STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495423	A. Building B. Wing	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southampton Rehabilitation and Healthcare Center	7246 Forest Hill Ave Richmond, VA 23225

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, resident interview, staff interview, clinical record review and facility document review, it was determined that facility staff failed to promote resident's dignity for two of 61 current residents in the survey sample, Residents #113 (R113) and R115. The findings include: 1. For R113, facility staff failed to allow person items to be placed on a shelf in front in the window of the resident's room. R113 was admitted to the facility with diagnosis that included but was not limited to major depressive disorder (1). On the most recent comprehensive MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 06/02/2025, R113 scored 15 out of 15 on the BIMS (brief interview for mental status), indicating R113 was cognitively intact for making daily decisions. On 06/11/25 at approximately 7:51 a.m. an interview was conducted with R113. R113 stated that she was told by a staff member that she was not allowed to have anything sitting on a shelf, above the PTAC (packaged terminal air conditioner) unit (self-contained heating and air conditioning system mounted through a wall), in front of the window in R113's room. R113 stated she had to remove some bottles of water and a stuff animal. On 06/11/2025 at approximately 9:05 a.m. an interview and observation of R113's room was conducted with OSM (other staff member) #1, director of maintenance. After observing the PTAC unit and shelf over the top of the unit he stated that the shelf was connected to the wall and that there was no reason why R113 could place anything in the window. When asked if the items would be resting on the PTAC unit he stated no. On 06/11/2025 at approximately 9:33 p.m. an interview was conducted with CNA (certified nursing assistant) #2. When asked about residents being allowed to place personal items in their room windows she stated that residents were not allowed because it was a safety hazard. On 06/11/2026 at approximately 2:20 p.m. an interview was conducted with LPN (licensed practical nurse) #2. When asked about residents being allowed to place personal items in their room windows she stated that residents were not allowed because it was a fire hazard. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/11/2025 at approximately 13:05 p.m. an interview was conducted with ASM (administrative staff member) #4, regional director of clinical services, regarding resident's placing personal items in their room windows. She stated that it was not a fire hazard, and residents were allowed to place items in their windows. When asked it was dignified to prevent a resident from displaying personal item in their room window she stated no. The facility's policy Resident Rights documented in part, 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: b. be treated with respect, kindness, and dignity. On 06/11/2025 at approximately 4:40 p.m., ASM #1, administrator, ASM #2, director of nursing, ASM #3 assistant administrator, ASM #4, regional director of clinical services, and ASM #5, regional vice president, were made aware of the above findings. No further information was provided prior to exit. References: (1) It occurs when feelings of sadness, loss, anger, or frustration get in the way of your life over a long period of time. It also changes how your body works. This information was obtained from the website: https://medlineplus.gov/ency/article/000945.htm. 2. For R115, facility staff failed to provide a meal in a timely manner. R115 was admitted to the facility with diagnoses that included but were not limited to swallowing difficulties and a stroke. On the most recent comprehensive MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 04/07/2025, R115 scored 15 out of 15 on the BIMS (brief interview for mental status), indicating R115 was cognitively intact for making daily decisions. The comprehensive care plan for R115 dated 11/26/2024 documented in part, I have an ADL (activities of daily living) Self Care Performance Deficit r/t (related to) impaired mobility .Requires total care from staff for ADLs. On 06/10/25 at approximately 2:40 p.m. an observation revealed R115's lunch tray sitting on his over-the-bed table. R115 he stated that he had not eaten lunch and that he had been waiting to receive assistance with eating. At approximately 2:42 p.m. a CNA (certified nursing assistant) was observed entering R115's room and began to feed him. On 06/10/25 at approximately 2:54 p.m. an interview was conducted with LPN (licensed practical nurse) #1. When asked what time the lunch trays arrived on the unit on 06/10/2025, she stated they arrives at 1:30 p.m. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/11/2025 at approximately 1:55 p.m. an interview was conducted with LPN #2, unit manager. When asked to describe the procedure for passing out meal trays and assisting residents with eating she stated that when the meal trays arrive on the unit, all the trays are passed out to all the residents except those who are unable to feed themselves. The meal trays for the residents who require assistance with eating are left on the tray carts to stay warm. She when all the trays are passed out the CNAs (certified nursing assistants) get the meals from the cart for the residents requiring assistance and assist the residents on the CNAs assignment. When asked if it was dignified that a resident should wait over an hour to receive assistance to eat she stated no. When asked if she knew which CNA was assigned to feed lunch to R115 on 06/10/2025 she stated it was (Name of CNA #1). On 06/11/2025 at approximately 1:55 p.m. an interview was conducted with CNA #1. When asked if she was assigned to feed R115 on 06/10/2025 during lunch she stated yes. When informed of the observation described above she stated that she was caught up conducting resident care before the lunch trays arrived on the floor. CNA #1 stated that the care took longer than she expected and when she finished she went to the food cart and R115's lunch tray was not there and assumed someone else feed R115. When asked if it was dignified that a resident should wait over an hour to receive assistance to eat she stated no. On 06/11/2025 at approximately 4:40 p.m., ASM #1, administrator, ASM #2, director of nursing, ASM #3 assistant administrator, ASM #4, regional director of clinical services, and ASM #5, regional vice president, were made aware of the above findings. No further information was provided prior to exit.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observation, resident interview, staff interview, facility document review, and clinical record review, the facility staff failed to provide a comfortable and homelike environment for one of 61 residents in the survey sample, Resident #85. The findings include: For Resident #85 (R85) (a resident who resided on the third floor), the facility staff failed to provide enough linens for resident care. R85's annual MDS (minimum data set) assessment with an ARD (assessment reference date) of 5/29/25 documented the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact for making daily decisions. On 6/11/25 at 3:44 p.m., an interview was conducted with R85. The resident voiced concern that there were not enough linens for resident care. On 6/11/25 at 3:47 p.m., an interview was conducted with LPN (licensed practical nurse) #1 and CNA (certified nursing assistant) #12. CNA #12 stated a laundry aide delivers a linen cart for the 3:00 p.m. to 11:00 p.m. shift at approximately 3:15 p.m. and usually there is not enough linens for resident care. CNA #12 stated the nursing staff do not have access to the laundry room to obtain more linens and the laundry aide becomes, fussy if staff ask for more linens. LPN #1 stated a lack of linens on the unit usually occurs every day. A resident census report documented 68 residents resided on the third floor on 6/11/25. A linen delivery schedule dated 6/11/25 revealed the following linens were delivered to the third floor for the 3:00 p.m. to 11:00 p.m. shift: - 20 flat sheets -20 fitted sheets -10 pillowcases -30 towels -50 wash cloths -10 gowns -10 pads -5 blankets -5 bedspreads (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/11/25 at 3:53 p.m., an observation of the designated third floor 3:00 p.m. to 11:00 p.m. linen cart (the only linen cart on the floor, located in the clean linen room) was conducted. The following was observed: - 29 washcloths - 10 gowns - 8 pillowcases - 13 towels - 12 fitted sheets - 4 pads - 8 fitted sheets - 7 bath blankets - 2 bed spreads On 6/11/25 at 5:03 p.m., an interview was conducted with OSM (other staff member) #7 (the environmental service district manager). OSM #7 stated linen aides take a linen cart to each floor in the morning, at 3:00 p. m., and then leave an extra cart for the 11:00 p.m. to 7:00 a.m. shift. OSM #7 stated extra linens are kept in the laundry room and the linen aides and receptionist have a key to the laundry room. (Note- linen aides were not scheduled for the entire 3:00 p.m.-11:00 p.m. and 11:00 p.m. to 7:00 a.m. shifts, and during an interview with the administrator on 6/11/25 at 5:15 p.m., the administrator stated the receptionist did not have a key to the laundry room). On 6/11/25 at 5:17 p.m., an interview was conducted with OSM #8 (a laundry aide who works part of the 3:00 p.m. to 11:00 p.m. shift). OSM #8 stated she has been a laundry aide for so long that she knows how to delegate how much linens should go on each cart but sometimes at the end of the month, she has to use her imagination because by then, the facility has to order more linens. OSM #8 stated she has to lock the door to the laundry room when she is not in there because staff will come in and take too many linens. OSM #8 stated no one has access to the laundry room after she leaves at 10:00 p.m. OSM #8 stated that when nursing staff requests extra linens, she may not have what they request because she is in the process of washing and drying linens, but she gives them what she can. On 6/12/25 at 11:04 a.m., an interview was conducted with RN (registered nurse) #1. RN #1 stated there usually is not enough linens to care for residents. On 6/12/25 at 11:39 a.m., an interview was conducted with CNA #9. CNA #9 stated some days there are enough linens on the cart and some days there are not enough linens on the cart. CNA #9 stated sometimes they have to wait for the laundry aides to wash and dry the linens and replenish the carts. On 6/12/25 at 3:12 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy titled, Homelike Environment documented, 2. The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: e. clean bed and bath linens that are in good condition .

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. Based on staff interview, facility document review, and clinical record review, the facility staff failed to implement a complete pain management program for one of 61 residents in the survey sample, Resident #317. The findings include: For Resident #317 (R317), the facility staff failed to attempt non-pharmacological interventions prior to the administration of PRN (as needed) tramadol (pain medication) on multiple dates in July 2024 and August 2024. A review of R317's clinical record revealed a physician's order dated 7/9/24 for tramadol 50mg (milligrams)-one tablet every six hours as needed for pain. A review of R317's July 2024 and August 2024 MARs (medication administration records) revealed the resident was administered PRN tramadol on 7/13/24, 7/17/24, 7/25/24, and 8/2/24. Further review of R317's clinical record (including the July 2024 and August 2024 MARs and nurses' notes) failed to reveal non-pharmacological interventions were offered/attempted prior to the administration of PRN tramadol on the above dates. On 6/12/25 at 10:24 a.m., an interview was conducted with RN (registered nurse) #1. RN #1 stated non-pharmaceutical interventions such as touch, relaxation, exercise, or music should be attempted prior to the administration of as needed pain medication, and this should be documented in a nurse's note. On 6/12/25 at 3:12 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, Pain Assessment and Management documented, 2. Non-pharmacological interventions may be appropriate alone or in conjunction with medications. Some non-pharmacological interventions include: a. environmental - adjusting the room temperature, smoothing the linens, providing a pressure reducing mattress, repositioning, etc.; b. physical - ice packs, cool or warm compresses, baths, transcutaneous electrical nerve stimulation (TENS), massage, acupuncture, etc.; c. exercise - range of motion exercises to prevent muscle stiffness and contractures; and d. cognitive or behavioral - relaxation, music, diversions, activities, etc. No further information was presented prior to exit.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident's drug regimen must be free from unnecessary drugs. Based on staff interview, facility document review, and clinical record review, the facility staff failed to monitor residents to prevent unnecessary medication administration for two of 61 residents in the survey sample, Residents #317, and #118. The findings include: 1. For Resident #317 (R317), the facility staff failed to monitor the resident's blood pressure for the administration of the medication Midodrine (used to treat low blood pressure) on multiple dates in July 2024. A review of R317's clinical record revealed a physician's order dated 7/17/24 for Midodrine 10mg (milligrams)-one tablet by mouth every eight hours. Hold for systolic blood pressure greater than 140. The medication was scheduled for 6:00 a.m., 2:00 p.m., and 10:00 p.m. Further review of R317's clinical record (including the July 2024 medication administration record, July 2024 blood pressure summary, and July 2024 nurses' notes) failed to reveal the resident's blood pressure was obtained prior to Midodrine administration on the following dates: -7/19/24 for the 2:00 p.m. and 10:00 p.m. doses -7/20/24 for the 2:00 p.m. dose -7/21/24 for the 2:00 p.m. dose -7/23/24 for the 2:00 p.m. dose -7/26/24 for the 2:00 p.m. dose -7/29/24 for the 6:00 a.m. dose -7/30/24 for the 2:00 p.m. dose On 6/12/25 at 10:24 a.m., R317's Midodrine order was reviewed with RN (registered nurse) #1. RN #1 stated the resident's blood pressure should have been checked right before every time Midodrine was administered, so the nurses knew if the resident's blood pressure was within parameters and if the medication could be given. On 6/12/25 at 3:12 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, Administering Medications documented, 11. The following information is checked/verified for each resident prior to administering medications: b. Vital signs, if necessary . No further information was presented prior to exit.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on observation, resident interview, staff interview, facility document review, and clinical record review, the facility staff failed to honor a resident's food preferences/dislikes for one of 61 residents in the survey sample, Resident #14. The findings include: For Resident #14 (R14), the facility staff failed to honor the resident's dislike for grits. R14's annual MDS (minimum data set) assessment with an ARD (assessment reference date) of 2/1/25 documented the resident scored 14 out of 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact for making daily decisions. On 9/11/25 at 9:46 a.m., R14's breakfast tray was observed. R14's meal ticket documented the resident disliked grits. A bowl of grits was observed on R14's breakfast tray. R14 stated she receives food that she dislikes almost every day. On 6/12/25 at 8:42 a.m., an interview was conducted with OSM (other staff member) #10, the dietary district manager. OSM #10 stated that upon admission, the dietary staff talks to residents and obtains a list of their dislikes. OSM #10 stated the dietary staff enters this list into the computerized meal tracker system then during meal service, the meal tracker system identifies the resident's dislikes and generates an alternative food item that is printed on the meal ticket to be served. OSM #10 stated the dietary staff are supposed to follow the printed meal ticket when preparing residents' meal trays. On 6/12/25 at 3:12 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, Resident Food Preferences documented, Individual food preferences will be assessed upon admission and communicated to the interdisciplinary team. No further information was presented prior to exit.