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	02/06/2026

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0627 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident representative interview, staff interview, facility document review and clinical record review, the facility staff failed to ensure a safe discharge to the community for two of three residents in the survey sample (Residents #1 and #2). Residents #1 and #2 were discharged to a lower level of care in the community without a documented basis for the discharge, a prior discharge plan, identification or verification of needed care/services, involvement of the interdisciplinary team, preparation/orientation for the residents and without involvement or consent from the legal guardian (for Resident #1). This resulted in the identification of immediately jeopardy regarding failure to provide a safe, appropriate discharge to the community.The findings include:1. Resident #1, residing in the nursing facility for over three years, was discharged to independent housing that provided no direct supervision, assistance with ADLs [activities of daily living] or medication administration. The facility documented no basis for the discharge and developed no discharge plan of care prior to the discharge that included goals or identification of the resident's care needs in the community. Facility documents referenced R1's discharge location as a group home. This location was not a licensed group home but an unsupervised independent living apartment. The facility provided no orientation for R1 of the housing location. R1 was discharged to this independent housing situation with no arrangements for any services and without any involvement or consent of the resident's legal guardian. Resident #1 (R1) was admitted to the facility with diagnoses that included muscle wasting/atrophy, diabetes, magnesium deficiency, peripheral vascular disease, congestive heart failure, atrial fibrillation, anemia, major depressive disorder, hypertension, insomnia, affective mood disorder, compulsive sexual behaviors, atherosclerotic heart disease, cerebral infarction and vitamin deficiency. The minimum data set (MDS) dated [DATE] assessed R1 with moderately impaired cognitive skills and as requiring set-up/touch assistance for eating, dressing, hygiene and ambulation along with occasional incontinent of bowel/bladder. Section Q. of this MDS documented that the resident did not want to be asked about returning to the community on this or any other MDS assessments. R1 had resided in the nursing facility for over 3.5 years at the time of discharge on [DATE]. The clinical record documented R1 was adjudicated incapacitated and included a court order dated 2/23/22 for the appointed guardian to make all decisions indefinitely for R1, including living arrangements, placements and finances.R1's clinical record documented the resident discharged to a group home on 9/30/25. The clinical record documented no involvement or consent from the legal guardian regarding the discharge. R1's clinical record included no documented basis for the discharge from a physician or provider. The clinical record documented comments from the resident about discharging to a group home, but included no discharge plan, rationale for the discharge and no documented request from the resident or the legal guardian about a desire to leave the nursing facility. It was unclear from the clinical record what prompted R1's discharge to the community. There was no record of care plan review or (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495423	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/06/2026
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F 0627 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	involvement from the interdisciplinary team regarding R1's discharge. The last review of R1's comprehensive care plan prior to the 9/30/25 discharge was eight months earlier on 1/21/25 and that care plan indicated the resident had no plans to discharge from the facility. Review of R1's clinical record revealed a psychiatric nurse practitioner (NP) assessed R1 on 9/3/25 and documented, .[R1] mentions that he is supposed to be moving soon, although he is unsure of the destination .A licensed clinical social worker (LCSW) documented on 9/4/25, .Pt [patient] reports feeling slightly anxious/excited stating he will be moving to a group home which will provide more independence, decrease in number of residents/roommates .states [R1] is looking forward to cooking meals, getting outside more frequently, and engage in meaningful activities . On 9/11/25, the resident's physician conducted a recertification assessment that indicated the resident was appropriate for nursing home placement and made no mention of discharge to the community. The 9/11/25 recertification note documented, .with history of multiple medical problems .review of all medications and medical record .Discussed with the nursing staff. Recommend to continue with all other medications, monitor labs and observe fall precautions .resident is appropriate for nursing home care and requires significant help with ADLs and has history of multiple medical problems .On 9/16/25, a LCSW documented, .Pt reports he has some anxiety over his new upcoming placement in a group home .Processed emotions around moving to a group home .R1 was assessed by the NP on 9/18/25 and 9/25/25 with no mention of any discharge plans. A social services note dated 9/26/25 documented, .Writer discussed resident discharge with resident and Group Home .Resident set to discharge to .Group home on 9/29. The NP documented a progress note on 9/29/25 stating, .with a complex medical history who is currently being evaluated for discharge. Per the assigned social worker, [R1] is scheduled for discharge today to a community-based group home .[R1] will be under the care of a designated primary care provider affiliated with the group home, ensuring continuity of medical oversight .Given his current clinical stability and the supportive structure of the group home environment [R1] is considered appropriate for discharge. Ongoing monitoring and management of his chronic conditions will be coordinated through his new primary care provider, with attention to both his physical and mental health needs .R1's Discharge summary dated [DATE] listed the resident's discharge destination as a Group Home with a street address and apartment number listed. The guardian's name and phone number were listed on the form but there was no documentation the guardian was notified of the discharge. The discharge summary documented that pre and post discharge medications had been reconciled. The resident's medication list on the discharge summary did not include aspirin, atorvastatin, ferrous sulfate, spironolactone and Trulicity. The NP listed in the 9/29/25 note, that these medications were among those to continue after discharge for treatment of cerebral infarction, hyperlipidemia, vitamin deficiency, congestive heart failure and diabetes. The discharge summary included no education/instruction to the resident about use of the Trulicity injection pen for diabetic management. The resident was not assessed at the nursing facility to self-administer any medication including injecting Trulicity. The discharge summary listed the resident was responsible for scheduling follow up appointments with a primary physician and was educated on the importance of follow up visits. A primary provider's name was listed on the discharge summary but spaces for the provider's office address and phone number were blank. It was unclear from the clinical record if the resident had a cell phone or access to a phone at the discharge destination and the discharge summary made no mention of money management or finance needs/concerns.A social services note dated 9/29/25 documented, .Resident discharge postponed to 9/30. Group Home providing transport .A social services note dated 10/7/25 documented R1's guardian had called concerning the resident's discharge and clarification of contact numbers. This note documented, .Writer informed [R1's legal (continued on next page)

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F 0627 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	discharge destinations were considered or presented to the resident. The SW stated the owner had visited the resident, but she did not know the date and again stated she had not visited or seen the discharge location. When asked again about notification or involvement of the resident's legal guardian, the SW stated she called the guardian on 9/29/25 telling her of the discharge then stated it was late and that she had left a voice message. The SW stated the guardian did not call her until 10/7/25. The SW stated prior to 9/29/25, she had talked with someone at the desk, asking the guardian to contact her but that no one ever called her back. The SW stated R1 could do everything for himself and that she thought the housing was appropriate.On 2/4/26 at 3:45 p.m., the administrator was interviewed about concerns regarding R1's discharge on [DATE]. The administrator stated R1 was independent and that the resident had asked about wanting to leave the facility. The administrator stated R1's legal guardian should have been involved prior to the resident's discharge and that there should have been agreement/consent from the legal guardian about the discharge plans. A documented discharge plan was requested. On 2/5/26 at 8:30 a.m., the administrator presented a copy of R1's discharge summary and stated the plan/summary were all in one.On 2/5/26 at 8:40 a.m., the facility SW (other staff #3) and the assistant administrator (administration #2) were interviewed about R1's discharge. The assistant administrator stated there was only a discharge summary and no documented discharge plan. The assistant administrator stated she reviewed the clinical record and found no care plan meetings since January 2025 and the care plan for R1 had not been updated regarding any discharge plans. The SW was asked if R1 had a cell phone for use after discharge and the SW stated, I don't recall that [R1] had a cell phone. The SW presented no documentation indicating discharge goals or identified care needs/concerns regarding R1's return to the community. The SW stated she thought the group home was providing a physician and help with medications. Concerning consent from the legal guardian, the SW stated she talked with whoever picked up at the main phone number and that she shared that there were discharge plans for R1. The SW stated she did not know when those call attempts were made or with whom she left a message. The SW stated there was no written letter sent to the resident or the guardian about the discharge. When asked again about the rationale for R1's discharge at this destination, the SW stated the owner was a registered nurse, was familiar with R1, that the destination had a physician to provide care and that R1 could have a more regular life. When asked how R1 would get the Trulicity injection needed for diabetic management, the SW stated she thought the group home would assist the resident with medications. The SW stated she only had conversations with the housing owner and had no documented list of services provided by the discharge destination.On 2/5/26 at 9:15 a.m., the NP (other staff #5) that routinely cared for R1 was interviewed about the resident's discharge on [DATE]. The NP stated she had taken care of R1 for several years and was very familiar with the resident's needs/care. The NP stated R1's condition had been stable in 2025 with no significant decline or improvement in condition. The NP stated R1 had mentioned the discharge, was happy to go and that the resident was alert and oriented. The NP stated R1 needed encouragement and cueing with hygiene but otherwise was independent with ADLs. The NP stated, I understood that [R1] was going to a group home and they had a provider. The NP stated she was informed the group home had their own physician/provider and that medication administration and structured services would be provided. The NP stated she was not familiar with the named destination, had been informed it was a group home and that she had not been made aware the location was an independent living situation. The NP stated R1 would not thrive on his own. The NP stated R1 required cueing for hygiene and required help with medication administration. The NP stated nursing administered medications to R1 at the nursing facility. The NP stated she was not sure if R1 would know when to take prescribed medicines. The NP stated (continued on next page)

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F 0627 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	she had not communicated with the legal guardian about the discharge. The NP stated she did not know what prompted the discharge. The NP stated she was never involved in discharge plans or a meeting about R1's discharge. The NP stated the facility's social worker communicated that arrangements had been made. The NP stated she was not aware the guardian was not notified or involved and thought the discharge destination was a licensed group home. The NP stated an independent living situation was not appropriate or safe for R1. The NP stated she gave the resident prescriptions for a 30-day supply of all discharge medications, including Trulicity. The NP stated R1 needed Trulicity for diabetic management and that the resident was not trained to give the injection prior to discharge. The NP stated she thought the group home would provide medication administration, including the Trulicity injection. The NP stated again independent living was not appropriate for R1 and that R1 needed assistance with medication administration and ongoing follow up by a primary medical provider. The NP stated appropriate/safe discharge destinations for R1 included another nursing facility or a structured group home with services. The NP stated R1 could not effectively manage money and again stated R1 needed help with medications. The NP stated that social services usually told her when a resident was ready for discharge. On 2/5/26 at 11:55 a.m., the licensed practical nurse unit manager (LPN #1) that routinely cared for R1 was interviewed. LPN #1 stated she did not know what prompted R1's discharge and that discharge planning was handled by social services. LPN #1 stated R1 was mostly independent with ADLs and that nurses administered the resident's medications. LPN #1 was not aware of any education to R1 about injecting Trulicity prior to discharge and that the resident did not self-administer any medications in the nursing facility. LPN #1 stated she thought R1 was going to a place that administered medications. LPN #1 stated all the resident's required medications should have been listed on the discharge summary. The survey team verified that R1's discharge destination was not included in the list of licensed group homes in the state. The owner's business card listed the owner's name and business address but referenced no services provided. The facility's policy titled Transfer or Discharge (revised March 2025) documented, .Transfers and discharges must meet specific criteria and require resident/representative notification, orientation, and documentation in the medical record .When the facility transfers or discharges a resident, information is documented in the medical record and appropriate information is communicated to the receiving health care institution or provider .If the basis for the discharge is that the resident's health has improved sufficiently so that the resident no longer needs the care of the facility, the resident's physician (or provider) documents information about the resident's condition and the appropriateness of the discharge . For residents discharging to the community, this policy documented, See Discharge Summary and Plan.The director of nursing (DON) was on leave and not available for interview during the survey. R1's hospital records for 10/6/25 were requested but not received prior to the end of the survey. 2. For Resident #2 (R2), who was dependent on assistance with activities of daily living (ADLs), medication administration, and required dialysis treatment, the facility staff failed to ensure a safe discharge and discharged the R2 to an independent living.On 2/5/26 at 10:40 AM, a closed record review was conducted of R2's clinical record. According to the census tab, R2 resided at the facility 04/15/22-10/31/25. According to R2's diagnosis listing, the resident's diagnosis included, but were not limited to: Non-ST Elevation (NSTEMI) Myocardial Infarction [heart attack], hemiplegia and hemiparesis following cerebral infarction affecting left non-dominate side, type 2 diabetes mellitus with proliferative diabetic retinopathy, cerebral infarction, need for assistance with personal care, other abnormalities of gait and mobility, and hypertensive chronic kidney disease with stage 5 chronic kidney disease or end stage renal disease.According to the Discharge Summary dated 10/31/25, from the medical provider (continued on next page)

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F 0627 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	actual discharge location, resident/representative participation and consent, assessment of functional status and care needs, confirmation of medication access and administration ability, and confirmed follow-up appointments and services. Residents that require assistance with Activities of Daily Living, Dialysis, medications, or supervision may not discharge to a lower level of care without documented support systems.3. All IDT members will be educated by the Regional Director of Operations or designee to include Administrator, Assistant Administrator, Director of Nursing, Assistant Director of Nursing, Unit Managers, Business Office, Social Services, Therapy, Licensed Nurses, Certified Nursing Assistants, and Providers. The education included Appropriate Discharge planning utilizing the Transfer and Discharge Policy and F627 requirements. Education included: ongoing IDT collaboration establishing discharge plan, physician order aligned with actual discharge location, resident/representative participation and consent, assessment of functional status and care needs, confirmation of medication access and administration ability, confirmed follow-up appointments and services. Residents that require assistance with Activities of Daily Living, Dialysis, medications, or supervision may not discharge to lower level of care without documented support systems. Any staff who are not present for immediate education will be educated prior to working their next scheduled shift. The plan documented actions taken would be completed on 2/5/26 by 11:00 p.m. On 2/6/26 starting at 8:45 a.m., the survey team verified that phone contacts and/or letters were issued to all residents discharged to lower level of care since 9/30/25. A documented discharge protocol was implemented that included a checklist of the required items with completion mandatory prior to any discharges to a lower level of care. The survey team verified education to staff members was conducted as listed. Implementation of the IJ removal plan was deemed sufficient and completed as documented. The immediacy was removed as of 2/6/25 at 10:00 a.m. The scope/severity was reduced to level 2 isolated following the removal of immediate jeopardy.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495423	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/06/2026

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident representative interview, staff interview, facility document review and clinical record review, the facility staff failed to provide written notice to the resident's legal guardian of discharge to the community and failed to accurately document medication reconciliation prior to discharge for one of three residents in the survey sample (Resident #1).The findings include:Facility staff failed to provide written notice to Resident #1's court-appointed legal guardian prior to or at the time of the resident's discharge to the community on 9/30/25. The clinical record documented no rationale for the resident's discharge to a lower level of care. Resident #1's discharge summary did not document all medications the resident was to continue after discharge.Resident #1 (R1) was admitted to the facility with diagnoses that included muscle wasting/atrophy, diabetes, magnesium deficiency, peripheral vascular disease, congestive heart failure, atrial fibrillation, anemia, major depressive disorder, hypertension, insomnia, affective mood disorder, compulsive sexual behaviors, atherosclerotic heart disease, cerebral infarction and vitamin deficiency. The minimum data set (MDS) dated [DATE] assessed R1 with moderately impaired cognitive skills and as requiring set-up/touch assistance for eating, dressing, hygiene and ambulation along with occasional incontinent of bowel/bladder. Section Q. of this MDS documented that the resident did not want to be asked about returning to the community on this or any other MDS assessments. R1 had resided in the nursing facility for over 3.5 years at the time of discharge on [DATE]. The clinical record documented R1 was adjudicated incapacitated and included a court order dated 2/23/22 for the appointed guardian to make all decisions for R1, including living arrangements, placements and finances on an indefinite basis.R1's clinical record documented the resident discharged to a group home on 9/30/25. The clinical record documented no involvement or consent from the legal guardian regarding the discharge. R1's clinical record included no documented basis for the discharge from a physician or provider. The clinical record documented comments from the resident about discharging to a group home, but included no discharge plan, rationale for the discharge and no documented request from the resident or the legal guardian about a desire to leave the nursing facility. It was unclear from the clinical record what prompted R1's discharge to the community. A social services note dated 9/26/25 documented, .Writer discussed resident discharge with resident and Group Home .Resident set to discharge to .Group home on 9/29. A note dated 9/29/25 documented the discharge was postponed to 9/30/25. There was no documented notification to the resident's legal guardian about the discharge.R1's Discharge summary dated [DATE] listed the resident's discharge destination as a Group Home with a street address and apartment number listed. The guardian's name and phone number were listed on the form but there was no documentation the guardian was notified of the discharge or provided written notice prior to the discharge. The discharge summary documented that pre and post discharge medications had been reconciled. The resident's Discharge summary dated [DATE] did not include all the resident's discharge medications. The resident's medication list on the discharge summary did not include aspirin, atorvastatin, ferrous sulfate, spironolactone and Trulicity. The NP listed in a 9/29/25 note, that these medications were among those to continue after discharge for treatment of cerebral infarction, hyperlipidemia, vitamin deficiency, congestive heart failure and diabetes. It was unclear from the discharge summary if the resident, resident's representative or the subsequent medical provider were issued copies of the discharge instructions.A social services note dated 10/7/25 documented R1's guardian had called concerning the resident's discharge and clarification of contact numbers. This note documented, .Writer informed [R'1 legal guardian] to feel free to reach out regarding resident .On 2/4/26 at 1:40 p.m., R1's legal (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	guardian (other staff #1) was interviewed about the resident's discharge on [DATE]. The guardian stated she was not aware of the resident's discharge until a local hospital social worker (SW) called on 10/6/25 and reported that the resident had been found on the street with his belongings and was brought to the emergency department by authorities. The guardian stated the hospital SW told her the resident had been living in a group home. The guardian stated she had no idea that R1 was living in the community and had not been notified or consulted about the discharge. The guardian stated she talked with the facility's social worker (other staff #3) on 10/7/25 after the hospital notified her of the resident's status in the community. The guardian stated the facility social worker (other staff #3) claimed she had reached out to discuss the discharge plan. The guardian stated she never received a call or message from the facility's social worker and that she had talked with no one from the facility regarding R1 discharging from the facility. The guardian stated the resident should never have been discharged without her consent or input in the discharge plan/destination. The guardian stated she received no written notice of the resident's discharge and was not aware of the discharge or location of discharge until contact by the hospital social worker. The guardian stated, I was never contacted . On 2/4/26 at 2:10 p.m., the facility's SW (other staff #3) and the regional SW (other staff #4) were interviewed about R1's discharge on [DATE]. The SW stated she spoke to the legal guardian and then stated she did not speak directly to the legal guardian but that she had left a message with someone at a desk, asking the guardian to call her. The SW stated again she contacted the legal guardian multiple times but did not know how many times or when. The social worker provided no evidence that the guardian was contacted or that a written notice was sent to the guardian about the discharge.On 2/4/26 at 3:10 p.m., the facility's SW (other staff #3) and the regional SW (other staff #4) were interviewed again about R1's discharge location. When asked again about notification to the resident's legal guardian, the SW stated she called the guardian on 9/29/25 telling her of the discharge then stated it was late and that she had left a voice message. The SW stated the guardian did not call her until 10/7/25. The SW stated prior to 9/29/25, she had talked with someone at the desk, asking the guardian to contact her but that no one ever called her back. The SW provided no evidence of written notification to R1's guardian regarding the resident's discharge.On 2/4/26 at 3:45 p.m., the administrator was interviewed about concerns regarding R1's discharge on [DATE]. The administrator stated R1's legal guardian should have been involved prior to the resident's discharge and that there should have been agreement/consent from the legal guardian about the discharge plans.On 2/5/26 at 8:40 a.m., the facility SW (other staff #3) and the assistant administrator (administration #2) were interviewed again about R1's discharge. The assistant administrator stated there was only a discharge summary and no documented discharge plan or notifications regarding the discharge. The SW stated there was no written letter sent to the resident or the guardian about the discharge. On 2/5/26 at 11:55 a.m., the licensed practical nurse unit manager (LPN #1) that routinely cared for R1 was interviewed. LPN #1 stated she did not know what prompted R1's discharge and that discharge planning was handled by social services. LPN #1 stated all the resident's required medications should have been listed on the discharge summary. There was no evidence written notice was provided to R1's legal guardian prior to the resident's discharge on [DATE] that included reasons for the discharge, anticipated discharge date or destination location.The facility's policy titled Transfer or Discharge (revised March 2025) documented, .Transfers and discharges must meet specific criteria and require resident/representative notification, orientation, and documentation in the medical record .When the facility transfers or discharges a resident, information is documented in the medical record and appropriate information is communicated to the receiving health care institution or provider . This (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	finding was reviewed with the administrator, assistant administrator, assistant director of nursing and regional nurse consultant during a meeting on 2/6/25 at 10:05 a.m. with no further information presented prior to the end of the survey.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, facility document review and clinical record review, the facility staff failed to review and revise the comprehensive care plan for two of three residents in the survey sample (Residents #1 and #2) and failed to ensure the interdisciplinary team conducted quarterly care plan reviews for one of three residents in the survey sample (Resident #1).The findings include: 1. Resident #1's care plan was not revised to include plans to discharge from the facility. Care plan review meetings for R1 were not conducted at the time of quarterly MDS assessments. Resident #1 (R1) was admitted to the facility with diagnoses that included muscle wasting/atrophy, diabetes, magnesium deficiency, peripheral vascular disease, congestive heart failure, atrial fibrillation, anemia, major depressive disorder, hypertension, insomnia, affective mood disorder, atherosclerotic heart disease, cerebral infarction and vitamin deficiency. The minimum data set (MDS) dated [DATE] assessed R1 with moderately impaired cognitive skills. R1's clinical record documented the resident was discharged to a group home on 9/30/25. R1's plan of care (revised 4/22/25) documented the resident desired to remain in the facility. The care plan goals included, I will remain long-term care at this facility . Interventions regarding discharge status included, Social worker and Care Navigation will meet quarterly and as needed regarding patients wishes to remain long-term care. If my wishes change at any point I will inform the social worker . (sic) R1's plan of care was not revised to include problems, goals and/or interventions regarding discharge to the community. R1's clinical record documented the last care plan meeting conducted by the interdisciplinary team was on 1/21/25. Quarterly MDS assessments were documented on 4/18/25 and 7/19/25. The clinical record documented no care plan review meetings were conducted at the time of quarterly MDS assessments dated 4/18/25 and 7/19/25. On 2/5/26 at 8:40 a.m., the assistant administrator and social worker (other staff #3) responsible for discharge planning and scheduling care plan meetings were interviewed. The social worker stated she was responsible for updating care plans regarding discharge plans or changes in discharge status. The assistant administrator stated she reviewed the medical record and found no record of a care plan review meeting for R1 since 1/21/25. The social worker stated care plan review meetings were conducted quarterly around the time of the MDS assessments. The social worker stated she found no record of care plan review meetings for R1 since January 2025. The social worker provided no explanation of why R1 did not have care plan meetings in April 2025 or July 2025. On 2/5/26 at 9:45 a.m., the assistant director of nursing (ADON) was interviewed about care plan meetings and revisions. The ADON stated the social worker was responsible for scheduling and sending invitations for care plan meetings. The ADON stated care plan review meetings were conducted quarterly around the time of the required MDS assessments and that care plans were revised based on assessments and results of the meeting/review. The ADON stated discharge plans were part of the care plan and were expected to be revised if changes in discharge status occurred. The ADON stated plans for discharge were discussed in weekly risk meetings. The ADON stated care plan meetings were supposed to be conducted for each resident on a quarterly basis and that plans were revised as needs, status or conditions changed. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The director of nursing (DON) was on vacation and not available for interview during the survey. The facility's policy titled Care Planning - Interdisciplinary Team (revised March 2022) documented, .The interdisciplinary team is responsible for the development of resident care plans .Resident care plans are developed according to the timeframes and criteria established by .483.21 [long-term care regulation tag F657] . This finding was reviewed with the administrator, assistant administrator, assistant director of nursing and regional nurse consultant during a meeting on 2/6/25 at 10:05 a.m. with no further information presented prior to the end of the survey. 2. For Resident #2 (R2), who discharged to an independent living, the facility staff failed to review and revise the care plan to include the discharge planning and discharge location. On 2/5/26 at 10:40 AM, a closed record review was conducted of R2's clinical record. According to the census tab, R2 resided at the facility 04/15/22-10/31/25. According to R2's diagnosis listing, the resident's diagnosis included, but were not limited to: Non-ST Elevation (NSTEMI) Myocardial Infarction [heart attack], hemiplegia and hemiparesis following cerebral infarction affecting left non-dominate side, type 2 diabetes mellitus with proliferative diabetic retinopathy, cerebral infarction, need for assistance with personal care, other abnormalities of gait and mobility, and hypertensive chronic kidney disease with stage 5 chronic kidney disease or end stage renal disease. According to the Discharge Summary dated 10/31/25, from the medical provider (nurse practitioner) it read in part, . He was seeing this afternoon after dialysis. He reports that he's having increased queasiness after dialysis, but he states that it is not nausea and he does not need any medication to manage his symptoms .Patient is stable for discharge to group home with home health PT OT [physical therapy and occupational therapy] Condition at discharge stable. According to R2's care plan a focus area initiated 7/25/24, which remained active until R2's discharge, read, [R2's name redacted] wishes to remain long-term care at this facility. Within R2's clinical record, there was not documented evidence of any discharge planning to include medication administration, medication education or training, management of the dialysis access site, medical equipment needs, home health being arranged as per physician orders/documentation, etc. The only notation was an entry by the social worker dated 8/28/25 that read, Writer received notice, resident is interested in discharging to a group home. Resident met with group home representative. UM aware, referral paperwork in reviewal. No discharge date in place. The next entry by the social worker was dated 9/29/25 that read, Resident discharge postponed to 10/31. On 2/4/26, during a conversation with the owner of the facility where R2 discharged to, the owner reported the facility was independent living On 2/5/26at 11:52 AM, an interview was conducted with the facility's social worker (SW). The SW reported, He [R2] was a long-term resident here for a while, he did discharge from facility per his request. The lady had come here and was touring, he met the owner. He was eager to discharge, he has been here a while, I went over it with him and made sure transport to dialysis was set to continue and the owner was aware. On 2/5/26 at 12:05 PM, an interview was conducted with the nurse practitioner (NP), who was R2's (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medical provider. The NP reported that R2 was a dialysis patient and discharge was delayed due to setting up transport to and from dialysis. The NP went on to report that R2 went to a group home that she described as a little nursing home, staffed by certified nursing assistants (CNAs) and nurses. When the NP was made aware that R2 was discharged to an independent living setting she stated she was not aware and felt R2 needed a group home. On 2/5/26 at 12:30 PM, an interview was conducted with LPN #1, who was the unit manager. The unit manager was asked if care plan meetings to discuss discharge planning for R2 were held and the unit manager said, I don't recall a care plan meeting for him. I can't say. On 2/6/26 at 8:35 AM, an interview was conducted with the Director of Social Services (DSS). When asked about discharge planning and care planning, the DSS said, Discharge planning starts on admission. Care plans are held quarterly. When asked if the plan or goals change, the SSD said that would be noted on the care plan. On 2/6/26 at approximately 10 AM, the facility administrator was made aware of the above findings. No further information was provided prior to conclusion of the survey.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident representative interview, staff interview, facility document review and clinical record review, the facility staff failed to provide medically related social services regarding discharge planning for two of three residents in the survey sample (Residents #1 and #2). The findings include:1. Facility staff failed to provide social services to ensure a safe discharge to the community for Resident #1 (R1). R1, residing in the nursing facility for over three years, was discharged to independent housing that provided no direct supervision, assistance with ADLs [activities of daily living] or medication administration. The social worker responsible for discharge planning failed to ensure a discharge plan of care was in place prior to the discharge that included goals, identification of the resident's care needs in the community, involvement of the interdisciplinary team and consent from the resident's legal guardian. The social worker referenced R1's discharge location as a group home and failed to verify what services were provided at this destination to meet the resident's needs. The location was not a licensed group home but an independent living apartment. Social services failed to provide orientation for R1 to the new housing location. Resident #1 (R1) was admitted to the facility with diagnoses that included muscle wasting/atrophy, diabetes, magnesium deficiency, peripheral vascular disease, congestive heart failure, atrial fibrillation, anemia, major depressive disorder, hypertension, insomnia, affective mood disorder, compulsive sexual behaviors, atherosclerotic heart disease, cerebral infarction and vitamin deficiency. The minimum data set (MDS) dated [DATE] assessed R1 with moderately impaired cognitive skills and as requiring set-up/touch assistance for eating, dressing, hygiene and ambulation along with occasional incontinent of bowel/bladder. Section Q. of this MDS documented that the resident did not want to be asked about returning to the community on this or any other MDS assessments. R1 had resided in the nursing facility for over 3.5 years at the time of discharge on [DATE]. The clinical record documented R1 was adjudicated incapacitated and included a court order dated 2/23/22 for the appointed guardian to make all decisions for R1, including living arrangements, placements and finances on an indefinite basis. R1's clinical record documented the resident discharged to a group home on 9/30/25. The clinical record documented no involvement or consent from the legal guardian regarding the discharge. R1's clinical record included no documented basis for the discharge from a physician or provider. The clinical record documented comments from the resident about discharging to a group home, but included no discharge plan, rationale for the discharge and no documented request from the resident or the legal guardian about a desire to leave the nursing facility. It was unclear from the clinical record what prompted R1's discharge to the community. There was no record of care plan review or involvement from the interdisciplinary team regarding R1's discharge. The last review of R1's comprehensive care plan prior to the 9/30/25 discharge was eight months earlier on 1/21/25 and that care plan indicated the resident had no plans to discharge from the facility. Review of R1's clinical record revealed a psychiatric nurse practitioner (NP) assessed R1 on 9/3/25 and documented, .[R1] mentions that he is supposed to be moving soon, although he is unsure of the destination . A licensed clinical social worker (LCSW) documented on 9/4/25, .Pt [patient] reports feeling slightly anxious/excited stating he will be moving to a group home which will provide more independence, (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	decrease in number of residents/roommates .states [R1] is looking forward to cooking meals, getting outside more frequently, and engage in meaningful activities . On 9/11/25, the resident's physician conducted a recertification assessment that indicated the resident was appropriate for nursing home placement and made no mention of discharge to the community. The 9/11/25 recertification note documented, .with history of multiple medical problems .review of all medications and medical record .Discussed with the nursing staff. Recommend to continue with all other medications, monitor labs and observe fall precautions .resident is appropriate for nursing home care and requires significant help with ADLs and has history of multiple medical problems . On 9/16/25, a LCSW documented, .Pt reports he has some anxiety over his new upcoming placement in a group home .Processed emotions around moving to a group home . R1 was assessed by the NP on 9/18/25 and 9/25/25 with no mention of any discharge plans. A social services note dated 9/26/25 documented, .Writer discussed resident discharge with resident and Group Home .Resident set to discharge to .Group home on 9/29. The NP documented a progress note on 9/29/25 stating, .with a complex medical history who is currently being evaluated for discharge. Per the assigned social worker, [R1] is scheduled for discharge today to a community-based group home .[R1] will be under the care of a designated primary care provider affiliated with the group home, ensuring continuity of medical oversight .Given his current clinical stability and the supportive structure of the group home environment [R1] is considered appropriate for discharge. Ongoing monitoring and management of his chronic conditions will be coordinated through his new primary care provider, with attention to both his physical and mental health needs . R1's Discharge summary dated [DATE] listed the resident's discharge destination as a Group Home with a street address and apartment number listed. The guardian's name and phone number were listed on the form but there was no documentation the guardian was notified of the discharge. The discharge summary documented that pre and post discharge medications had been reconciled. The discharge summary included no education/instruction to the resident about use of the Trulicity injection pen for diabetic management. The resident was not assessed at the nursing facility to self-administer any medication including injecting Trulicity. The discharge summary listed the resident was responsible for scheduling follow up appointments with a primary physician and was educated on the importance of follow up visits. A primary provider's name was listed on the discharge summary but spaces for the provider's office address and phone number were blank. It was unclear from the clinical record if the resident had a cell phone or access to a phone at the discharge destination and the discharge summary made no mention of money management or finance needs/concerns. A social services note dated 9/29/25 documented, .Resident discharge postponed to 9/30. Group Home providing transport . A social services note dated 10/7/25 documented R1's guardian had called concerning the resident's discharge and clarification of contact numbers. This note documented, .Writer informed [R'1 legal guardian] to feel free to reach out regarding resident . On 2/4/26 at 1:40 p.m., R1's legal guardian (other staff #1) was interviewed about the resident's discharge on [DATE]. The guardian stated she was not aware of the resident's discharge until a local hospital social worker (SW) called on 10/6/25 and reported that the resident had been found on the (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	street with his belongings and was brought to the emergency department by authorities. The guardian stated the hospital SW told her the resident had been living in a group home. The guardian stated she had no idea that R1 was living in the community and had not been notified or consulted about the discharge. The guardian stated she talked with the facility's social worker (other staff #3) on 10/7/25 after the hospital notified her of the resident's status in the community. The guardian stated the facility social worker (other staff #3) claimed she had reached out to discuss the discharge plan. The guardian stated she never received a call or message from the facility's social worker and that she had talked with no one from the facility regarding R1 discharging from the facility. The guardian stated the resident should never have been discharged without her consent or input in the discharge plan/destination. The guardian stated if she had known, she would have visited the potential location to be sure it was a safe place and that the resident had services/care needed. The guardian stated she researched R1's discharge location and stated it was not a licensed group home but an apartment. The guardian stated, [R1] was living in an apartment with other men. The guardian stated the hospital reported that R1 was found wandering in the community, that someone called 911 and the resident was taken to a local hospital by authorities. The guardian stated the resident experienced no injuries and had since been placed in another nursing facility. The guardian stated, I was never contacted .This should not have happened . On 2/4/26 at 2:10 p.m., the facility's SW (other staff #3) and the regional SW (other staff #4) were interviewed about R1's discharge on [DATE]. The SW stated the plan for R1 was to discharge to the community. The SW stated she spoke to the legal guardian and then stated she did not speak directly to the legal guardian but that she had left a message with someone at a desk, asking the guardian to call her. The SW stated R1 was able to do a lot for himself, had no family and had asked about going to a group home. When asked if the discharge destination was a licensed group home, the SW was not sure and stated the owner came and assessed the resident prior to discharge. When asked if she or the resident visited the discharge destination prior to discharge, the SW stated, No. When asked about what prompted R1's discharge from the facility since he had been there over three years, the SW stated the resident had approached her about going back to the community and that the discharge location would provide the resident increased freedoms. The SW stated she became aware of the destination after the owner had visited the facility and left a business card. The SW stated again she contacted the legal guardian multiple times but did not know how many times or when. The social worker provided no evidence the guardian had been contacted or involved in R1's discharge. On 2/4/26 at 2:45 p.m., the owner of R1's discharge destination (other staff #2) was interviewed about the facility and services offered. The owner stated, We offer apartments and rooms. The owner stated the housing was independent living and that all those staying at the apartments were required to be independent with all ADLs. The owner stated the apartments were not a group home and the facility was not licensed by any state agency. The owner stated services provided included assistance with meal prep if requested and pill reminders but that no direct care or services were provided. The owner stated there was no medicine administration, only reminders to take medicines. The owner stated, We don't take anyone that needs assistance. The owner stated those that reside at the housing do their own thing and that some that stayed there had their own room and others shared a room. On 2/4/26 at 3:10 p.m., the facility's SW (other staff #3) and the regional SW (other staff #4) were interviewed again about R1's discharge location. The SW stated the owner met with R1, that R1 got along with the owner so she moved forward with plans for the discharge. The SW stated no other discharge destinations were considered or presented to the resident. The SW stated the owner had visited the resident, but she did not know the date and again stated she had not visited (continued on next page)

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

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