

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495291	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/28/2024
NAME OF PROVIDER OR SUPPLIER Shalom Gardens Health & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 1600 John Rolfe Parkway Richmond, VA 23233	

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 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40711</p> <p>Based on observation, resident interview, staff interview, clinical record review, and review of facility documents, the facility's staff failed to follow physician orders for 3 of 28 residents (#293, #2 and #30) in the survey sample</p> <p>The findings included:</p> <p>1. Resident #293, the facility staff failed to ensure that a dressing for a wound on the resident's right lower extremity was changed according to physician's order. Resident #293 was originally admitted to the facility 6/26/24 after an acute care hospital stay. The current diagnoses included; Cellulitis of Right Lower Limb.</p> <p>The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 6/26/24 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 11 out of a possible 15. This indicated Resident #293 cognitive abilities for daily decision making were moderately impaired.</p> <p>The Care Plan dated 6/27/24 read that Resident #293 has potential for impairment to the skin integrity related to Cellulitis of right lower leg. The goal for Resident #293 was that skin will be intact, free of redness and discoloration. An Intervention was to administer medications, supplements and treatments as ordered. Monitor/document.</p> <p>The June 2023 Order Summary dated 6/27/24 read: Right foot wound care-Remove old packing and apply the Lidocaine for 5 minutes prior to wound care. Cleanse the wound by irrigating it with the Vashe solution (use a syringe) and then wipe the wound bed. Pack the wound with Vashe moistened packing strip and then cover with an Calcium Ag w/silver and bordered dressing. Reapply the sock after dating/timing the dressing. change daily and as needed as needed for wound care.</p> <p>The order details dated 6/27/24 at 8:48 AM., read the above order.</p> <p>The Medication Administration Record (MAR) read to change the above dressing daily and as needed with a start date of 6/27/24 at 9:00 AM.,</p> <p>On 6/28/24 at approximately 11:25 AM., Resident #293's family member was observed approaching Registered Nurse (RN) B, Unit Manager. The family member was heard asking RN, B if they going to change the resident's dressing. RN, B informed the family member that the dressing should be changed today.</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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An interview was conducted on 06/28/24 at approximately 11:25 AM., concerning Resident #293. RN, B said that the dressing should be changed today.</p> <p>A review of the Medical Records/MR showed that RN, B revised the wound care orders on 6/28/24 at 11:27 AM., after speaking to the resident's family member concerning wound care.</p> <p>On 6/28/24 at approximately 11:27 AM., Resident #293's dressing was observed on her right foot with a date of 6/26/24.</p> <p>According to the Physician's Order Summary (POS), the dressing on the resident's right foot should have been changed on 6/27/24 during the day shift.</p> <p>On 6/28/24 at approximately 3:20 p.m., the above findings were shared with the Administrator, Director of Nursing (DON) and Corporate Consultant. The DON said that the dressing should have been change according to the orders.</p> <p>34894</p> <p>2. For Resident # 2, the facility staff failed to administer medications and treatments on several dates as ordered by the physician .</p> <p>Resident # 2 was admitted to the facility on [DATE]. Diagnoses included but were not limited to: Fracture of Left Fibula, Edema, Alzheimer's Disease, Gastroesophageal Reflux Disease, Anxiety and Hypertension.</p> <p>Resident #2's most recent MDS (Minimum Data Set Assessment) with an ARD (Assessment Reference Date) of 05/17/2024 was a quarterly assessment. The MDS coded Resident # 6 with a BIMS (Brief Interview for Mental Status) score of 2 out of 15, indicating severe cognitive impairment. The MDS coded Resident # 2 as requiring extensive to total staff assistance with Activities of Daily Living.</p> <p>Review of the clinical record was conducted 6/26/2024-6/28/2024.</p> <p>The Medication and Treatment Administration Record (MAR/TAR) was reviewed for June 2024, and revealed medications were not administered as ordered by the physician. Those dates were as follows:</p> <p>There were valid Physician orders for the medications and treatments that were omitted.</p> <p>The nursing facility stated Mosby's as their nursing standard. Mosby's stated all medications must be administered by the physician's order.</p> <p>Guidance for nursing standards for the administration of medication provided by Fundamentals of Nursing, 7th Edition, Mosby's/ [NAME]-[NAME], p. 705 stated Professional standards, such as the American Nurses Association's Nursing Scope and Standards of Nursing Practice of (2004), apply to the activity of medication administration. To prevent medication errors, follow the six rights of medications. Many medication errors can be linked, in some way, to an inconsistency in adhering to the six rights of medication administration. The six rights of medication administration include the following:</p> <p>1. The right medication</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>2. The right dose</p> <p>3. The right client</p> <p>4. The right route</p> <p>5. The right time</p> <p>6. The right documentation.</p> <p>Resident 2's care plan was reviewed and revealed a care plan that instructed to administer medications and treatments as ordered by the physician.</p> <p>On 6/27/2024 at 10:20 a.m., an interview was conducted with Licensed Practical Nurse D who stated the expectation was for nurses to administer medications and treatments as ordered by the physician.</p> <p>On 6/27/2024, during the end of day debriefing with all surveyors, the Administrator and Director of Nursing were made aware of the failure of staff to administer medications as ordered. The Director of Nursing stated the expectation was for the staff to administer medications and treatments as ordered by the physician.</p> <p>No further information was provided.</p> <p>31199</p> <p>3. For Resident #30, the facility staff failed to provide Lidocaine pain patches as ordered by a physician for a Resident with bilateral leg ulcers and leg pain, to manage that pain.</p> <p>The findings included;</p> <p>Resident #30 was admitted on [DATE], with diagnoses including; ESRD (end stage renal disease), dialysis, dysphagia, peripheral vascular disease (PVD) with vascular ulcers, heart failure, heart disease, and cardiac pacemaker.</p> <p>A review of the clinical record revealed that on admission, Resident #30 had no real cognitive impairment, and was able to make her needs known.</p> <p>A review of the clinical record revealed physician's orders given on 5-24-24 for the following;</p> <p>- Lidocaine external patch 4% apply 2 patches to skin topically two times per day for pain, to remove per schedule.</p> <p>The Lidocaine patches were intended for bilateral leg pain (one patch on each leg), and were only ever scheduled to be applied on the medication administration record (MAR) once per day at 9:00 AM, and scheduled to be removed at 9:00 PM. The patches were never scheduled to be applied twice per day as was ordered.</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>On 6-25-24 at approximately 1:00 PM, the Resident was interviewed and stated my legs hurt all the time. The pain patches help but don't last long enough, I need them more often, and sometimes I don't get them at all and some of the girls say you were at dialysis and I can't get them.</p> <p>The MAR was reviewed and revealed that the patches were only scheduled to be given once per day at 9:00 AM, and they were not applied even once per day, and omitted entirely for both ordered doses on the following days;</p> <p>6-3-24, 6-4-24, 6-5-24, 6-6-24, 6-7-24, 6-8-24, 6-11-24, 6-12-24, 6-18-24, 6-19-24, 6-24-24, and 6-27-24, omitting 12 of 27 daytime doses.</p> <p>All of the 27 evening doses that were ordered, were never scheduled for administration leaving the resident without the prescribed pain medication throughout the evening and night.</p> <p>The Resident only received the pain patches on 4 occasions on her dialysis days for the 27 day period. Those follow;</p> <p>6-10-24, 6-14-24, 6-17-24, and 6-21-24. Resident #30 went to dialysis on Monday, Wednesday, and Friday, and was scheduled to leave for dialysis at 5:30 AM, (chair time 6:00 AM), and return to the facility at 9:30 AM. which would not have interfered with the 9:00 AM ordered administration time.</p> <p>An interview with LPNs on the afternoon of 6-25-24, revealed that if the medication was ordered to be given twice per day the person transcribing the order made a mistake. When asked to review the MAR, each stated yes, that's clear and it's a mistake. When asked if this meant the resident was without pain medication, the LPNs stated that Residents usually have an order for Tylenol that they can use. They were asked if they felt that Tylenol was adequate pain control for all types of pain, they stated that it was not. They also stated that Resident #30 often complained of leg pain, and back pain.</p> <p>The nursing facility stated Mosby's and [NAME] as their nursing standard. Both followed the NIH guidelines, as below;</p> <p>Nurses follow health care providers' orders unless they believe the orders are in error or harm patients. Therefore you need to assess all orders; if you find one to be erroneous or harmful, further clarification from the health care provider is necessary. To prevent medication or treatment errors, follow the six rights of medication administration consistently every time you administer medications or treatments. Many errors can be linked, in some way, to an inconsistency in adhering to these rights:</p> <ol style="list-style-type: none"> 1. The right medication 2. The right dose 3. The right patient 4. The right route 5. The right time <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>6. The right documentation</p> <p>Resident #30's care plan was reviewed and revealed a care plan for medications to be administered per physician's orders.</p> <p>On 6-26-24, during the end-of-day meeting, the Administrator and Director of Nursing (DON) were made aware of the findings, and they stated they had no further information to provide.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>34894</p> <p>Based on observation, resident interview, facility staff interview, clinical record review, and facility documentation review, the facility staff failed to provide the necessary services to maintain personal hygiene for one resident (Residents # 43) in a survey sample of 28 residents.</p> <p>Findings included:</p> <p>1. For Resident # 43, the facility staff failed to provide showers as scheduled and failed to document completion of bathing tasks every shift.</p> <p>Resident # 43 was admitted to the facility in June 2024 with diagnoses that included but were not limited to: Multiple Sclerosis, Pulmonary Embolism and Urinary Tract Infection.</p> <p>The most recent MDS (minimum data set) assessment was an Admission assessment with an ARD (Assessment Review Date) of 06/6/2024. The MDS coded Resident #43 with a BIMS (Brief Interview for Mental Status) Score of 15/15 indicating no cognitive impairment. Resident # 43 required extensive assistance of staff persons with ADLs (activities of daily living.) Resident # 43 was coded as continent of bowel and bladder.</p> <p>Review of the clinical record was conducted 6/26/2024-6/28/2024.</p> <p>On 6/27/2024 at 10:30 a.m., an interview was conducted with Resident # 43 who stated no showers had been provided by the facility staff during the 3 week stay at the facility (at the time of the survey.) Resident # 43 stated only on one evening, a Certified Nursing Assistant asked her about getting a shower that evening. Resident # 43 stated she declined the shower that evening because she did not feel well. Resident # 43 stated that she was not offered a shower on the next shift, next day nor any time after that evening. Resident #43 stated she would like to receive showers at least twice a week as scheduled.</p> <p>On 6/27/2024 at 11:20 a.m., an interview was conducted with the Unit Manager who stated she was not aware that Resident # 43 did not receive showers as scheduled. The Unit Manager stated Resident # 43 was alert and oriented with no cognitive impairment. The Unit Manager stated she wanted to talk with Resident # 43. The Unit Manager and surveyor went to Resident # 43's room. The Unit Manager asked Resident # 43 if she had received any showers. Resident # 43 stated she had not received any showers since admission to the facility.</p> <p>Certified Nursing Assistants (CNAs) were interviewed on all three units during survey, and indicated they documented all care in the Point of Care computerized system for each of their residents at the end of every shift.</p> <p>Review of the records for June 2024 revealed there was no documentation of showers being provided twice a week.</p> <p>Review of Resident # 43's physician orders, Treatment administration records (TAR's), Care plan, and progress notes indicated that Resident # 43 needed assistance with Activities of Daily Living.</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 - Few</p>	<p>The records indicated that Resident # 43 was dependent on staff for bathing and showering.</p> <p>Review of the ADLs Bathing task revealed there were 9 shifts with missing documentation of the task being provided or completed since admission.</p> <p>Review of the Progress Notes revealed no documentation of reasons for the missing documentation of bathing or showering.</p> <p>On 6/27/2024, the Director of Nursing (DON), and Administrator were interviewed and asked about their expectation for bathing and showering. They stated all residents should receive showers twice a week and bed baths on the other days, and that the provision of care must be documented afterwards.</p> <p>Staff stated that the facility's policy was for residents to receive showers twice a week and bed baths on they days they did not get a shower.</p> <p>On 6/28/2024 at 3:05 p.m., an interview was conducted with the Director of Nursing who stated the expectation was for all residents to receive a bed bath on the days they did not receive a shower. The Director of Nursing stated the staff should document all baths and showers in the clinical record.</p> <p>A review was conducted of the facility policy titled, Activities of Daily Living (ADLs). The policy read, .4. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: a. Hygiene (bathing, dressing, grooming, and oral care); i. Each resident shall receive tub or shower baths as often as needed, but not less than twice weekly or as required by state law .</p> <p>During the end of day debriefing on 6/28/2024, the facility's Administrator, Director of Nursing and two Corporate Nurse Consultants (Employee-J and Employee N) were informed of the findings.</p> <p>No further information was provided.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40711</p> <p>Based on observation, resident interview, staff interview, clinical record review, and review of facility documents, the facility's staff failed to ensure an area on the resident's groin was assessed and reported to the physician for 1 of 28 residents (Resident #74), in the survey sample.</p> <p>The findings included:</p> <p>Resident #74 was originally admitted to the facility 12/05/23 and readmitted [DATE] after an acute care hospital stay. The resident has never been discharged from the facility. The current diagnoses included; Traumatic Brain Injury.</p> <p>The quarterly, Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 6/07/24 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 13 out of a possible 15. This indicated Resident #74 cognitive abilities for daily decision making were intact.</p> <p>The Person-Centered Care Plan dated 12/13/23 read that resident has a potential for impairment to skin integrity related to muscle weakness and incontinence. The goal for the resident was to ensure skin remain intact. Interventions for the resident would be for staff to follow facility policies/protocol for routine skin monitoring and to report any changes and to administer medications, supplements and treatments as ordered.</p> <p>On 06/25/24 at approximately 2:01 PM., during the initial tour an interview was conducted with the resident and Responsible Party (RP). The RP said that Resident #74 has an Ingrown hair follicle to the left groin area for a week that causes irritation. Resident #74 says that the area only hurts when you press on it. The RP also said that she had informed Licensed Practical Nurse C saw the area a week ago. Certified Nursing Assistant (CNA) F entered the resident's room and assisted the RP to show resident's groin area. A visual observation was made of the resident's left groin area. A small brown bump with some redness was observed with no discharge noted. Shortly thereafter, Licensed Practical Nurse (LPN) D entered the room, assessed the area on the resident's left area saying that the Nurse Practitioner will be notified.</p> <p>On 6/26/24 at approximately 2:26 PM., NP, M entered the room, assessed the area on the resident's left groin, asked the resident how long has the area been on the groin. The RP stated that the area has been there for 1 week. The NP informed the resident that she will prescribe an antibiotic.</p> <p>On 06/28/24 at approximately 10:28 AM., an interview was conducted with LPN C. LPN C said that she was not assigned to the resident a week ago but stopped by to see how he was doing. LPN C also said she informed the resident and the resident's RP that the area on the left groin looked like a small hair bump. LPN C also said that she thought that the CNA assigned to the resident was going to inform the resident's nurse, but moving forward she should have informed the nurse as well.</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A progress note dated on 6/25/24 at approximately 3:14 PM., read: I was asked to exam bump to L groin. Wife reports she noticed it last week and does not think it has become larger in size. He reports mild tenderness to palpation. On exam folliculitis suspected to two (2) follicle areas to L groin merged into one larger nodule about 3/4 inch in length on exam with erythema, no current open pustule areas. Discussed antibiotic treatment with wife and patient and RN and watching catheter as tubing near area can be irritating as well. irritating as well.</p> <p>On 6/28/24 at approximately 3:20 p.m., the above findings were shared with the Administrator, Director of Nursing (DON) and Corporate Consultant. No further comments were made.</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31199</p> <p>Based on observations, clinical record review, staff interviews and facility documentation, the facility staff failed to provide pain management for one of 28 residents (R #30) in the survey sample.</p> <p>The findings included;</p> <p>For Resident #30, the facility staff failed to provide Lidocaine pain patches as ordered by a physician to manage pain for a Resident with bilateral leg ulcers and leg pain.</p> <p>Resident #30 was admitted on [DATE], with diagnoses including; ESRD (end stage renal disease), dialysis, dysphagia, peripheral vascular disease (PVD) with vascular ulcers, heart failure, heart disease, and cardiac pacemaker.</p> <p>A review of the clinical record revealed that on admission, Resident #30 had no real cognitive impairment, and was able to make her needs known.</p> <p>A review of the clinical record revealed physician's orders given on 5-24-24 for the following;</p> <p>- Lidocaine external patch 4% apply 2 patches to skin topically two times per day for pain, to remove per schedule.</p> <p>The Lidocaine patches were intended for bilateral leg pain (one patch on each leg), and were only ever scheduled to be applied on the medication administration record (MAR) once per day at 9:00 AM, and scheduled to be removed at 9:00 PM. The patches were never scheduled to be applied twice per day as was ordered.</p> <p>On 6-25-24 at approximately 1:00 PM, the Resident was interviewed and stated my legs hurt all the time. The pain patches help but don't last long enough, I need them more often, and sometimes I don't get them at all and some of the girls say you were at dialysis and I can't get them.</p> <p>The MAR was reviewed and revealed that the patches were only scheduled to be given once per day at 9:00 AM, and they were not applied even once per day, and omitted entirely for both ordered doses on the following days;</p> <p>6-3-24, 6-4-24, 6-5-24, 6-6-24, 6-7-24, 6-8-24, 6-11-24, 6-12-24, 6-18-24, 6-19-24, 6-24-24, and 6-27-24, omitting 12 of 27 daytime doses.</p> <p>All of the 27 evening doses that were ordered, were never scheduled for administration leaving the resident without the prescribed pain medication throughout the evening and night.</p> <p>The Resident only received the pain patches on 4 occasions on her dialysis days for the 27 day period. Those follow;</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 - Few</p>	<p>6-10-24, 6-14-24, 6-17-24, and 6-21-24. Resident #30 went to dialysis on Monday, Wednesday, and Friday, and was scheduled to leave for dialysis at 5:30 AM, (chair time 6:00 AM), and return to the facility at 9:30 AM. which would not have interfered with the 9:00 AM ordered administration time.</p> <p>An interview with LPNs on the afternoon of 6-25-24, revealed that if the medication was ordered to be given twice per day the person transcribing the order made a mistake. When asked to review the MAR, each stated yes, that's clear and it's a mistake. When asked if this meant the resident was without pain medication, the LPNs stated that Residents usually have an order for Tylenol that they can use. They were asked if they felt that Tylenol was adequate pain control for all types of pain, they stated that it was not. They also stated that Resident #30 often complained of leg pain, and back pain.</p> <p>On 6-26-24, during the end-of-day meeting, the Administrator and Director of Nursing (DON) were made aware of the findings, and they stated they had no further information to provide.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495291	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/28/2024
NAME OF PROVIDER OR SUPPLIER Shalom Gardens Health & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 1600 John Rolfe Parkway Richmond, VA 23233	
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 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** 34894</p> <p>Based on observations, clinical record review, staff interview and facility document review, the facility staff failed to acquire medications for 2 of 28 residents (R#2 and R#291) in the survey sample.</p> <p>The findings include:</p> <p>1. For Resident # 2, the facility staff failed to ensure medications were available for administration as ordered by the physician.</p> <p>Resident # 2 was admitted to the facility on [DATE]. Diagnoses included but were not limited to: Fracture of Left Fibula, Edema, Alzheimer's Disease, Gastroesophageal Reflux Disease, Anxiety and Hypertension.</p> <p>Resident #2's most recent MDS (Minimum Data Set Assessment) with an ARD (Assessment Reference Date) of 05/17/2024 was a quarterly assessment. The MDS coded Resident # 2 with a BIMS (Brief Interview for Mental Status) score of 2 out of 15, indicating severe cognitive impairment. The MDS coded Resident # 2 as requiring extensive to total staff assistance with Activities of Daily Living.</p> <p>Review of the clinical record was conducted on 6/26/2024 to 6/28/2024.</p> <p>Review of the Progress Notes revealed the following documentation regarding medications being unavailable:</p> <p>6/25/2024-Protonix 40 milligrams one tablet by mouth on order.</p> <p>6/15/2024-Boost supplement on order.</p> <p>6/11/2024-Mucinex 400 milligrams three times per day x 3 days on order.</p> <p>Review of the Inventory of Medications on hand at the facility revealed Pantaprazole 40 milligrams was available as a bulk medication in the facility.</p> <p>Review of the June 2024 Medical Administration Record (MAR) revealed the medication, Protonix was documented as not available for administration on 6/25/2024.</p> <p>Review of Physicians Orders revealed valid orders for the medication not available for administration.</p> <p>On 6/27/2024 at 11:48 a.m., an interview was conducted with LPN (Licensed Practical Nurse) D who stated the staff should notify the Pharmacy when medications are not available for administration, check the Pixus STAT box, notify the MD (Medical Doctor) and make sure the Pharmacy sends the medication STAT.</p> <p>(continued on next page)</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>On 6/27/2024 at 12:10 p.m., an interview was conducted with the Unit Manager who stated if a medication was not available at the time of scheduled administration, the nurses should go to the Pixus (on-site Stat box) to see if the medication was available in that stock.</p> <p>On 6/27/2024 at 1:55 p.m., an interview was conducted with the Director of Nursing who stated the Pharmacy should have medications available for administration as per Physicians Orders. A copy of the Pixus Stat Box medications list to determine if the missing medications were available in that supply was requested and received.</p> <p>On 6/27/2024 at 3:05 p.m., an interview was conducted with the Director of Nursing who stated the Pharmacy was responsible for delivery of medications. The Director of Nursing stated the nurses had access to medications that were delivered to the facility, if a medication was not available at the time of scheduled administration, the nurses should go to the Pixus (on-site Stat box) to see if the medication was available in that stock. The Director of Nursing stated if the medication was not in the Pixus, the nurse was expected to inform the physician to see if there was another medication order or if the doctor would give the approval for the medication to be started later when available from the Pharmacy.</p> <p>The Director of Nursing stated the facility always had a supply of Boost supplement available for residents. She stated It should have administered as ordered by the physician.</p> <p>Review of the Pixus Medbank STAT box contents revealed Pantaprozole 40 milligrams was on hand and available as a bulk medication.</p> <p>During the end of day debriefing on 6/27/2024, the facility Administrator and Director of Nursing were informed of the findings.</p> <p>Review of Physicians Orders revealed valid orders for the medications not available for administration.</p> <p>Guidance from the National Institutes of Health in the article The nurses medication day stated that Nurses serve as a barrier, protecting residents from potential hazards. Calls were also common to request 'missing meds' followed by waits until they were delivered. Waiting reflected system failures</p> <p>ncbi.nlm.nih.gov accessed 6/28/2024.</p> <p>On 6/28/2024 at 9:15 a.m., the Director of Nursing was interviewed.</p> <p>The Director of Nursing stated she reviewed some of the documentation and noticed that several of the entries about medications being unavailable were written by one of the Agency nurses who worked in the facility as needed. The Director of Nursing stated some of those medications were available in the Pixus when the nurse documented they were not available. The Director of Nursing stated she and the Staff Development Coordinator would continue to conduct training with all of the nursing staff (including agency nurses) to make sure they understood the procedures regarding medications being unavailable.</p> <p>(continued on next page)</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>During the end of day debriefing on 6/28/2024, the Corporate Director of Clinical Services (Employee J), Director of Nursing and Administrator were informed of the findings. They stated medications should be available for administration. They also stated the facility's nursing staff and agency staff were being inserviced on the procedures to follow when medications were not available as ordered by the physician.</p> <p>No further information was provided.</p> <p>40711</p> <p>2. Resident #291, the facility staff failed to ensure her Over The Counter meds were available for administration for 9 days. Resident #291 was originally admitted to the facility 6/16/24 after an acute care hospital stay. The resident has never been discharged from the facility. The current diagnoses included; After Care Following Joint Replacement Surgery.</p> <p>The admission, Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 6/16/24 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 14 out of a possible 15. This indicated Resident #291 cognitive abilities for daily decision making were intact.</p> <p>The Medication Administration Record (MAR) read:</p> <p>Apple Cider Vinegar Oral Tablet (Apple Cider Vinegar) Give 2 tablet by mouth one time a day for Supplement Start date 6/17/24.</p> <p>Beet Root Oral Capsule (Misc Natural Products) Give 6 tablet by mouth one time a day for Supplement. Start Date 6/17/24.</p> <p>Biotin Oral Tablet 5000 MCG (Biotin) Start Date 6/17/24. Give 6 tablet by mouth one time a day for Supplement Start Date 06/17/2024.</p> <p>The above medications were missed for 9 consecutive days June 17th -June 25th, 2024. Coded as 9 meaning see progress notes.</p> <p>A review of progress notes revealed no reason for the missed doses of the above medications.</p> <p>On 06/27/24 at approximately 5:01 PM., an interview was conducted with Resident #291 concerning medications. Resident #291 said that she has not received her vitamins since her admission.</p> <p>On 06/28/24 at approximately 11:34 AM., an interview was conducted with Resident #291 concerning her missed vitamins. Resident #291 said that she was informed by the staff this morning that she needs to bring her vitamins from home because they don't have them available at the facility.</p> <p>On 06/28/24 at approximately 11:20 AM., an interview was conducted with Registered Nurse B concerning the above missed medications. RN B said that the Over the Counter (OTC) meds that she was taking at home should have been brought to the facility. RN B also mentioned that the DON does the ordering of OTC meds.</p> <p>(continued on next page)</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>On 6/28/24 an interview was conducted with Licensed Practical Nurse (LPN) B. LPN B said that the Director of Nursing (DON) usually orders OTC medications in house.</p> <p>On 6/28/24 at approximately 3:20 p.m., the above findings were shared with the Administrator, Director of Nursing (DON) and Corporate Consultant. The DON said that she was not aware that the resident wasn't getting her OTC medication nor was she aware that she would have to get the medications from CVS pharmacy.</p>		