p> <p>5. NUTRITION: Usual food intake pattern: Adequate: Eats over half of most meals. Eat a total of 4 servings of protein (meat, dairy products per day.</p> <p>6. FRICTION & SHEAR: Potential Problem: Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down.</p> <p>SCORING: 16. AT RISK 15-18. MODERATE RISK 13-14. HIGH RISK 10-12. VERY HIGH RISK 9 or below.</p> <p>The Physician's Order Summary (POS) for September 2024 read: Low air loss mattress- Check placement and function every shift for wound management-Order Date 09/10/2024 4:59 pm.</p> <p>The POS for November 2024 Prostat SF one time a day for prevention of malnutrition/wound healing 30ml QD -Order Date- 09/06/2024 10:41 pm., discontinued Date- 12/11/2024 2:52 pm.</p> <p>The Physician's Order Summary (POS) for December 2024 dated 12/06/24 at 11:10 am., read: Wound care:(R) Ischium- Cleanse with wound cleanser, apply manuka HD alginate and cover with border gauze dressing every day shift for wound management-Order Date 12/06/2024 11:10 am.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the Treatment Administration Record (TAR) read: Wound care: (R) ischium- Cleanse with wound cleanser, apply manuka HD alginate and cover with border gauze dressing every day shift for wound management. (12/06/24).</p> <p>A review of skin assessments read:</p> <p>9/04/24=No skin issues</p> <p>10/07/24= small open area to right buttocks 1cm x 1cm red and pink MD aware TX. in place.</p> <p>10/14/24=Tx cont. to wound to buttocks. Wound is healing.</p> <p>10/21/24= Wound to right buttocks is healed.</p> <p>10/28/24=No open areas noted to skin.</p> <p>11/05/24=no open areas</p> <p>11/11/24=No open areas noted</p> <p>11/25/24=Healed areas noted to sacrum, condom catheter in place, tx cont. to fungal rash noted to face and scalp</p> <p>12/02/24=Treatment in place to face and scalp</p> <p>A review of the above skin assessments do not mention any pressure ulcers of the right Ischium prior to 12/05/24.</p> <p>The wound assessment report dated 12/05/24 read: Pressure Ulcer of the right Ishium: Length: 1.50 cm Width: 3.50 cm L x W: 5.25 cm 2 Depth: 0.20 cm. Acquired in House: as a stage 3 pressure ulcer, 50% slough, subcutaneous, moderate exudate, serosanguineous.</p> <p>A skin/wound note dated 12/05/24 at 11:32 am., written by the WCNP read: Wound Assessment: Wound: 2 Location: right ischium Primary Etiology: Pressure Stage/Severity: Stage 3. Wound Status: New Odor Post Cleansing: None. Size: 1.5 cm x 3.5 cm x 0.2 cm. Calculated area is 5.25 sq cm. Wound Base: 0% epithelial , 50% granulation , 50% slough , 0% eschar Wound Edges: Attached. Periwound: Fragile, Dryness. Exposed Tissues: Subcutaneous. Exudate: Moderate amount of Serosanguineous.</p> <p>Procedure: A sharp debridement was not performed today. Initial assessment completed, wound debridement pain management discussed with patient for future wound care if appropriate. Preventive Measures: The patient has a pressure injury. Recommend ongoing pressure reduction and turning/repositioning precautions per protocol, including pressure reduction to the heels and all bony prominences. All prevention measures were discussed with the staff at the time of the visit. The patient is incontinent of urine and stool and is at an increased risk of skin breakdown. Recommend continuing ongoing interventions and protocol for incontinence management. Pain management: Tylenol, Oxycodone. Anticoagulant: Xarelto. Supplements: Multivitamins, Vitamin D3</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>New Recommendations: 12/5/24 - new sacral pressure wound, stage 3 identified by nursing staff. The patient has a pressure injury. Recommend ongoing</p> <p>pressure reduction and turning/repositioning precautions with per protocol, including pressure reduction to the heels and all bony prominences. All prevention measures were discussed the staff at the time of the visit. Recommend low air loss mattress. Recommend continued zinc oxide pm incontinence care, pressure reduction and offloading, daily emollients, and floating heels while in bed.</p> <p>On 04/22/25 at approximately 11:47 am., an interview was conducted with Resident #50. Resident #50 said that he got the pressure ulcer on his bottom because they were short staffed, they wouldn't get him out of the bed nor turn and reposition him every two hours.</p> <p>On 04/23/25 at approximately 1:55 pm, an interview was conducted with the Wound Nurse Practitioner (WNP) Wound NP. The WNP said I did an initial wound assessment on the resident and staged it as a stage 3 pressure ulcer in December 24. The WNP also said that the resident was known to sit in his wheelchair for an entire day not allowing him to shift his weight or reposition. The WNP also mentioned that Resident #50s wound evolved, became deep, but the slough is all gone now. The WNP also said that she staged the wound as a stage 4 instead of stage 3.</p> <p>A review of the medical records did not mention that Resident #50 was non-compliant until after the Stage 3 pressure ulcer of the Ischium was identified.</p> <p>A review of a 60 day recertification note dated 12/03/24 read that resident has an open area on his right buttock measuring 1x1 centimeters (cm) but did not mention if a pressure ulcer was found on the right Ischium.</p> <p>A (Late Entry) review of a Skin/Wound Note dated 12/5/2024 at 6:15 PM., read: Resident receiving ADL care, while this writer and Wound Care Services Nurse Practitioner (WCNP) on weekly wound rounds. Certified Nursing Assistant (CNA) asked writer to come and assess area to the resident's buttocks area. Upon assessment with Wound Care Nurse Practitioner (WCNP), resident noted with a pressure wound to right ischium. POC is manuka HD alginate and border gauze dressing daily. Resident is own RP and aware.</p> <p>On 4/25/25 at approximately 4:55 pm., Corporate staff C was asked if The Plan of Correction document (POC) for pressure wounds was available for review. The Corporate staff said, I will email the document tonight.</p> <p>From 4/25/25-4/27/25-no document was received via email from the facility or corporate staff.</p> <p>On 4/28/25 at approximately 9:10 am., The Director of Nursing (DON) presented a POC (document) on pressure ulcers stage 3 or higher and weekly wound measurements. The date of implementation was dated 4/08/25 and the date of compliance was dated 4/14/25. There were no resident specific names entered in the document.</p> <p>What Is a Stage 3 Bedsore?</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A stage 3 bedsore, also known as a grade 3 pressure sore, has burrowed past the dermis (the skin ' s second layer) and reached the subcutaneous tissue (fat layers) beneath. Stage 3 pressure ulcers pose a high risk of infection and can take months to heal. Some pressure sores may even progress to the fourth and most dangerous stage without proper treatment.</p> <p>Nursing homes that hire enough staff and train them properly can avoid most causes of stage 3 bedsores. So, if a resident develops a stage 3 bedsore, it may be due to negligence. stage 3 pressure ulcers can usually be prevented even in high-risk patients. It ' s the duty of nursing home staff members to identify these risk factors in residents and take steps to prevent bedsores from forming. https://www.nursinghomeabusecenter.com/nursing-home-injuries/bedsores/stages/stage-3/</p> <p>On 04/28/25 at approximately 3:15 p.m., the above findings were shared with the Administrator, Director of Nursing (DON) and Corporate Consultant. The DON said that she presented the survey team with the Plan of Correction (POC) book on Friday (4/25/25). No other documents were presented.</p>

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<p>F 0687</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate foot care.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, a clinical record review and staff interviews, the facility staff failed to provide foot care for 1 of 57 residents (Resident #116), in the survey sample.</p> <p>The findings included:</p> <p>Resident #116 was admitted to the facility on [DATE] with diagnoses of but not limited to muscle weakness, major depressive disorder, left artificial hip, seizures and fibromyalgia.</p> <p>The most recent Minimum Data Set (MDS) was a Quarterly Assessment with an Assessment Reference Date (ARD) of 03/18/25. Resident # 116's BIMS (Brief Interview for Mental Status) Score was a 15 out of 15, indicating no cognitive impairment. Resident #116 required assistance with Activities of Daily Living.</p> <p>On 4/16/2025 during an afternoon tour, Resident #116's was observed in bed on her back, both legs were bent laying open to either side with feet meeting in the middle bottom to bottom. Resident #116's toenails were thick, long with uneven edges. They were mostly brown in color with some yellowish areas. Resident #116 said she had seen the podiatrist before but that it had been a long time ago. She stated that she would let the Podiatrist trim and treat her toenails because they get caught in the bedcovers now and cause her pain.</p> <p>A review of Resident #116's progress notes did not reveal any foot or podiatry care.</p> <p>On 04/24/2025, at 1:40 p.m., an interview was conducted with the LPN #B who stated that Resident #116 refused to have Podiatry in the evaluate her feet and toenails in the past but that she would put her on the schedule to see Podiatry when they come to the facility next month.</p> <p>On 04/24/2025, an interview was conducted with the DON who stated that the facility does not have an independent Foot Care Policy, but she provided the Health Care Service Agreement for Podiatry. She went on to say that Resident #116 had been added to the Podiatry list for evaluate and treat.</p> <p>On 04/25/25 at approximately 6:00 PM, during the end of day meeting the Interim Administrator, DON (Director of Nursing) and two Regional Consultants were informed of the concerns. No additional information was provided.</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, resident interviews, clinical record reviews, and facility documentation reviews, the facility staff failed to ensure the environment remained safe for residents and was free from hazards for one (1) resident (Resident #61) and potentially other residents, in a survey sample of 57 residents, resulting in a finding of Immediate Jeopardy. Unrelated to the IJ, the facility staff failed to ensure that the exhaust pipe from the generator was in good repair.</p> <p>The findings included:</p> <p>1. The facility staff failed to ensure that a hazardous environment and other materials were not accessible to Resident #61.</p> <p>Resident #61 was admitted to the facility on [DATE] with diagnoses that included but were not limited to heart failure, type 2 diabetes, hypertension, difficulty walking, shortness of breath, chronic kidney disease stage 3, obstructive sleep apnea, peripheral vascular disease, and major depressive disorder. Resident #61's most recent MDS (Minimum Data Set) dated 3/31/25 coded Resident #61 as having a BIMS (Brief Interview of Mental Status) score of 15/15, indicating no cognitive impairment.</p> <p>On 4/17/25 at 8:45 a.m., outside the rear of the building, Resident #61 was observed ambulating in his wheelchair, opening and reaching into a large lidded 55-gallon red biohazard bin/receptacle. Twenty (20) unsecured, dirty, biohazard containers were observed in this area. When the resident was asked if he knew what the bin was used for, he stated, Yes, pointing toward the Biohazard label on the bin, It is for needles, blood, and stuff.</p> <p>Also observed on 4/17/25, at the rear of the building in the same area, Resident #61 had access to an open generator that appeared to be in the process of being repaired; the housing was off, exposing the running motor and inner mechanical parts. A power drill and drill bits were left on the ground directly in front of the generator.</p> <p>Additionally, on 4/17/25, a third hazardous area accessible to Resident #61 was an extensive collection of paint cans and wooden pallets with exposed nails stacked against an outside wall. It was unknown to the facility how long these had been there, as they consisted of large, old paint cans and wooden pallets with exposed nails stacked against an outside wall.</p> <p>Approaching the rear entrance to the facility, the walkway was littered with sharp louvered machinery panels, cardboard, and other debris. This unsecured area led to the mechanical room, which was cluttered with tools, sharp objects, electrical cords, drills, rolling metal carts, and lawn equipment.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Upon proceeding through this area, it was observed that the door leading to the resident hallway was unsecured and unlocked, as it had neither a doorknob nor any other method to prevent residents from entering the hazardous area. At the time of the survey, residents were observed ambulating in the hallways with walkers and wheelchairs, as well as independently, and had access to these hazardous areas. On 4/18/25 at 4:00 pm, an interview was conducted, and Employee F stated that he had informed the Maintenance Director, Around 2 weeks ago (4/4/25), that they needed a new doorknob and lock for the maintenance room door. Employee F said, All of us maintenance staff have to go into that room. It's where the tools are stored.</p> <p>On 4/17/25 at 9:15 a.m., an interview was conducted, and Employee F stated, We try to keep him [Resident #61] out of this area; he comes out here all the time. When asked why the bins were in this area, he stated that he was responsible for bringing the full bins outside when the biohazard company came to pick them up, but he noted that these were already empty. Employee F was asked how long the Resident had been accessing this area, and he estimated approximately 3 weeks, 3/31/25. Employee F requested that LPN C come outside. When asked about the risks to residents who go into the biohazard bins, she stated that they could get stuck with a needle or come into contact with infectious substances.</p> <p>A review of the clinical record revealed the following progress notes:</p> <p>Effective Date: 04/17/2025 10:28 AM Type: Health Status -Resident spoken with about rummaging in trash outside the building and safety risk involved with items that are possibly located in the trash. Resident stated that he only lifted the lid of trash can. Resident encouraged to wash hands stated that he was coming in the building. Resident own RP provider made aware of resident's behaviors. Entry by DON</p> <p>Effective Date: 04/17/2025 10:58 AM Type: Behavior Note - Type of Behavior: Going in hazard waste outside the building after multiple attempts to stop him from going in the trash. Residents have been educated multiple times r/t medical debris. Non-pharmacological Intervention: Educated on dangers of sharp objects and human waste effect: Resident continues to go through the trash outside PRN Medication: none Outcome: Resident remains going in trash outside after multiple attempts from the staff. Entry by LPN B.</p> <p>Effective Date: 04/17/2025 3:15 p.m. Spoke with resident about the back portion of the building being for staff and that the resident should not be back there. Resident acknowledged that he would not go back there after speaking with writer and being made aware. Resident asked what he use to-do, and he stated that he was previously a Maintenance man. Writer talked with resident about his tools that he works with and how he keeps them locked away. Resident verbalized understanding. Entry by LPN B</p> <p>Effective Date: 04/17/2025 6:57 p.m. - Communication - with Resident DON and RDCS spoke to resident regarding suicidal ideation with use of sharp something, he reports it has been a year ago and has not had any further thoughts since that time. He declines psych services, declines social service, he said he will speak to Reverend [NAME], declined for us to call and said he will call if needed. He denies feeling depressed, reports I am fine, reiterated about maintaining safety with not going to outside work area, he agreed and reports understanding.</p> <p>Entry by Regional Director of Clinical Services (Employee C)</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>On April 18, 2025, at 2:30 p.m., after consultation with the state survey and certification agency office supervisors, the survey team notified the facility that it was in immediate jeopardy (IJ) in the areas of accidents and hazards. The survey team, along with the state survey and certification agency supervisors, accepted the IJ removal plan. The survey team validated the IJ Plan, and the Immediate Jeopardy was removed on 4/22/25 at 2:37 p.m.</p> <p>The removal plan read as follows:</p> <p>1. Resident #61 who was observed accessing hazardous areas including biohazard containers, an open generator, and paint materials, was immediately removed from all hazardous areas and assessed by the nurse on 4/17/25.</p> <p>Resident #61 no signs of injury or contamination were observed on 4/17/25.</p> <p>Resident #61 received individualized education on the risks associated with biohazard, unauthorized access to restricted zones with understanding to prevent injury and maintain safety on 4/17/25.</p> <p>Resident #61's care plan was updated on 4/17/25.</p> <p>The Regulated Medical Waste policy was reviewed and implemented on 4/18/25 by the Administrator. All 20 biohazard containers were secured with locks or discarded as of 4/18/25.</p> <p>The biohazard bins were locked and secured on 4/18/25 with a tarp placed and labeled with biohazard signage until a POD to store or biohazard waste company pick up the bins tentative date 4/21/25. When the POD is picked up by the company the biohazard waste company will pick up the biohazard waste from the utility rooms with biohazard waste.</p> <p>The generator was repaired, closed and secured on 4/18/25. All tools and maintenance equipment were removed from the resident assessable areas immediately on 4/18/25. Debris cleared from all walkways and exterior areas on 4/18/25.</p> <p>Door to mechanical room was fitted with keypad lock and auto-closure mechanism on 4/17/25. All maintenance areas are marked with signage 4/18/25 to prevent the entrance of residents. The dirty utility storage rooms on the units had signage posted with biohazard signs on 4/18/25.</p> <p>Resident #61 and no other residents have been identified outside in the rear of the building on 4/18/25. At the rear of the building in the same area of the biohazard materials, the maintenance staff and designees immediately removed, discarded or placed in appropriate secured storage areas, all biohazard materials, mechanical tools, paint cans, wooden pallets, with exposed nails stacked against the wall, sharp louvered machinery panels, cardboard and other debris were cleared, and the generator repaired, closed and secured with tools retrieved and securely stored.</p> <p>Security measures were promptly implemented, including reinforcement or replacement of doorknobs and or locks to secure access to the maintenance doors, dirty utility rooms and posted warning signage for areas of biohazard waste and containers storage area outside and units to prevent entry of residents in hazardous areas and maintain safety.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Current residents of the facility have the potential to be affected by the deficient practice. By 4/20/25 the Director of Nursing or designee conducted a facility wide assessment of all residents to identify anyone else with similar behaviors who may attempt to access restricted or hazardous areas. All ambulatory residents and those using mobility devices will be assessed for risk entering the rear side of the building. The identified residents will be educated to not enter the rear of the building. The identified residents will be educated to not enter the rear of the building of the maintenance service area, biohazard waste and bins to prevent injury and maintain safety with understanding safety boundaries. The maintenance director or designee conducted a full facility inspection of the inside and outside grounds to identify any additional hazardous areas accessible to the residents beyond those already identified. No other areas identified with this practice.</p> <p>2. The SDC or designee initiated on 4/18/25 in-service training for all staff, regarding biohazard waste and bins, secured areas doors closed and locked, posted signage, removal and storage of biohazard waste in designated bins and secured to prevent accessibility to residents and maintain safety in addition the maintenance and housekeeping staff received training by the Administrator or designee on this information as well, ensuring biohazard bin are secured and not accessible to the residents, ensure picked up by the waste management company, tool security, chemicals, paints, and work areas contaminants are not accessible to residents, maintenance and housekeeping door remain closed and locked when not in use.</p> <p>3. The maintenance director or designee will complete weekly audits of all biohazard containers and storage areas for 4 weeks, then monthly for 2 months, to ensure residents are protected from avoidable hazards in multiple locations surrounding the building including (1) unsecured 55 gallon red biohazard receptacle (2) an open generator with scattered mechanical tools; (3) paint can and wooden pallets with exposed nails and (4) a unsecured mechanical room containing sharp tools, lawn equipment, and exposed wiring.</p> <p>All corrective action, audit findings and incident reviews will be integrated into the facility's performance improvement plan to ensure ongoing vigilance and proactive culture of safety. The review results will be presented to the QAPI committee for review and recommendations. Any identified issues will trigger immediate corrective action and may lead to the revision of protocols. The review will be conducted randomly once the committee determines that the problem no longer exists and is sustained.</p> <p>The survey team validated the facility's removal plan by proceeding to the rear of the building to inspect the walkways, generator, and area where the biohazard bins were to ensure they had been placed in the POD awaiting pickup. The bins were locked in the POD, and the walkways were clean and free of debris; the generator was no longer open. The doorknob and locks had been repaired so that the mechanical room was no longer accessible to the residents. The pallets had been stacked out of the way of residents, and the paint, chemicals, and tools had all been put away.</p> <p>Inside the building, the doors to all dirty utility rooms were locked, and biohazard bins were stored in the biohazard room. The survey team reviewed the policies and procedures and interviewed staff regarding the proper storage of biohazardous materials. The staff were interviewed and expressed understanding that the bins were to stay locked in that room until picked up by the biohazard waste company. Resident #61 was interviewed, and he verbalized an understanding of the importance of not going to the rear area of the building. Ambulatory residents, either by walking or wheelchair, were interviewed and expressed knowledge of the area behind the building being designated for staff use.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>The Immediate Jeopardy was removed on 4/22/25 at 2:37 p.m., and the scope and severity were lowered to Level 2, Pattern.</p> <p>2. Unrelated to the IJ, on the morning of 4/21/25, observation was made of an exhaust pipe leading from the generator up past the window that vents into the building. The exhaust pipe had a large rusted-out hole at the level of the window vent. An interview was conducted with the Maintenance Director at that time, and he stated that it was the first time he had observed the hole, but that it needed to be fixed. When asked what kind of fumes are emitted from a generator when it's running, he stated, Possibly Carbon Monoxide. When asked if these fumes could leak into the building from the hole in the exhaust pipe that runs parallel to the window vent, he stated that it was possible. On 4/22/25, the state Life-Safety department was notified and subsequently visited the facility. The facility was notified that the temporary fix they had in place on 4/22/25, was only a temporary measure until the company servicing the generator could come and replace the pipe. Life-Safety notified the facility that in the event the generator was required due to a power outage, the facility would have to implement a 15-minute fire watch until the pipe was replaced.</p> <p>On 4/22/25, during the end-of-day meeting, all of the aforementioned issues were reviewed, and no further details were provided.</p>

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, and clinical record review, the facility staff failed to provide required care to prevent complications while requiring use of an indwelling catheter for two (2) of 57 residents (Resident #124, and #50), in a survey sample of 57 Residents.</p> <p>The findings included:</p> <p>1. Resident #124 was originally admitted to the facility 3/22/25 after an acute care hospital stay. The resident's current diagnoses multiple advanced stage pressure ulcers, a-fib and obstructive uropathy.</p> <p>The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 3/28/25 coded the resident as resident as completing the Brief Interview for Mental Status (BIMS) and scoring 6 out of a possible 15. This indicated Resident #124's cognitive abilities for daily decision making were severely impaired. At section H0100 A - the resident was coded for requiring use of an indwelling catheter.</p> <p>Physician orders dated 3/23/25 stated change the Foley anchor every week and as needed every night shift every 7 days for Foley care, check the Foley anchor placement every shift, and change the Foley Catheter as needed for clinical indications such as infection, obstruction, or when the closed system is compromised. The physician's orders failed to identify the size of the catheter and bulb as well as the rationale for the indwelling catheter use.</p> <p>The person centered care plan dated 4/14/2025 had a problem which stated the resident requires a 14 french, 5-10 milliliter bulb Foley catheter related to pressure ulcer care. The goal stated the resident will be free from complications from catheter use thru the review period, 7/12/25. The interventions included change per physician order, provide catheter care every shift and observe for signs and symptoms of infection such as dark or cloudy urine or</p> <p>blockage and notify the physician as indicated.</p> <p>On 4/23/25 at 11:20 AM, Resident #124 was observed in bed with her right leg hanging off the bed. The catheter stat lock was observed coiled around the catheter tubing, which contained cloudy urine with much sediment. It was dated 4/21/25. On 4/24/25 at approximately 12:32 PM the resident was observed in bed again and the stat lock (a device to stabilize an indwelling catheter) was viewable coiled around the catheter tubing, it was dated 4/21/25. On 4/25/25 at 3:45 PM Licensed Practical Nurse (LPN) C was notified of the above observations.</p> <p>This information was obtain from the Internet on 5/8/25 - If urinary catheters are not secured appropriately, they can lead to severe trauma of a patient's urethra, potential damage to bladder neck, infection and inflammation, pain and irritation, possible bypassing, accidental dislodging of a catheter and a cleaving (condition whereby the catheter splits the penile or labial tissues). https://pubmed.ncbi.nlm.nih.gov/24335791/</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/28/25 at approximately 4:00 PM, a final interview was conducted with the Administrator, Director of Nursing, [NAME] President of Operations and a Regional Nurse Consultant. They offered no comments and voiced no concerns regarding the above information.</p> <p>2. The facility staff failed to ensure a catheter urine drainage bag was clamped to prevent leakage of urine. Resident #50 was originally admitted to the facility on [DATE] after an acute care hospital stay and re-admitted on [DATE]. The current diagnoses included; Quadriplegia, Unspecified.</p> <p>The significant Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 12/12/24 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #50 cognitive abilities for daily decision making were intact. Section M Skin Conditions. Coded Resident as having a stage one or greater unhealed pressure ulcers/injuries as Yes. Coded as having one stage 3 pressure ulcer. The number of these stage 3 pressure injuries present on admission/entry was coded as 0.</p> <p>The personal centered care plan dated 9/05/24 read that the resident requires a condom catheter. A Goal for the resident, the resident will be free from complications of catheter use. The interventions are: condom cath as ordered, observe for signs and symptoms of infection such as dark or cloudy urine or blockage and notify md as indicated.</p> <p>The March 2025 Physician Order Summary read: condom catheter daily every shift Verbal Active 09/05/2024.</p> <p>On 4/17/25 at approximately 12:00 PM., a moderate amount of fluid was observed on the floor in the lobby. Visitors and staff observed walking about the lobby area. Resident #50 was observed sitting in his wheel chair in the middle of the lobby with a trail of the substance leading to his wheel chair. The substance was immediately observed to be a urine like substance coming from the resident's catheter drainage bag. A facility staff, notified by the receptionist, quickly wheeled the resident away.</p> <p>On 4/17/25 at approximately 12:03 PM., a brief interview was conducted with the receptionist. The receptionist said that she didn't notice urine was on the floor until someone told her. At 12:04 PM., housekeeping personnel was observed mopping up the fluids.</p> <p>On 4/18/25 at approximately 1:50 PM., a brief interview was conducted with Certified Nursing Assistant (CNA) F. concerning the above issue. CNA F said that once the foley bags are emptied, the valve should be clamped to keep it from leaking.</p> <p>On 04/24/25 at approximately 10:33 AM. a brief interview was conducted with Resident #50 concerning his drainage bag. Resident #50 said that his Certified Nurses Assistant (CNA) forgot to close the valve at the bottom of the his foley bag which caused it to leak last week.</p> <p>A review of a health status note dated 4/17/2025 at 2:21 PM., read: Patient was brought to his room due to foley bag leakage, pt assessed, foley bag was unclipped, clipped bag properly and moved bag to middle of wheelchair so it would not rub the wheelchair wheels, no signs of distress, will continue to monitor for safety.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of a Health Status note dated 4/17/25 at 3:39 PM., read: Resident reassessed due to urine leak.</p> <p>Condom catheters are external urinary catheters that are worn like a condom. They collect urine as it drains out of your bladder and send it to a collection bag strapped to your leg. They're typically used by men who have urinary incontinence (can't control their bladder). https://www.healthline.com/health/condom-catheter</p> <p>On 04/28/25 at approximately 3:15 p.m., the above findings were shared with the Administrator, Director of Nursing (DON) and Corporate Consultant.</p>

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interview, staff interview, clinical record review, and facility documentation review, the facility staff failed to ensure adequate nutrition to prevent weight loss for one (1) Resident (#56) in a survey sample of 57 Residents.</p> <p>The findings included:</p> <p>For Resident # 56, the facility staff failed to recognize signs of weight loss, resulting in 39 lb. weight loss from 07/10/2024 - 4/03/2025.</p> <p>Resident # 56 was readmitted to the facility on [DATE]. Diagnoses included but were not limited to: Septic Shock, Hypertension, Acute Metabolic Encephalopathy, Chronic Kidney Disease-Stage 3, Acute Embolism and Thrombosis of deep veins of right lower extremity, peripheral vascular disease and non-pressure chronic ulcer of right calf.</p> <p>The most recent Minimum Data Set (MDS) assessment was a Significant Change Assessment with an assessment reference date (ARD) of 4/10/2025. Resident #56 was coded with a Brief Interview of Mental Status score of 15 out of 15 indicating no cognitive impairment. Resident # 56 required extensive assistance on staff for activities of daily living.</p> <p>Review of the electronic clinical record was conducted from 4/16/2025-4/28/2025.</p> <p>During the tour of the facility, Resident # 56 was interviewed. He stated the food is bad. Resident # 56 stated he had lost a lot of weight. He stated he has had to send out for food to eat because the food in the facility tastes like garbage. He complained that the food is like prison food, mostly processed foods and too salty. Resident # 56 stated he had lost 42 pounds.</p> <p>Review of the Progress Notes revealed the following weights listed:</p> <p>4/3/2025 14:39 166.8 Lbs Wheelchair</p> <p>3/19/2025 23:26 205.0 Lbs Last weight obtained-refusal</p> <p>2/8/2025 09:29 205.0 Lbs Last weight obtained-refusal</p> <p>12/6/2024 12:50 205.0 Lbs Last weight obtained-refusal</p> <p>11/5/2024 12:50 205.0 Lbs Last weight obtained-refusal</p> <p>10/21/2024 15:30 205.0 Lbs Last weight obtained-refusal</p> <p>7/10/2024 17:55 205.0 Lbs Wheelchair</p> <p>6/7/2024 14:16 210.0 Lbs Wheelchair</p> <p>Review of the Physicians orders revealed the following:</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Regular diet- Regular texture, Thin Liquids consistency</p> <p>House supplement one time a day for prevention of malnutrition/wound healing 90 ml (milliliters) PO (by mouth) QD (daily)</p> <p>04/02/2025 04/03/2025</p> <p>Prostat SF every 12 hours for prevention of malnutrition/wound healing 30 ml PO BID (twice a day) 4/5/2025</p> <p>Review of the document entitled Nutrition/Dietary Note dated 4/2/2025 signed by the Registered Dietitian revealed the following excerpts:</p> <p>Effective Date: 04/02/2025 13:37 Type: Nutrition/Dietary Note</p> <p>Note Text : Nutrition Assessment resident has refused to be weighed for several months. CBW (Current Body Weight) listed is his weight taken from July 2024.</p> <p>PMH (Past Medical History): Chronic wound R (right)Leg, HTN (Hypertension) , Hyperlipidemia, Depression,</p> <p>Meds: Metoprolol, Cholecalciferol, Omeprazole, Lipitor, MVI (multivitamin) with minerals, Iron sulfate</p> <p>Diet: Regular diet, Regular texture, Thin Liquids consistency, large portions</p> <p>Skin: pressure wounds noted increased needs d/t pressure wounds</p> <p>Estimated needs (IBW(Ideal Body Weight- 86 kg(kilograms): 2580-3000kcal (30-35kcal/kg); 103-172g protein (1.2-2.0g/kg); 2580-3000ml fluid (1ml/kcal)</p> <p>Resident reports decrease appetite and altered taste, he tells me he usually eats a good dinner but did not eat much for breakfast or dinner.</p> <p>He reports some things don't taste the same as the use to. He recently has developed pressure wounds and noted overall decline. He reports no chewing or swallowing difficulty and is able to feed himself.</p> <p>He reports enjoying sandwiches and would like to receive these more often. Will d/c large portions and add sandwich to lunch meal.</p> <p>He states he will try house shakes once a day, will offer QD (daily) and add prostat BID for aiding in wound healing to provide 200kcal, 30g protein daily.</p> <p>Recent weight shows weights are stable however, noted s/s (signs and symptoms) of muscle wasting (interosseous muscle) and fat loss (clavicle area, scapular area)</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>nutrition dx: severe malnutrition in context of chronic illness r/t (related to) inadequate energy intake AEB (as evidenced by) severe muscle wasting and severe fat loss</p> <p>he orders outside food when he has money as well. Preferences updated/honored.</p> <p>Suggest starting weekly weights as resident will allow.</p> <p>RD (Registered Dietitian to f/u (follow up) as needed</p> <p>Review of the clinical record revealed the following excerpts from Resident # 56's care plan:</p> <p>Focus:</p> <p>the resident is at risk for weight loss or malnutrition related to chronic disease, hx (history) non-pressure related chronic wound and hx of HTN (hypertension), wounds, decreased appetite severe malnutrition dx (diagnosis)</p> <p>-supplements for wound healing/nutrition</p> <p>4/3 significant weight loss noted, overall</p> <p>decline in health status</p> <p>dx of GERD, high cholesterol</p> <p>Date Initiated: 08/02/2023</p> <p>Created on: 08/02/2023</p> <p>Revision on: 04/16/2025</p> <p>GOAL:</p> <p>the resident will have optimal nutrition and hydration status thru review period</p> <p>Date Initiated: 08/02/2023</p> <p>Created on: 08/02/2023</p> <p>Revision on: 04/16/2025</p> <p>INTERVENTIONS:</p> <p>RD consult as needed</p> <p>Date Initiated: 08/02/2023</p> <p>Created on: 08/02/2023</p> <p>(continued on next page)</p>

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Diet</p> <p>-record meal % intake</p> <p>Date Initiated: 08/02/2023</p> <p>Created on: 08/02/2023</p> <p>&middledot;review dietary preferences with the resident as needed</p> <p>Date Initiated: 08/02/2023</p> <p>Created on: 08/02/2023</p> <p>&middledot;snacks at bedside for easy access</p> <p>Date Initiated: 08/02/2023</p> <p>Created on: 08/02/2023</p> <p>&middledot;supplements as ordered</p> <p>Date Initiated: 08/02/2023</p> <p>Created on: 08/02/2023</p> <p>&middledot;weekly weights</p> <p>Date Initiated: 08/02/2023</p> <p>Revision on: 04/02/2025</p> <p>Weekly weights were not obtained. There was documentation of refusal of weights once a month from October 2024 to December 2024. There was no documented attempt to obtain a weight in January 2025. The weight was refused in February and March 2025. The staff listed the last known weight of 205 pounds from July 2024 on each of the dates of refusal.</p> <p>There was no documentation of the staff addressing the resident's complaints about the food and not eating the food sent from the dietary department. There was no documentation of updated food preferences. There was no documentation of staff trying to determine the reason for the refusal to be weighed nor any attempts to weigh the resident on a different day or time. There was only one attempt to weigh each month. There also was no documentation of weekly weights after the dietitian rewrote the order on 4/3/2025.</p> <p>Further review of the record revealed there was no documentation that the staff was closely monitoring Resident # 56's intake of food, proper nutrients and obtaining weights as ordered. There was no documentation of other assessments, evaluations or observations to determine nutritional status or weight loss.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident # 56 stated he lost weight because the food tastes so bad at the facility and he had to order food from restaurants regularly when he had the money. Resident # 56 stated We want food that is cooked a certain way. He stated they just give us stuff that can be heated in the oven. It's already prepared. They don't really cook food here. Resident # 56 stated he knew it was important to eat so he could get better but he could not eat the facility's food. He stated he did not have the money to buy all of his meals from a restaurant.</p> <p>On 4/23/2025 at 2:20 p.m., an interview was conducted with Licensed Practical Nurse-P who stated it was important for Resident # 56 to have proper nutrition to help with healing of his wounds and other medical diagnoses. She stated Resident # 56 complained about the food at the facility and would order from restaurants sometimes.</p> <p>On 4/25/2025 during the end of day meeting, the Administrator, Director of Nursing, Corporate Nurse Consultants were made aware of the concerns.</p> <p>No further information was provided.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>Based on observations, resident interview, staff interviews, and clinical record review, the facility staff failed to ensure the resident received the physician ordered milliliters (ml) of oxygen for one (1) of 57 residents (Resident #271), in the survey sample.</p> <p>The findings included:</p> <p>Resident #271 was originally admitted to the facility 04/17/25 after an acute care hospital stay. The resident's current diagnoses included Acute on chronic hypoxic respiratory failure status post tracheotomy, COPD advanced age, and acute on chronic diastolic heart failure.</p> <p>The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 04/27/25 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #271's cognitive abilities for daily decision making were intact. Resident #271 was coded in Section C1., as requiring Oxygen therapy. The baseline care plan did not address the O2 concentrator.</p> <p>An interview was conducted with Resident #271 on 4/22/25 at 11:18 AM. Resident #271 stated she managed her tracheotomy care in the community and she would continue caring for it in the facility. She stated she was hospitalized for pneumonia and an exacerbation of COPD and was at the facility to regain her strength.</p> <p>An Observation was made on 4/22/25 at approximately 11:18 AM of Resident #271's O2 concentrator delivering 6 liters of oxygen per minute. Another observation was made of Resident #271's O2 concentrator on 4/25/25 at 3:45 PM with Licensed Practical Nurse (LPN) N. The O2 concentrator was delivering 10 liters of oxygen per minute. LPN N stated she would review the resident's order for the amount of O2 the concentrator was to deliver, set the concentrator accordingly and speak with the resident of the resident of the ordered O2 delivery.</p> <p>On 4/28/25 at approximately 4:00 PM, a final interview was conducted with the Administrator, Director of Nursing, [NAME] President of Operations and a Regional Nurse Consultant. They offered no comments and voiced no concerns regarding the above information.</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>Based on observations, resident interview, staff interviews, and clinical record review, the facility staff failed to manage pain for one (1) of 57 residents (Resident 43), in the survey sample.</p> <p>The findings included:</p> <p>Resident #43 was originally admitted to the facility 11/14/2024 after an acute care hospital stay. The current diagnoses included Parkinson's disease, heart failure and dementia with depression and anxiety. The quarterly MDS with an assessment reference date (ARD) of 2/21/25 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 11 out of a possible 15. This indicated Resident #43's cognitive abilities for daily decision making were moderately impaired.</p> <p>The resident had a care plan problem dated 4/15/25 which stated complaints of a toothache. The goal read the residents pain will be resolve thru review period, 5/22/25. The interventions included a dental appointment and administer medications as ordered.</p> <p>A review of the nurse's notes revealed the resident complained of a toothache on 4/12/25 and was evaluated by a dentist of 4/14/25 with instructions to return to the dentist on 4/15/25 for dental services. The clinical record contained no documentation of what services the resident received on 4/15/25 or documentation of an assessment by the facility's staff regarding the resident's status after the dental services.</p> <p>On 4/18/25 at 11:35 AM an interview was conducted with Resident #43. The resident's face was noticeably edematous and he presented with a grimace and grumpiness. The resident stated he had a tooth which had broken off and required surgical removal by the dentist. He stated that his mouth was hurting and he was still spitting out blood. The resident stated the nurse's would not give him any pain medications so he was just dealing with the pain.</p> <p>An interview was conducted with Licensed Practical Nurse (LPN) H on 4/18/25 at approximately 11:48 AM regarding Resident #43's statement about his dental procedure, aftercare and ongoing monitoring. LPN H stated she ensured medications for pain were ordered and would be available for administration after the procedure. LPN H reviewed the medication administration record and stated the resident had not received any pain medication since the dental procedure and it was likely because he aggravates the nurses and refuses all medications.</p> <p>LPN H stated the resident had refused all medication during the morning medication pass but she would ask Resident #43 if he wanted a pain pill to help with his mouth pain but she left without the pain medication. Upon LPN H's return to the medication cart she stated Resident #43 said he would accept the pain medication for pain rated seven (7) out of 10. LPN H administered Oxycodone 10 mg to the resident at 12 noon.</p> <p>Another interview was conducted with Resident #43 on 4/18/25 at approximately 3:15 PM. The resident stated the pain continued and he was reminded to notify the nurse for they were available to assist him.</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 4/28/25 at approximately 4:00 PM, a final interview was conducted with the Administrator, Director of Nursing, [NAME] President of Operations and a Regional Nurse Consultant. They offered no comments and voiced no concerns regarding the above information.</p>

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, clinical record review and facility documentation the facility staff failed to ensure Residents received dialysis and ongoing communication and collaboration with the dialysis facility regarding dialysis care and services for 1 Resident (#64) in a survey sample of 57 Residents.</p> <p>The findings included:</p> <p>For Resident #64 the facility failed to ensure proper transportation to the dialysis facility and failed to ensure ongoing communication and collaboration with the facility to ensure continuity of care.</p> <p>Resident #64 was admitted to the facility on [DATE] with diagnoses that included, but we're not limited to acute osteomyelitis of left ankle and foot cellulitis of left lower, limb, and stage renal disease, dialysis dependent, muscle weakness, hypertension, diabetes type two, arthrosclerosis of arteries in the bilateral legs, ischemic cardiomyopathy, and congestive heart failure. Resident #64 was alert, oriented and listed as his own Responsible Party, however he admitted to being non-compliant with the BIMS (Brief Interview of Mental Status) assessment because he felt the questions were stupid, thus, explaining the MDS scoring of 99 on his BIMS exam. Resident is non weight bearing to both legs due to wounds and diagnosis of osteomyelitis.</p> <p>On 4/15/25 at approximately 10 a.m. an interview was conducted with Resident #64 who stated that since his admission he has missed several dialysis appointments because they don't always send the right vehicle. When asked to elaborate he stated that he is 6'4 tall and has a high-backed wheelchair, and if they send the regular wheelchair minivan, he is too tall, and his head hits the top of the van. He stated he has to ride hunched over almost looking down and it makes him sick. When asked if he had told the facility this, he stated that he had told Everyone that would listen. When asked if he always refuses, he stated I go when they send the right vehicle.</p> <p>On the afternoon of 4/15/25 an interview was conducted with LPN K who stated that Resident #64 has behaviors of refusing dialysis. She stated that he likes to get his way. When asked to elaborate she stated that he wants a particular type of vehicle for transportation and won't accept anything else.</p> <p>On 4/16/25 an interview with the DON was conducted and she stated that Resident #64 has behaviors of refusing dialysis. When asked why he refused she stated he said the van was too small. When asked, has he always refused since admission, she stated that he has gone a few times. When asked if the same type of van is sent on the days, he accepted she stated He will not go if they send a regular mini-van or a stretcher transport. He wants the extra tall striker van. [cargo van] When asked why she stated he says he is too tall and won't fit. When asked if he was measured, she stated that he is 6' 4. When asked what type of wheelchair he has she said a high-backed wheelchair. When asked if measurements were taken of him to see if he has a valid concern, she stated they were not.</p> <p>A review of the clinical record revealed the following regarding missed dialysis appointments:</p> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3/27/25 - 11:18 a.m. Spoke with resident r/t him missing his dialysis appointment yesterday 3/26/2025, resident states he did not go because they sent a stretcher transport, and he need a large wheelchair transport van. This writer discussed the importance of keeping his appointments with dialysis and his risk of fluid overload by not eating the proper nutrition. Resident states he understands the risk and states I will go if they provide the correct transportation. This writer asked why he was missing his appointments before he was admitted to the facility, he states he missed the appointment for the same reason of incorrect transportation.</p> <p>3/28/25 - 11:42 a.m. -Resident refused his dialysis appointment once again this am r/t transportation issues. They sent a stretcher transport he states he needs the large wheelchair transport van. Resident have been educated on the importance of dialysis.</p> <p>3/31/25 - 9:57 p.m. [Physician Note] -was notified by nursing staff that he has been refusing to go to hemodialysis. I discussed with him and asked why he was refusing. He reported that he is not going to dialysis on the stretcher and he is not going with dirty clothes. I did discuss the importance of hemodialysis. He is scheduled to receive his antibiotic for osteomyelitis during antibiotic treatment. He refused PICC line prior to hospital discharge. No signs of fluid overload noted. Continue to encourage increased compliance with HD treatments His concerns were Discussed with nursing staff.</p> <p>4/9/25 - 5:05: refused to go dialysis. Van is too small. NP [Name Redacted] is aware.</p> <p>4/14/25 - 3:00 p.m. -Resident was dressed and ready to go to dialysis, but the transportation did not show up. Writer tried calling [Dialysis name redacted] dialysis several times, but no one picked up.</p> <p>4/16/25 [physician note] -He is seen to follow-up on hemodialysis treatment refusals. He continues to be noncompliant with hemodialysis treatment. There have been issues with transportation as well. He is scheduled to receive his antibiotic for osteomyelitis during hemodialysis treatment.</p> <p>4/18/25 - 2:44 p.m. Resident transport arrived at the facility to take him to dialysis. Insurance was made aware of resident preference today prior to arriving. Resident was rolled to the front lobby to the hospital to home van. Resident immediately stated that he was not going to get in the van because he has told the building that it was not the right size and he would not fit. Resident asked if he would at least try to get on the van so that he would see if he was able fit. Resident stated that he does not care he was not being put on the van because he can't fit and would be sick riding back from dialysis on that size van .</p> <p>4/19/25 - 10:27 -Resident c/o nausea, his assigned nurse offered and administered prn Zofran. Resident stated I think I'm feeling like this because I missed dialysis resident missed dialysis r/t his refusals, he was offered to go the ER on yesterday 4/18/2025 which he declined, he was offered this am to go to the ER by his assigned nurse and thus writer he declined both times.</p> <p>4/19/25 - 11:51 a.m. -Received report from his assigned nurse that he is yelling out for help, this writer went to his room immediately. On arrival to his room the resident was laying in his bed with the sheet over his head, this writer asked was he ok and what did he need help with, resident responded I just need to rest that's all. This writer asked him if he would like to go out to the hospital, the resident stated no I just need to rest I'll be ok.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Parham Health Care & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2400 E Parham Road Richmond, VA 23228	
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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4/20/25 - 8:35 a.m. Monitor resident for s/s of fluid overload. (swelling, SOB, abnormal v/s) related to 3 missed dialysis every shift.</p> <p>4/21/25 - 9:57 a.m. Pt refusing dialysis said he can't fit in van, the minivan sent does accommodate pt however pt stated he needs more room because he is 6'2. advised pt we can send him to ER for dialysis because he has refused 4 times, pt still refusing NP is aware no new order.</p> <p>On 4/22/25 - Resident #64 was interviewed, and he stated the staff measured him in his wheelchair and then they made some phone calls and got me approved to go in the big van every appointment. I feel so much better today since I had my dialysis.</p> <p>4/22/25 - at 10:08 AM. Resident measured sitting in the chair from floor to head. Resident measures 54 inches.</p> <p>4/22/25 - at 10:03 AM. Spoke with resident about the new transport for dialysis with request for larger van, the new company was able to accommodate, he went to his scheduled dialysis, the request for larger van was made to send for further schedule transport for dialysis, he understands the other company will no longer provide services and is in agreement, more alert today and respond. He feels better.</p> <p>A review of the clinical record revealed that Resident #64 had not had labs drawn at the facility and was also scheduled to receive his antibiotic IV Gentamicin at dialysis.</p> <p>On 4/22/25 an interview was conducted with LPN K who stated that Residents who are on dialysis have communication books that are sent to dialysis with them and the center should enter information for the facility to review, and the facility puts in the weights and vitals prior to leaving the facility to communicate with dialysis.</p> <p>A review of Resident #64's Communication Book for dialysis revealed that the pages were mostly blank except for vital signs. The dialysis center and facility did not check the boxes and fill in names of Meds to be given at dialysis or Meds given at dialysis.</p> <p>There were no copies of labs or written results of labs drawn, for facility to review, weights were not entered, nor was refusal of wts entered.</p> <p>On 4/23/25 at approximately 3:00 p.m. an interview was conducted with the DON who was asked if the dialysis book should be sent to the center with the resident, filled out prior to the Resident leaving the facility, any medication entered on the sheet, and weight and vital signs. When asked what is expected from the center with regards to the communication book, she stated that they expected any lab results, medications given, and any weights or vitals taken as well as any other pertinent information related to dialysis care and treatment, but it was not done. The DON state it was the expectation is for a nurse receiving the book from dialysis with no communication from them, she stated they should call the center and get an update, but it was not done.</p> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During the above interview, the DON stated the labs obtained at dialysis should be part of the clinical record, but they were not and it was the dialysis center's responsibility to administer the resident the doses of Gentamicin. When asked who is responsible for reporting medications compliance to the physician, she stated that the facility is. When asked how the facility is keeping record of this if the communication book or the MAR does not notate it and they would have to contact dialysis. The DON was then asked to obtain any labs drawn at the dialysis center.</p> <p>4/24/25 11:45 AM, Surveyor F received copies of labs faxed to DON by the dialysis center. Labs were reviewed with the DON, who stated she has made the NP aware.</p> <p>4/24/25 1:21 PM Note Text: Received a call from [dialysis name redacted] dialysis r/t abnormal labs hemoglobin 5.6 gave orders to send to ER. Resident was verbally informed by his assigned nurse of his results and new orders; resident is refusing to go to the ER stating I feel good there's nothing wrong with me I'm not going to the er. Resident is declining to go to the ER at this time. NP made aware.</p> <p>4/24/25 7:37 P.M. Called NP in regard to potassium level, NP advised to call dialysis (Name redacted) and get results from yesterday, no answer from dialysis, NP authorized labs cbc, and cmp stats, spoke with pt he stated he will allow lab to try one time, advised if Lab can not get labs call dialysis in am to get the labs results they take.</p> <p>A review of the clinical record revealed that Resident #64 eventually agreed to be transported to the hospital on 4/25/25 for a blood transfusion due to low hemoglobin and returned to the facility on 4/26/25.</p> <p>A review of the facility policy regarding transportation revealed the following:</p> <p>Policy: The center will ensure transportation to medically related appointments and will be responsible for coordinating accommodations, as needed.</p> <p>PROCEDURE 1. The center will schedule a provider appointment when a consult recommendation is received.</p> <p>2. The responsible party may be requested to contact the transportation company for completion of appropriate forms allowing patient to use transportation services.</p> <p>3. Transportation services will be notified at least 24 hours before the appointment time to schedule their service, when possible.</p> <p>4. If transportation is not available or cancelled, provider and the patient and/or responsible party will be notified, and the appointment will be rescheduled.</p> <p>A review of the policy entitled Hemodialysis dated 1/29/24 revealed the following excerpt:</p> <p>Policy: A licensed nurse will monitor dialysis access grafts/devices as ordered by the provider and will oversee</p> <p>the care of the hemodialysis patient pre and post treatment.</p> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Paragraph 2</p> <p>Outpatient Hemodialysis:</p> <ol style="list-style-type: none"> 1. The Dialysis Communication Form will be initiated prior to sending patient for dialysis. A dialysis center ' s designated form may be used in place of the center ' s Dialysis Communication Form. 2. Patient reports received from dialysis center will be uploaded to the medical record. <p>On 4/29/25 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.</p>

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident interview, staff interview, and review of the clinical record, the facility staff failed to assess and attempt to use alternatives prior to the use of bedrails for one (1) of 57 residents (Resident #156), in the survey sample.</p> <p>The findings included:</p> <p>Resident #156 was originally admitted to the facility 2/8/2025 and readmitted [DATE] after a right above the knee amputation (RAKA). The resident's current diagnoses included atherosclerosis, diabetes and chronic kidney disease.</p> <p>The 5-day Medicare Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 03/17/2025 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #156's cognitive abilities for daily decision making were intact.</p> <p>In MDS section GG0130. Self-Care the resident was coded as requiring supervision or touching assistance with eating, oral hygiene, rolling from left to right, sitting on side of bed to lying flat, partial/moderate assistance with lower body dressing and chair/bed-to-chair transfers, substantial/maximal assistance with toileting hygiene, shower/baths, and upper body dressing, dependent with putting on/taking off footwear, sit to stand, toilet transfers and wheeling a wheel chair.</p> <p>Resident #156 was observed on 4/23/25 at 11:24 AM seated in a wheelchair at bedside, bilateral bedrails were attached to the bed with the bedrail closer to the door lowered. On 4/24/25 at approximately 12:35 PM the resident was observed in bed unarousable, with the head of the bed elevated to approximately 50 degrees and a meal tray before him. Bilateral bedrails were observed attached to the bed and in the up position. On 4/25/25 at 3:50 PM the resident was observed in bed as he conversed. The bed was in a high position and bilateral bedrail were in an up position.</p> <p>An interview was conducted with the resident on 4/25/25 at approximately 3:53 PM. The resident stated he likes having the bedrails but he could not recall requesting them or receiving information concerning risk or benefits. A review of the resident's record failed to disclose alternatives attempted prior to use of the bedrails, how the alternatives failed to meet the resident's needs and a bedrail assessment.</p> <p>On 4/28/25 at approximately 4:00 PM, a final interview was conducted with the Administrator, Director of Nursing, [NAME] President of Operations and a Regional Nurse Consultant. They offered no comments and voiced no concerns regarding the above information.</p>		

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<p>F 0742</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder.</p> <p>Based on observations, resident interviews, staff interviews, and clinical record review, the facility staff failed to ensure that a resident who exhibited behavioral health symptoms received clinically appropriate services for one (1) of 57 residents (Resident #43), in the survey sample.</p> <p>The findings included:</p> <p>Resident #43 was originally admitted to the facility 11/14/2024 after an acute care hospital stay. The current diagnoses included Parkinson's disease, heart failure and dementia with depression and anxiety. The quarterly MDS with an assessment reference date (ARD) of 2/21/25 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 11 out of a possible 15. This indicated Resident #43's cognitive abilities for daily decision making were moderately impaired.</p> <p>In MDS section D0150 (Mood), the resident was coded as having trouble falling or staying asleep, or sleeping too much, nearly every day, feeling down, depressed, or hopeless, nearly every day, feeling tired or having little energy, nearly every day, and experiencing trouble concentrating on things, nearly every day. In MDS section E0800. Rejection of Care the resident was coded as rejecting care 4 to 6 days each week.</p> <p>A care plan problem dated 12/23/24 stated the resident has behaviors (refuses medications, ADL care, and weights) related to dementia, and a depressive disorder. The goal read the resident's behaviors will not cause him or other resident's distress thru the review period, 5/22/25. The interventions included administer medications as ordered, and assign staff members that are familiar or preferred by the resident whenever possible.</p> <p>An interview was conducted with Resident #43 on 4/18/25 at approximately 3:15 PM. The resident stated his mouth pain continued and he was reminded to notify the nurses because they were available to help him. The resident was noticeably more agitated than he was earlier in the day and he required gentle encouragement to share his feelings. Frequently Resident #43 required reminders that the Health Department had authorized the Survey Team to ascertain care practices in the facility and his statement was valued.</p> <p>The resident also stated that the people who lived and worked in the facility did not like him, and they did not treat him fairly. The resident further stated he believed they were giving him the wrong medications and he did not need most of the medication they wanted him to take. The resident shared he was a retired police officer and he knew how to protect himself.</p> <p>On 4/22/25 at 9:35 AM the facility's staff called the police to come to the facility because the resident was agitated, swinging and threatening others with wheelchair foot pedals. The resident was surrounded by the police officers and staff and could be heard stating that God was not listening to him, because he asked to be taken out of his misery and leave this world.</p> <p>(continued on next page)</p>		

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<p>F 0742</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of the nurse's notes revealed the resident was nonadherent with the medication regimen and an interview with the Psychiatric-Mental Health Nurse Practitioner (PMHNP) on 4/23/25 at 12:02 PM revealed that the provider was not made aware of the medication noncompliance. The PMHNP stated the resident's cognitive screening revealed significant dementia (a score of 4 out of 10) and the resident was exhibiting paranoia (he believed that the staff was giving him the wrong medications).</p> <p>A further review of the nurse's notes revealed the resident had experienced weekly confrontation with his peers and/or staff and the care plan intervention to assign staff members that were familiar or preferred by the resident whenever possible, displayed no evidence it was instituted or reevaluated. The caregivers documentation and the care plan interventions failed to include interventions for working with the resident's beliefs of not being liked or treated fairly, or receiving the wrong medications. The documenting failed to reveal care and services had resulted in improved mental and/or psychosocial functioning.</p> <p>On 4/28/25 at approximately 4:00 PM, a final interview was conducted with the Administrator, Director of Nursing, [NAME] President of Operations and a Regional Nurse Consultant. They offered no comments and voiced no concerns regarding the above information.</p>

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

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, clinical record review and facility documentation the facility staff failed to ensure Residents were free from significant medication errors for 1 Resident (#64) in a survey sample of 57 Residents.</p> <p>The findings included:</p> <p>For Resident #64 the facility staff failed to ensure the Resident received all of his medications as ordered by the physician.</p> <p>Resident number 64 was admitted to the facility on [DATE] with diagnoses that included, but we're not limited to acute osteomyelitis of left ankle and foot cellulitis of left lower, limb, and stage renal disease, dialysis dependent, muscle weakness, hypertension, diabetes type two, arthrosclerosis of arteries in the bilateral legs, ischemic cardiomyopathy, and congestive heart failure. Resident #64 was alert, and oriented and listed as his own Responsible Party, however he admitted to being non compliant with the BIMS (Brief Interview of Mental Status) assessment because he felt the questions were stupid, thus, explaining the MDS scoring of 99 on his BIMS exam. Resident is non weight bearing to both legs due to wounds and diagnosis of osteomyelitis.</p> <p>On 4/15/25 at approximately 10 a.m. an interview was conducted with Resident #64 who stated that since his admission he has missed several dialysis appointments because transportation does not always send the right vehicle. When asked to elaborate he stated that he is 6'4 tall and has a high backed wheelchair, and if they send the regular wheelchair mini-van he is too tall and does not fit.</p> <p>Clinical record review revealed that Resident #64 has missed 6 dialysis appointments. Resident #64 is ordered to receive Gentamicin IV while at dialysis therefore missing his dialysis has caused him to also miss 6 critical doses of antibiotics needed for his Osteomyelitis.</p> <p>Resident #64 also was supposed to receive Calcium Acetate (a phosphorus binder used to lower blood phosphorus levels in dialysis patients) with each meal.</p> <p>The following excerpts were entered in the chart regarding the missed medications:</p> <p>3/26/25 8:07 p.m. - Calcium Acetate (Phos Binder) Oral Capsule 667 MG Give 2 capsule by mouth with meals for hyperphosphatemia r/t dialysis to be given at dialysis.</p> <p>3/29/25 7:13 p.m. -Writer called the Pharmacy to inquire about resident's calcium acetate oral capsule give 2 cap. with meals. Pharmacy stated this has to be provided by dialysis to give facility to give to resident. Will call Dialysis on Monday.</p> <p>3/30/25 10:37 a.m. -Calcium Acetate (Phos Binder) Oral Capsule 667 MG Resident have refused dialysis since he has been here. Give 2 capsule by mouth with meals for hyperphosphatemia r/t dialysis to be sent from dialysis.</p> <p>3/30/25 12:07 p.m.Calcium Acetate (Phos Binder) Oral Capsule 667 MG Give 2 capsule by mouth with meals for hyperphosphatemia r/t dialysis Dialysis will provide.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3/31/25 - Writer spoke to [name redacted] at the dialysis center today, pertaining to resident. [Name redacted] stated that resident had his gentamycin ABT at dialysis center and will find out about resident's Calcium acetate capsule and will call facility tomorrow.</p> <p>On 4/21/25 an interview was conducted with the DON who was asked why the Calcium Acetate was being documented as being given at dialysis, she stated there was some confusion about who was supposed to supply it. We eventually got it straight that the dialysis center supplied it to the facility to dispense with each meal. When asked who was responsible for ensuring that the Resident received all of his doses of Gentamicin she stated that the dialysis center is the one administering it. When asked who is responsible for reporting medications compliance to the physician, she stated that the facility is. When asked how the facility is keeping record of this if the communication book does not mention it and the MAR does not mention it either, she stated they would have to contact dialysis.</p> <p>A review of the MAR (Medication Administration Record) for March revealed that Resident #64 did not receive the Calcium Acetate from admission on [DATE] through the end of the month 3/31/25. A review of the MAR for April revealed that Resident #64 missed 19 doses in April. A review of the lab results received on 4/24/25 that were results from labs drawn at dialysis on 3/31/25 revealed that the Resident had a high phosphorus level of 5.3.</p> <p>A review of the MAR revealed that there was no mention of the Gentamicin IV being given at dialysis.</p> <p>On 4/23/25 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495097	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/28/2025
NAME OF PROVIDER OR SUPPLIER Parham Health Care & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>Based on observations and staff interviews, the facility staff failed to safely store drugs and biological in one of three medication rooms and in the Infection Preventionist refrigerator.</p> <p>The findings included:</p> <p>On 4/23/25 at 11:34 AM an observation of the medication room on the [NAME] wing was conducted with Licensed Practical Nurse (LPN) O. An expired dose of Pevnar 20 was observed in the refrigerator for a resident who was discharged . LPN O stated it was not administered because the resident discharged prior to administration. LPN O stated it should have been removed from the refrigerator and returned to the pharmacy.</p> <p>On 4/25/25 at 11:30 AM an observation was conducted with the Infection Preventionist of the Infection Preventionist's medication refrigerator and testing supplies. Two expired RSV test kits had an expiration date of 12/2024 and one culture test kit had an expiration date of 10/19/2023. The above test kits were stored with other testing supplies which were still appropriate for use.</p> <p>It was also identified that seventeen influenza vaccines had names which had been redacted and remained in the refrigerator, twenty-two COVID-19 vaccine with an expiration date of 4/7/25, were incorporated with COVID-19 vaccines still appropriate for administration. In the refrigerator was also one T-dap vaccine expired 1/8/24, and three expired Shingrix vaccines with expiration dates ranging 10/17/24 to 12/3/24.</p> <p>An interview was conducted with the Infection Preventionist directly after the observations and finds. The Infection Preventionist stated she accepted the position less than a week before and she had not had an opportunity to assess and plan how to manage the department therefore she was not aware of the above findings prior to the review. The Infection Preventionist stated the expired drugs and test kits were given to the Director of Nursing for proper disposal.</p> <p>On 4/28/25 at approximately 4:00 PM, a final interview was conducted with the Administrator, Director of Nursing, [NAME] President of Operations and a Regional Nurse Consultant. They offered no comments and voiced no concerns regarding the above information.</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident interviews, staff interviews, and clinical record review, the facility staff failed to ensure meals served were palatable to consume by 2 of 57 residents (Resident #55, & #41) in the survey sample.</p> <p>The findings included:</p> <p>1. Resident #55 was originally admitted to the facility 5/25/23 and the resident was readmitted [DATE] after a hospital stay. The resident's current diagnoses included quadriplegia secondary to gunshot wound in 2017, and neuromuscular dysfunction of the bladder. The annual Minimum Data Set (MDS) with an assessment reference date (ARD) of 3/24/25 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 14 out of a possible 15. This indicated Resident #55's cognitive abilities for daily decision making were intact.</p> <p>The resident's nutrition care plan with a revision date of 9/3/24 stated the resident often orders food from outside entities and frequently ask other residents and staff for money to make purchases. On 4/25/25 at 12:15 PM, an interview was conducted with Resident #55 regarding why she orders out so often. The resident stated she does not eat anything prepared by the facility for she has knowledge that the kitchen is roach infested and she knows the food is horrible.</p> <p>The resident also stated she often puts her personal food in the unit pantry and it is stolen. Resident #55 further stated on the weekends there is little dietary staff so it looks like they take left overs from various days during the week to make trays to serve. The resident stated her family provides all of her meals.</p> <p>On 4/25/25 at 3:05 PM an interview was conducted with the Dietary Manager (DM). The DM stated that they prepare all meals in-house and she was attempting to add new items to the cycle menu, but she did not make a great deal of changes except to offer more alternatives. The DM stated she was still consulting with the Registered Dietitian and others to serve more of the resident preferences. The DM also stated there had been problems with roaches in the kitchen but the infestation was currently under control.</p> <p>On 4/28/25 at approximately 4:00 PM, a final interview was conducted with the Administrator, Director of Nursing, [NAME] President of Operations and a Regional Nurse Consultant. They offered no comments and voiced no concerns regarding the above information.</p> <p>2. Resident #41 was originally admitted to the facility 9/6/22. The resident's current diagnoses included blindness, chronic back pain and migraines. The quarterly MDS assessment with an assessment reference date (ARD) of 2/11/25 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #41's cognitive abilities for daily decision making were intact.</p> <p>Resident #41's had a care plan problem with a revision date of 12/20/24 which stated the resident prefers to leave personal items in the windowsill, a preference of purchasing and eating food from outside of the facility and storing food items in their personal refrigerator.</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The goal stated the resident will have his preferences honored if possible thru the review period, 5/14/2025. The interventions included encourage the resident to adhere to a therapeutic diet, and not to store food items outside of recommended time frames and temperatures.</p> <p>Observations were made in the resident's room of many spices and food products such as oodles of noodles, crackers and canned goods which could be opened and heated in a microwave. Therefore an interview was conducted with Resident #41 on 4/22/25 at 11:29 AM. The resident stated his blood sugars gets low and he has no foods to consume like a sandwich for his bedtime snack, except a cheese sandwich, which causes him constipation. The resident also stated that there are times he is hungry because the food is often not cooked well and most of the items are processed foods, that the dietary staff only warms and plates.</p> <p>The resident further stated he desired fresh fruits, but other than a banana which was recently added to the menu, there is no fresh fruits, just little cups of fruits in a juice. Resident #41 stated the food just doesn't have any flavor and most people use they few dollars to order out until their funds are depleted or arrange for their family to order food and have it delivered.</p> <p>On 4/25/25 at 3:05 PM an interview was conducted with the Dietary Manager (DM). The DM stated that they prepare all meals in-house and she was attempting to add new items to the cycle menu, but she did not make a great deal of changes except to offer more alternatives. The DM stated she was still consulting with the Registered Dietitian and others to serve more of the resident preferences. The DM also stated there had been problems with roaches in the kitchen but the infestation was currently under control.</p> <p>On 4/28/25 at approximately 4:00 PM, a final interview was conducted with the Administrator, Director of Nursing, [NAME] President of Operations and a Regional Nurse Consultant. They offered no comments and voiced no concerns regarding the above information.</p>		

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<p>F 0809</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times.</p> <p>Based on observation, resident interview, and staff interview, the facility's staff failed to provide meals at regular times and in accordance with resident needs, preferences and requests on three out of three units.</p> <p>The facility staff failed to offer and provide snacks at bedtime and failed to serve meals timely.</p> <p>The findings included:</p> <p>During the Resident council meeting conducted on 4/21/2025 at 2:00 p.m., the ten alert and oriented residents who attended complained that they did not get offered bedtime snacks and did not receive snacks on a regular basis. The attendees represented all three units. The residents stated that it was rare to receive snacks at bedtime. They all stated they would like a snack at bedtime. The residents further stated that they had witnessed the dietary staff bring snacks to the unit occasionally, and left them at the nursing station desk. Some of the residents stated they were Diabetic and did not get a snack on a regular basis. They stated the nursing staff left the snacks at the nursing desk, which allowed ambulatory residents who could get to the desk to get a snack but the residents who could not ambulate, often did not get a snack. They all stated they had observed nursing staff eating the snacks that were supposed to be given to residents.</p> <p>The residents complained that the foods were salty and starchy foods for each meal. They also stated the only fresh fruit allowed were bananas. They stated they were served canned fruit which tastes old.</p> <p>An interview was conducted with the Dietary Manager (DM) on 4/18/2025 at approximately 4:15 p.m. The Dietary Manager stated that the only bedtime snacks provided were for the Diabetics on the units. She stated that was what was included in the Dietary contract. The Dietary Manager stated she provided nursing staff with the snacks for Residents diagnosed with Diabetes. She stated the snacks provided were labeled with the names of the Residents with Diabetes. The Dietary Manager stated she did not provide snacks for the other residents due to the contract with the facility.</p> <p>Review of Resident Council minutes for January to March 2025 revealed documentation of concerns regarding dietary.</p> <p>There were no observations of snacks being offered or provided to residents prior to the survey team informing the administrative staff of the concerns expressed by residents and the findings.</p> <p>On 4/23/2025 at 8:51 a.m., Resident # 75 was observed standing in her room near the door to her room. She stated she was waiting for the breakfast trays to come to the floor.</p> <p>(continued on next page)</p>		

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<p>F 0809</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Resident # 75 stated she wanted some coffee. When asked if she could get coffee prior to the trays being served, she stated no. We have to wait until the trays come. Resident # 75 also stated that the staff know I love my coffee. Resident # 75 stated I would have to get it myself. She stated the only way she could get coffee prior to breakfast being served was if she bought it. When asked what that meant, she stated she would have to ask the staff to go out to a Restaurant to buy some coffee for her.</p> <p>On 4/23/2025 at 8:55 a.m., Resident # 75 was observed in the hallway. Stated she went to the Dining Room to read the breakfast menu and was coming back to the room to tell her roommate what was on the menu.</p> <p>Resident # 75 was observed walking back and forth to the door of her room and later in the hallway asking dietary staff members what time they were going to deliver the breakfast trays to the unit where she resided.</p> <p>Resident # 75's room was located on the East wing perpendicular to the hall where the door to the kitchen was located. Resident # 75 could stand in the doorway to her room, look to the left and see the carts being transported out of the kitchen to the units.</p> <p>On 4/23/2025 at 9:06 a.m., observed a Certified Nursing Assistant who knocked on the kitchen door, asked about trays for the Central Unit. A dietary staff member was observed coming down the hall. He stated he just delivered trays to Central Short.</p> <p>Dietary staff members were observed transporting carts out of the kitchen and going to different units between 8:53 a.m. and 9:12 a.m.</p> <p>On 4/23/2025 at 9:18 a.m., observed the dietary staff delivering the carts for the East unit where Resident # 75 resided, The nursing staff delivered the tray to Resident # 75 at 9:21 a.m. Observations were made that other residents on East Unit long and short halls received their trays after 9:25 a.m. The nursing staff were passing the trays and setting them up for the residents as needed.</p> <p>On 4/23/2025 at 11:50 a.m., observed Residents eating lunch in the dining room. There were approximately 21 residents (representing all three units) in the dining room eating lunch. For the residents who resided on the East Unit and Central Unit, there had been only two-two and a half hours between the breakfast and lunch meals.</p> <p>Review of the facility's documentation of meal times revealed the listed times for delivery of meals were more than 14 hours between the dinner meal and breakfast. Examples included:</p> <p>East Long/East Short- Dinner-6 p.m.- Breakfast- 8:15 a.m.</p> <p>Central Long/Central Short-Dinner-5:45 p.m.- Breakfast 7:50 a.m.</p> <p>Another copy of the facility's meal times was presented to the survey team. That copy had typed times along with some handwritten designation of the units associated with times.</p> <p>Examples of more than 14 hours included but were not limited to:</p> <p>(continued on next page)</p>		

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<p>F 0809</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Dining Room-Dinner-5:35 p.m.-Breakfast-8:30 a.m.</p> <p>West Long-Dinner- 5:00 p.m.- Breakfast- 7:30 p.m.</p> <p>Central Short-Dinner- 5:50 p.m.- Breakfast-8:10 p.m.</p> <p>East Short-Dinner-6:35 p.m.- Breakfast-8:45 p.m.</p> <p>The breakfast trays were over an hour late on the East and Central Units</p> <p>Residents who attended the Resident Council meeting stated the facility was always short staffed and it affected everything. They stated they could not get their trays fast because there was not enough staff to pass the trays. They also stated they often order food from the outside because they get hungry. They stated they often do not like the food but have to eat it since they need food.</p> <p>On 4/24/2025 at approximately 10:45 a.m., an interview was conducted with the Dietary Manager. Regarding times of delivery of food carts to the units, the Dietary Manager stated she was aware that residents on the East Unit complained about the delivery times of their meals. She stated that's why sometimes I deliver meals on the East unit first instead of always doing the [NAME] Unit first. The Dietary Manager stated the dietary department was delivering the meals to the units as fast as possible. The Dietary Manager stated the dietary staff delivers the meal carts and nursing staff distribute them to the residents.</p> <p>On 4/25/2025 during the end of day debriefing, the findings were discussed with the Executive Director (Administrator), Director of Nursing, [NAME] President of Operations, and Regional Corporate Nurse Consultant. Some residents had lunch two hours after breakfast and then had to wait 6 or more hours for dinner. Breakfast was more than 14 hours after the dinner meal. Most residents did not receive a bedtime snack. They stated snacks should be provided to residents and that meals should be delivered on time.</p> <p>No additional information was provided.</p>

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>Based on observations and staff interviews, the facility staff failed to ensure resources necessary to provide for the needs of the residents who resided at the facility were available.</p> <p>The findings included;</p> <p>On 4/24/25 at approximately 1:00 PM., a tour of the laundry room was conducted. Three industrial sized washing machines were observed. Employee U, laundry aide, said that only 2 out of the 3 washing machines were working, It's been about a year.</p> <p>On 4/24/25 at approximately 1:10 PM., a brief interview was conducted with the Housekeeping Director (HD)/Laundry Services Director. The HD said that he had made the administrator aware of the washing machine not working because the administrator has only been working for a few weeks. An observation of the laundry storage area (located through the HD's office) was conducted with the HD, multiple boxes were observed stacked on the floor. The HD said that they were boxes of linen. The HD was asked if he was aware that staff and residents were saying there was not enough linen on the floors, the HD said he was not informed.</p> <p>A document entitled Laundry Work Order was provided on 4/24/25. The document dated 4/21/25 read: Maintenance. Performed routine maintenance on 2 washers.</p> <p>On 4/24/25 at approximately 2:05 PM., a brief meeting was conducted with the corporate staff, the [NAME] President of Operations (VP-OPs), the Director of Nursing (DON), the Corporate Nurse, the Administrator, and the Housekeeping Director concerning the washing machine. They were informed that the Housekeeping Director didn't feel like he should inform the present administrator issues involving the laundry room having 2 out of 3 workable washing machines. According to current facility staff there were issues receiving linen and clothing in a timely manner. The Housekeeping Director mentioned that the estimated cost of repairing the inoperable washing machine could be around \$5500.00, while a new washing machine would cost about \$16000.00. The [NAME] President of Operations said that he was not aware of the laundry room needing a washing machine.</p> <p>On 04/28/25 at approximately 3:15 p.m., the above findings were shared with the Administrator, Director of Nursing (DON), Corporate Consultant and the VP of Operations.</p>		

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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, clinical record review and facility documentation, the facility staff failed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases for one (1) resident (Resident #61) in a survey sample of 57 residents, resulting in a finding of immediate Jeopardy.</p> <p>The findings included:</p> <p>The facility staff failed to ensure that Resident #61 did not have access to dirty, biohazard containers, which posed a risk of injury and the transmission of disease to other facility residents.</p> <p>Resident #61 was admitted to the facility on [DATE] with diagnoses that included but were not limited to heart failure, type 2 diabetes, hypertension, difficulty walking, shortness of breath, chronic kidney disease stage 3, obstructive sleep apnea, peripheral vascular disease and major depressive disorder. Resident #61's most recent MDS (Minimum Data Set) dated 3/31/25 coded Resident #61 as having a BIMS (Brief Interview of Mental Status) score of 15/15 indicating no cognitive impairment.</p> <p>On 4/17/25 at 8:45 a.m., outside in the rear of the building, Resident #61 was observed ambulating in his wheelchair, opening and reaching into a large lidded 55-gallon red biohazard bin/receptacle. Twenty (20) unsecured, dirty, biohazard containers were observed in this area. When the resident was asked if he knew what the bin was used for, he stated, Yes, pointing toward the Biohazard label on the bin, It is for needles, blood and stuff.</p> <p>A review of the clinical record revealed the following progress notes:</p> <p>Effective Date: 04/17/2025 10:28 Type: Health Status -Resident spoken with about rummaging in trash outside the building and safety risk involved with items that are possibly located in the trash. Resident stated that he only lifted the lid of trash can. Resident encouraged to wash hands stated that he was coming in the building. Resident own RP provider made aware of resident's behaviors. Entered by DON</p> <p>Effective Date: 04/17/2025 10:58 Type: Behavior Note -Type of Behavior: Going in hazard waste outside the building after multiple attempts to stop him from going in the trash. Residents have been educated multiple times r/t medical debris. Non-pharmacological Intervention: Educated on dangers of sharp objects and human waste effect: Resident continues to go through the trash outside PRN Medication: none Outcome: Resident remain going in trash outside after multiple attempts from the staff. Entry by LPN B.</p> <p>Effective Date: 04/17/2025 3:15 p.m. Spoke with resident about the back portion of the building being for staff and that the resident should not be back there. Resident acknowledged that he would not go back there after speaking with writer and being made aware. Resident asked what he use to-do, and he stated that he was previously a Maintenances man. Writer talked with resident about his tools that he works with and how he keeps them locked away. Resident verbalized understanding. Entry by LPN B</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Effective Date: 04/17/2025 6:57 p.m. - Communication - with Resident DON and RDCS spoke to resident regarding suicidal ideation with use of sharp something, he reports it has been a year ago and has not had any further thoughts since that time. He declines psych services, declines social service, he said he will speak to Reverend [NAME], declined for us to call and said he will call if needed. He denies feeling depressed, reports I am fine, reiterated about maintaining safety with not going to outside work area, he agreed and reports understanding. Entry by Regional Director of Clinical Services</p> <p>On April 18, 2025, at 2:30 p.m., after consultation with the state survey and certification agency office supervisors, the survey team notified the facility that it was in immediate jeopardy (IJ) in the areas Infection Control. The survey team, along with the state survey and certification agency supervisors, accepted the IJ removal plan. The survey team validated the IJ Plan, and the Immediate Jeopardy was removed on 4/22/25 at 2:37 p.m</p> <p>The removal plan read as follows:</p> <p>Resident #61 who was observed accessing hazardous areas including biohazard containers, an open generator, and paint materials, was immediately removed from all hazardous areas and assessed by the nurse on 4/17/25. Resident #61 no signs of injury or contamination were observed on 4/17/25. Resident #61 received individualized education on the risks associated with biohazard, unauthorized access to restricted zones with understanding to prevent injury and maintain safety on 4/17/25. Resident #61's care plan was updated on 4/17/25.</p> <p>The Regulated Medical Waste policy was reviewed and implemented on 4/18/25 by the Administrator. All 20 biohazard containers were secured with locks or discarded as of 4/18/25.</p> <p>The biohazard bins were locked and secured on 4/18/25 with a tarp placed and labeled with biohazard signage until a POD to store or biohazard waste company pick up the bins tentative date 4/21/25. When the POD is picked up by the company the biohazard waste company will pick up the biohazard waste from the utility rooms with biohazard waste . All maintenance areas are marked with signage 4/18/25 to prevent the entrance of residents. The dirty utility storage rooms on the units had signage posted with biohazard signs on 4/18/25. Resident #61 and no other residents have been identified outside in the rear area of the building on 4/18/25.</p> <p>Security measures were promptly implemented, including reinforcement or replacement of doorknobs and or locks to secure access to the maintenance doors, dirty utility rooms and posted warning signage for areas of biohazard waste and containers storage area outside and units to prevent entry of residents in hazardous areas and maintain safety.</p> <p>(continued on next page)</p>

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NAME OF PROVIDER OR SUPPLIER Parham Health Care & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Current residents of the facility have the potential to be affected by the deficient practice. By 4/20/25 the Director of Nursing or designee conducted a facility wide assessment of all residents to identify anyone else with similar behaviors who may attempt to access restricted or hazardous areas. All ambulatory residents and those using mobility devices will be assessed for risk entering the rear side of the building. The identified residents will be educated to not enter the rear of the building. The identified residents will be educated to not enter the rear of the building of the maintenance service area, biohazard waste and bins to prevent injury and maintain safety with understanding safety boundaries. The maintenance director or designee conducted a full facility inspection of the inside and outside grounds to identify any additional hazardous areas accessible to the residents beyond those already identified. No other areas identified with this practice.</p> <p>The SDC or designee initiated on 4/18/25 in-service training for all staff, regarding biohazard waste and bins, secured areas doors closed and locked, posted signage, removal and storage of biohazard waste in designated bins and secured to prevent accessibility to residents and maintain safety.</p> <p>The facility staff will be educated on infection control protocols, safety and the facility's obligation to ensure environmental security with specific accountability and focus on hazardous areas.</p> <p>In addition, the maintenance and housekeeping staff received training by the Administrator or designee on this information as well, ensuring biohazard bin are secured and not accessible to the residents, ensure picked up by the waste management company, tool security, chemicals, paints, and work areas contaminants are not accessible to residents, maintenance and housekeeping door remain closed and locked when not in use.</p> <p>The IP nurse or designee will complete weekly audits of all biohazard containers and storage areas for 4 weeks, then monthly for 2 months, to verify that they are secured and that no patients have access to the areas. This practice aims to ensure the facility maintains good infection control practices.</p> <p>Additionally, the Director of Environmental Services will conduct daily rounds to ensure all biohazard containers remain secure, with documentation on a compliance checklist.</p> <p>The review results will be presented to the QAPI committee for review and recommendations. Any identified issues will trigger immediate corrective action and may lead to the revision of protocols. The review will be conducted randomly once the committee determines the problem no longer exists and is sustained.</p> <p>The survey team validated the facility's removal plan by proceeding to the rear of the building to inspect the walkways, generator, and area where the biohazard bins were to ensure they had been placed in the POD awaiting pickup. The bins were locked in the POD. Inside the building, the doors to all dirty utility rooms were locked and biohazard bins, currently being utilized, were stored in the room. The survey team reviewed the policies and procedures and interviewed staff regarding the proper storage of biohazardous materials. The staff were interviewed and expressed understanding that the bins were to stay locked in that room until picked up by the biohazard waste company. Resident #61 was interviewed, and verbalized understanding of the importance of not going into the rear area of the building. Residents who are ambulatory, either by walking or wheelchair were interviewed and expressed knowledge of the area behind the building being designated for staff use.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>The Immediate Jeopardy was removed on 4/22/25 at 2:37 p.m., and the scope and severity were lowered to Level 2, Pattern.</p> <p>On 4/22/25 during the end of day meeting the above concerns were reviewed with the Administrator. No further information was provided.</p>

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Keep all essential equipment working safely.</p> <p>Based on observation, interview, clinical record review and facility documentation, the facility staff failed to maintain all mechanical and electrical equipment in safe operating condition for the facility.</p> <p>The findings included:</p> <p>The facility staff failed to ensure all kitchen equipment was in working order.</p> <p>On 4/15/25 at approximately 9 a.m. observations of meals being served on Styrofoam trays were made. During the inspection of the kitchen the Dietary Manager stated that the dishwasher and the oven were not working.</p> <p>The interview with the Dietary Manager revealed the dishwasher had not been working. When asked how long the dishwasher had been down, she stated that she would have to check the work orders, and she stated she was not sure how long the oven had been broken either.</p> <p>Review of facility documentation from the repair technician revealed the following:</p> <p>On 4/14/25 at 2:11 p.m. (after Surveyors entered on day 1 of survey) an email was sent from the maintenance director to the company responsible for repairs to both the dishwasher and oven that read:</p> <p>4/14/25 at 2:11 p.m. - Please have a tech service come for repairs as soon as possible as this is a priority situation.</p> <p>A review of the invoices for repairs to the dishwasher and the oven read as follows:</p> <p>3/26/25 - Customer complaint was unit not washing at all, found 214VAC on the T1,2 and 3 of 3CON, diagnosed as bad wash pump, putting in estimate for repair.</p> <p>4/10/25 - When removing the bottom panel found roaches running throughout the entire unit, found roaches and roach excrement inside of the old motor, advising customer to get an exterminator out before replacing the unit to prevent the motor going bad again after I replace it as well as, so I don't take any roaches home, a majority of them had egg sacs attached to their body.</p> <p>4/15/25 -Customer wanted me to come out today to remove the panels of the warewasher to verify if infestation had been stopped, we found together that there were a reduced number of bugs but still persistent, customer wants to reschedule to Friday to have exterminator out one more time to prevent bugs from breaking a new motor.</p> <p>4/18/25 - Arrived onsite and replaced motor it was filled with roaches, after replacing the motor unit is working and functioning normally.</p> <p>A review of the work orders revealed that the oven had also been out of service, excerpts are as follows:</p> <p>(continued on next page)</p>		

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4/9/25 - Oven not heating. Troubleshoot the problem found need to replace fan motor. Blower spacer and mounting screws. Parts ordered.</p> <p>4/15/25 - Received part. Removed the old blower and motor. Installed new blower and motor. Oven working at normal function.</p> <p>A review of the facility policy entitled Timely Repairs dated 1/22/24 revealed the following:</p> <ol style="list-style-type: none"> 1. Verify identified repairs are completed within two (2) business days from the date the work order was generated in the preventative maintenance electronic record unless the repairs require the acquisition of outside resources. 2. For repairs that require the acquisition of outside resources, and/or parts that must be ordered which will delay and extend repair time past ten (10) working days, document in the preventative maintenance electronic record the parts ordered, P.O. number(s), contractor, and/or anticipated date for repairs. <p>On 4/18/25 during the end of day survey the Administrator was made aware of the concerns and no further information was provided.</p>

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<p>F 0909</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame.</p> <p>Based on observation, resident interview, staff interview, clinical record review, and review of facility documents, the facility's staff failed to ensure the resident's mattress was compatible for the bedframe for 1 of 57 residents (Resident #119), in the survey sample.</p> <p>The findings included:</p> <p>Resident #119 was originally admitted to the facility 11/12/24 after an acute care hospital stay. The resident has never been discharged from the facility. The current diagnoses included; Low Back Pain Unspecified.</p> <p>The quarterly revision Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 2/04/25 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #119 cognitive abilities for daily decision making were Intact.</p> <p>In sectionGG(Functional Abilities Goals) the resident was coded as requiring partial to moderate assistance with rolling from left to right, sitting to lying and lying to sitting.</p> <p>The person-centered care plan dated 1/13/25 read that the resident the resident prefers to stay in bed. A goal for the resident was to have their preferences honored if possible. An intervention for the resident was to review resident's preferences with them as needed.</p> <p>A Health Status note dated 4/16/2025 at 4:27 PM., revealed: Resident stated his mattress is broke Maintenance in to look at bed resident stated mattress lopsided causing pain ibuprofen given also get schedule tramadol ask resident if we could switch out his bed resident stated no he will get up tomorrow ask 3 times can we switch his bed resident refused adjusted legs for comfort effective.</p> <p>On 4/16/25 at approximately 4:00 PM., a brief interview was conducted with Resident #119 concerning his bed. Resident #119 said that he stays in constant hip pain due to his bed leaning lower at the foot of the bed on the right. Upon visual inspection, the right side of the resident's mattress (at the foot of the bed) appeared lower than the left side. Resident #119 also said that the maintenance man has been trying to fix his bed, but cannot fix it. Shortly thereafter, the maintenance staff walked into the residents' room. The maintenance staff was asked to measure the mattress on the resident's bed. The measurements were: 26 inches high on the right lower end of the mattress and 31 inches higher on the left end of the mattress at the foot of the bed. The maintenance staff said that he tried to fix the resident's bed but couldn't. Licensed Practical Nurse (LPN) C knocked, entered the residents' room and asked him if he was ok. The resident informed her that he was in pain due to his mattress being lopsided. LPN C informed him that she would be back with pain medication.</p> <p>On 4/16/25 at approximately 4:15 PM., LPN C entered the room with ibuprofen. LPN C and the maintenance staff offered to replace the residents old mattress with a new one but the resident declined saying that it was too close to eating dinner and that he would wait until tomorrow for fear he's be left sitting up too long waiting to be transferred from out of his bed.</p> <p>(continued on next page)</p>		

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<p>F 0909</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 04/28/25 at approximately 3:15 p.m., the above findings were shared with the Administrator, Director of Nursing (DON) and Corporate Consultant.</p>

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, clinical record review and facility documentation, the facility staff failed to maintain a safe, functional, sanitary, and comfortable environment for residents, staff and the public throughout the facility.</p> <p>The findings included:</p> <p>For the facility, the staff failed to maintain comfortable ambient temperatures throughout the facility.</p> <p>4/17/25 9:00 a.m. Residents on 3 of 3 units complained about the temperature being cold in the facility. Residents were observed in the hallway wrapped in blankets. The overnight temperature in the area according to the national weather service was 41 degrees. The facility maintenance director escorted Surveyors E and F to each unit and the temps were as follows:</p> <p>Central Unit - room [ROOM NUMBER] - 65 degrees</p> <p>East Unit - room [ROOM NUMBER] - 65 degrees</p> <p>West Unit - room [ROOM NUMBER] - 68 degrees</p> <p>West Unit hallway - 72 degrees</p> <p>The maintenance director was asked what the acceptable temperatures were for the facility, and he stated the building should be no less than 71 degrees and no more than 80 degrees. When asked why the heat was not on when the temperatures in the rooms were 65 and 68 degrees, he stated, This time of year in Virginia it is sometimes cold at night and hot during the day, and it is not good for the system to keep turning on and off the heat and air. He stated that this is an old system and cannot keep up with the demands of this building. The maintenance director also informed surveyors that the chiller they have now is from another building and is not functioning properly.</p> <p>The surveyors requested repair and service information for the heat and air conditioning for the past year below are excerpts from the emails between the Regional Director of Physical Plant and Corporate offices regarding the repairs:</p> <p>5/21/24 - This chiller was working when it was turned off last year at [facility where it was moved from name redacted]. [Company name redacted] moved it for us, it was vandalized sitting in [Facility currently being surveyed name redacted] parking lot overnight. Since it was installed a few months ago in the mechanical room, a large circulating pump has ruptured spraying all over the mechanical room. The control board is ruined and has to be built and programmed for this particular chiller . Given the issues last year with the state, I think we need to move on this asap.</p> <p>(continued on next page)</p>

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>4/1/25 - The chiller project at [Facility being surveyed name redacted] which began in 2023, remains unresolved despite a significant financial investment. The original chiller was relocated and installed, only to find the control board was nonfunctional. We then incurred additional costs to bring in a temporary chiller while awaiting a new control board. We were told installation would proceed in the spring, but that was followed by further delays. We've now been informed that the system is still not operational and are told guidance is pending from [Company name redacted]. This has gone on too long. We are now at risk of the state shutting down the building if the issue is not resolved immediately.</p> <p>On 4/21/25 at 4 p.m., a large trash can was observed in the hallway on the [NAME] Unit. Water was dripping from the ceiling into the trash can. An interview with the maintenance director, at that time, revealed that since the temperature had gone up to 81 degrees that afternoon the a/c was turned on. He stated that the air conditioning was leaking into the building as a result of condensation from the rooftop unit. He stated that the [NAME] Unit has a separate air conditioning system, and he had a technician come out because of the condensation leaking into the building. He said that the technician said there was 3 1/2 inches of ice on the coils and the facility would have to turn off the unit and let the ice melt before any repairs could be done, and he would come back the next day after it had a chance to melt.</p> <p>A review of past surveys revealed that the facility thewas cited on 9/14/24 for lack of a functioning air conditioning system.</p> <p>By the close of survey on 4/22/25 the facility was still working on repairs to the heat and air conditioning.</p> <p>A review of the facility policy entitled Timely Repairs dated 1/22/24 revealed the following:</p> <ol style="list-style-type: none"> 1. Verify identified repairs are completed within two (2) business days from the date the work order was generated in the preventative maintenance electronic record unless the repairs require the acquisition of outside resources. 2. For repairs that require the acquisition of outside resources, and/or parts that must be ordered which will delay and extend repair time past ten (10) working days, document in the preventative maintenance electronic record the parts ordered, P.O. number(s), contractor, and/or anticipated date for repairs. <p>On 4/29/25 during the end of day meeting the Administrator was made aware of the findings and no futher information was provided</p>		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>Based on observation, interview, and clinical record review the facility staff failed to maintain an effective pest control program for the facility.</p> <p>The findings included:</p> <p>For the facility staff failed to keep the building free from pests, namely roaches.</p> <p>On 4/15/25 during the initial tour of the facility the shower rooms were observed by surveyors E & F, the shower room on East Unit had a live roach crawling in the shower area.</p> <p>4/15/25 - 4/16/25 observations of meals being served on styrofoam trays. The interview with the Dietary Manager revealed the dishwasher had not been working. When asked how long the dishwasher had been down, she stated that she would have to check the work orders.</p> <p>Review of facility documentation from the repair technician revealed the following:</p> <p>3/26/25 - Customer complaint was unit not washing at all, found 214VAC on the T1,2 and 3 of 3CON, diagnosed as bad wash pump, putting in estimate for repair.</p> <p>4/10/25 - When removing the bottom panel found roaches running throughout the entire unit, found roaches and roach excrement inside of the old motor, advising customer to get an exterminator out before replacing the unit to prevent the motor going bad again after I replace it as well as, so I don't take any roaches home, a majority of them had egg sacs attached to their body.</p> <p>4/15/25 -Customer wanted me to come out today to remove the panels of the warewasher to verify if infestation had been stopped, we found together that there were a reduced number of bugs but still persistent, customer wants to reschedule to Friday to have exterminator out one more time to prevent bugs from breaking a new motor.</p> <p>4/18/25 - Arrived onsite and replaced motor it was filled with roaches, after replacing the motor unit is working and functioning normally.</p> <p>During the Resident Council meeting on 4/21/25, all 10 Residents that were in attendance agreed there currently is a Problem with roaches and ants throughout the building.</p> <p>On 4/23/25 a review of the pest control logs revealed that although the facility has a contract with pest control services for monthly service it is not effective, in that 3 of 3 units are still complaining of pests in the building, ants roaches and mice.</p> <p>While in the confrence room during most days of the survey ants were observed by all survyours in attendance.</p> <p>On 4/28/25 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.</p>		