PRINTED: 02/11/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES ((X1)) PROVIDER/SUPPLIER/CILIA (XX) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION OKSI) DATTE SURVEY IDENTIFICATION NUMBER: A BUILDING COMPLETIED 495272 B. WING NAME OF PROVIDER OR SUPPLIER 02/05/2021 STIRBET ADDRESS, CITY, STATE, ZIP ODDE CANTERBURY REHABILITATION & HEALTH CARE CENTER 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238 (0X40) ID SUMMARY STATEMENT OF DEFICIENCIES IID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE TUAG REGULATORY OR LSC IDENTIFYING INFORMATION) COMPLETION CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY E 000 Initial Comments E 000 An unannounced abbreviated Emergency Preparedness COVID-19 Focused Survey was This plan of correction is respectfully conducted 2/2/21 through 2/5/21. The facility was submitted 25 evidence of alleged in substantial compliance with 42 CFR Part compliance. The submission is not an 483.73, Requirement for Long-Term Care admission that the deficiencies existed or Facilities. that we are in agreement with them. It is an F 000 **INITIAL COMMENTS** F 000 affirmation that An unannounced abbreviated COVID-19 Correction to areas cited have been made Focused Survey was conducted 2/2/21 through and the facility is in compliance with 2/5/21. A complaint was investigated. Corrections participation requirements. are required for compliance with F-880 of 42 CFR Part 483 Federal Long Term Care requirement(s). The census in this 190 certified bed facility was 161. Of the 161 current residents, 13 residents were currently positive for the COVID-19 virus. The survey sample consisted of six current resident reviews (Residents #1 through #6). F 580 Notify of Changes (Injury/Decline/Room, etc.) F 580 F580 SS=D CFR(s): 483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room) §483.10(g)(14) Notification of Changes. Resident 1 physician and responsible party (i) A facility must immediately inform the resident; notified of missed dialysis appointments on consult with the resident's physician; and notify, 2-5-21. consistent with his or her authority, the resident Residents that currently reside in the facility representative(s) when there is-(A) An accident involving the resident which that receive dialysis services have the results in injury and has the potential for requiring potential to be affected by this alleged physician intervention; deficient practice. DON/Designee will review (B) A significant change in the resident's physical, medical records for current residents mental, or psychosocial status (that is, a receiving dialysis to ensure physician and deterioration in health, mental, or psychosocial responsible party have been notified of status in either life-threatening conditions or missed dialysis appointments. Notification clinical complications); will be made for any discrepancy that is (C) A need to alter treatment significantly (that is, identified. LABORATOR DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE

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

Event ID: 0FQR11

Facility ID: VA0034

	OF DEFICIENCIES F CORRECTION	(XX) PROVIDENCUPPLIERCUM IDENTIFICATION NUMBER:	(XZ) MULTIPI A. BUILDING	UE CONSTRUCTION	100	TE SURVEY MPLETIED
		495272	B. WING		03	C 2/05/2021
	ROVIDER OR SUPPLIER BURY REHABILITATION	& HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238		
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F 580	a meed to discontinuit treatment due to advice the advice a mew for (D) A decision to train resident from the fact §483.15(c)(1)(ii). (ii) When making no (14)(ii) of this section all pertinent informal is available and proximally pertinent informal is available and proximal pertinent in §483 (B) A change in residue) (A) A change in residue) (IV) The facility must update the address in phone number of the representative(s). §483.10(g)(15) Admission to a computate is a composite of §483.5) must disclosits physical configurations that comproart, and must specific room changes between the pertinent in the pertinent in the part of the pertinent in the per	we an existing form of verse consequences, or to orm of treatment); or insfer or discharge the collity as specified in tification under paragraph (g) in the facility must ensure that tion specified in §483.15(c)(2) wided upon request to the also promptly notify the ident representative, if any, in or roommate assignment 10(e)(6); or dent rights under Federal or ons as specified in paragraph in. The record and periodically (mailing and email) and a resident resident resident in the paragraph of the resident res	F 580	3- Procedure for physician and notification reviewed on 2-5-21 m implemented at this time Development Coordinator/Designeducate the Licensed Nursing Stapprocedure for notifying the physician and responsible party dialysis appointments and downotification in the medical record nursing staff will document the appointed on the 24 hour report of 14- The Interdiscipinary Team will authour reports and nursing prograduring clinical meeting daily through Friday for missed appointments and document physician and responsible party week for 2 weeks, then 3 days as weeks and then monthly unit reaches 100% compliance. Result audits will be brought forth to committee for review and recommendations.	o changes e. Staff mee will off on the attending of missed cumenting . Licensed e missed or review. dit the 24 ess notes Monday dialysis ation of 5 days a veek for 2 cil facility s of these the QAPI	

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STATEMENT	TOF DEFICIENCIES	(XII) PROVIDER/SUPPLIER/CUA			OMBIN	VO. 0938-0391
AND PLANG	DF CORRECTION	IDENTIFICATION NUMBER:	(XXX) MULTIPLE C	ONSTRUCTION		THE SURVEY
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INAME OF	PROVIDER OR SUPPLIER		STR	BET ADDRESS, CITY, STATE, ZIP CODE		2/05/2021
CANTER	BURY REHABILITATION	& HEALTH CARE CENTER	1776	CAMBRIDGE DRIVE HMOND, VA 23238		
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	RR (resident represer in the resident's dialytersidents in the surversident's dialytersidents in the surversidents in the surversident staff failed to me RR when the resident 1/5/21. The findings include: Resident #1 was admit 11/26/18, and most restrained to ESRD (end stage of dialysis (2), history of bipolar disorder (4), and (5). On the most recension a significant change at (assessment reference Resident #1 was code impaired for making dialysis dialysis dialysis as mobility, dressing, and was coded as being consistence of two staff bathing. She was code sitting to standing position the lookback period. He awheelchair. Resident #1 was unavaluring the survey. She appointment. A review of Resident #1	itted to the facility on cently readmitted on ses including, but not limited renal disease) (1) requiring a stroke, diabetes (3) and morbid (extreme) obesity of MDS (minimum data set), sesessment with an ARD a date) of 12/30/20, d as severely cognitively aily decisions, having on the BIMS (brief latus). She was coded as sistance of staff for bed personal hygiene. She impletely dependent on the members for transfers and d as not moving from a lion, or as walking, during er only mobility device was #1 was coded as g the lookback period. 's clinical record revealed	F 580			
1	he following physician of Dialysis T-Th-Sat (Tue:	order dated 11/19/20: sday, Thursday, Saturday)				

STATEMENT OF IDEFICIENCIES AND PLAN OF CORRECTION		((XII) PROVIDER/SUPPLIER/CUM IDENTIFICATION NUMBER:	(XZ) MULTIPLE CO	ONSTRUCTION		E SURVEY IPLETED
		495272	B. WING		02	C 2/05/2021
	ROVIDER OR SUPPLIER BURY REHABILITATION (MEALTH CARE CENTER	1776	EET ADDRESS, CITY, STATE, ZIP OODE CAMBRIDGE DRIVE HMOND, VA 23238		
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F 580	day every Tue (Tuesd (Saturday)." The order (Saturday)." The order Further review of Reservealed a TAR (treat for January 2021, whith physicians order for direction of Resident #1's dialysis review of Resident #1' contained no evidence dialysis that day, or the (resident representation). A review of Resident #1 contained no evidence dialysis that day, or the (resident representation). A review of Resident #1 contained no evidence dialysis appointments every Tuesday. Thurston 2/4/21 at 11:29 and was interviewed. When when a resident's TAR blank on a day the residialysis, RN #3 stated did not receive dialysis what should be done in receive scheduled dial stated the physician stresident should be resident should sh	fialysis center] one time a lay), Thu (Thursday), Sat r did not have a stop date. ident #1's clinical record ment administration record) ch documented the above ialysis. The box for on 1/5/21 was blank. A 's nurses' notes for 1/5/21 e that Resident #1 received at her physician or RR ve) was notified. #1's comprehensive care ocumented, in part: "I need esident to go for scheduled. Resident receives dialysis day, and Saturday." In., RN (registered nurse) #3 in asked what it means is with dialysis orders is ident should have received it must mean the resident is that day. When asked for a resident does not lysis for any reason, she mould be notified, and the cheduled, if ordered by the in., LPN (licensed practical)	F 580			
	on a day the resident s	d. "If it's not documented.				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUIA IDENTIFICATION NUMBER:	(XZ) MULTIPLE OF	ONSTRUCTION	(KB) DATE SURVEY COMPLETED
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	PROVIDER OR SUPPLIER BURY REHABILITATION	N & HEALTH CARE CENTER	117776	EET ADDRESS, CITY, STATE, ZIP CODE CAMBRIDGE DRIVE HMOND, VA 23238	02/03/2021
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	if's not done." When if a resident does not for any reason, he s notified, as well as the representative). LPN placed in the chart, watched carefully follack of dialysis. On 2/4/21 at 12:20 p with Resident #1 on When asked if she in Resident #1 received stated it was too long. When asked if there documentation in the #1 had received dialythere was not. When evidence that the phythat the resident did stated there was not. On 2/4/21 at 4:30 p.in member) #2, the reginand RN #1, the assis (ADON) were informed and RN #1, the assis (ADON) were informed information related to physician or RR if a redialysis for any reason. A review of the facility Resident's Condition of The nurse will notify the physician or physic	n asked what should be done of receive scheduled dialysis stated the physician should be the RR (resident W #2 stated a note should be and the resident whether or not a dialysis on 1/5/21, was interviewed. The should be a gag for her to remember. It was any indication or a clinical record that Resident was any indication or a clinical record that Resident was on 1/5/21, LPN #2 stated asked if there was any ysician or RR was notified not receive dialysis, she The should be done in a state of the second of the second of the second of the second of the esident does not receive in. The policy, "Change in a por Status" revealed, in partitive resident's Attending on call when there has the resident's medical.	F 580		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CUIA AND PLAN OF CORRECTION IDENTIFICATION INUMBER:			(XX) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495272	B. WING_				C /05/2021	
	ROVIDER OR SUPPLIER BURY REHABILITATION (S HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	E	1 02	10312021	
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F 580	Continued From page	5	F 5	580				
	No further information	was provided prior to exit.						
	REFERENCES							
	stage of long-term (ch is when your kidneys body's needs. End-sta	disease (ESKD) is the last fronic) kidney disease. This can no longer support your age kidney disease is also						
	information is taken fr	I disease (ESRD)." This om the website ov/ency/article/000500.htm.						
	your blood. They also your bones strong and your kidneys fail, you the work your kidneys have a kidney transpla							
	types of dialysis. Both your body of harmful water. Hemodialysis u	ses a machine. It is						
	go to a special clinic for a week." This informal	artificial kidney. You usually or treatments several times tion was taken from the eplus.gov/dialysis.html.						
	blood glucose, or bloo) is a disease in which your d sugar, levels are too is taken from the website v/diabetes.html.						
	a mental disorder that mood, energy, activity	ess or manic depression) is causes unusual shifts in levels, concentration, and day-to-day tasks." This						

	OF DEFICIENCIES OF CORRECTION	(XII) PROVIDER/SUPPLIER/CUA IDENTIFICATION INUMBER:	(XX) MULT A. BUILDI	TIPLE CONSTRUCTION NG		E SURVEY PLETED
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	PROVIDER OR SUPPLIER BURY REHABILITATION	& HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238		30012021
((X4) IID IPREFIX TIAG	(EACH DEFICIENC	TATIONENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	PRIEFI) TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	((XS)) CONPLETION DATE
SS=D	https://www.nimh.nih.order/index.shtml. (5) "Obesity, defined = 30 kg/m2, is recogn factor. The Centers for Prevention (CDC) repeated the U.S. have increased the U.S. have i	as a body mass index (BMI) as a body mass index (BMI) aized as an important risk or Disease Control and borted that obesity rates in sed dramatically over the last or is now epidemic in the 2009). For adults 60 years ence of obesity is about 37% or among women (NHANES - Nutrition Examination or be further classified 1 30.0-34.9 kg/m² be further classified 1 35.0-39.9 kg/m² be from the website medicare-coverage-databas sheet.aspx?NCAId=258&fr buse/Neglect Policies (3) or must develop and cies and procedures that: and prevent abuse, on of residents and sident property, the policies and procedures on allegations, and	F 60	F607 Develop/Implement	nd neglect r/t will complete ry of unknown ury of unknown be affected by it practice. incident reports dentify injuries ave not been and investigate	

	OF DEFICIENCIES OF CORRECTION	(XII) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(XZ) MULTIPU A. BUILDING	LE CONSTRUCTION		TTE SURVEY MPLETED	
		495272	B. WING_	MING02/05/20			
	PROVIDER OR SUPPLIER BURY REHABILITATION	& HEALTH CARE CENTER		Street address, City, State. Zip Code 1776 Cambridge Drive RICHMOND, VA 23238			
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F 607	This REQUIREMENT by: Based on staff intervireview, clinical record a complaint investigate the facility staff failed report an injury of unknown abuse) as required for survey sample, Resided required agencies on The findings include: A review of the facility Program," revealed, in resident abuse prever will:Identify and asses abuseInvestigate an abuse within timefram requirements The stainput as needed, will in and neglect to clarify who possible causes." Resident #1 was admit 11/26/18, and most record to: ESRD (end stage in dialysis (2), history of a bipolar disorder (4), and (5). On the most recent a significant change as (assessment reference Resident #1 was code cognitively impaired for having scored seven of interview for mental staff.	is not met as evidenced iew, facility document review, and in the course of ition, it was determined that to implement its policy to mown origin (possible r one of six residents in the ent #1. The facility staff ent #1's broken tibia (leg) to 12/17/20. policy, "Abuse Prevention o part: "As part of the ation, the administration ess all possible incidents of d report any allegations of e's as required by federal eff, with the physician's evestigate alleged abuse what happened and identify tted to the facility on cently readmitted on ses including, but not limited enal disease) (1) requiring a stroke, diabetes (3) and morbid (extreme) obesity at MDS (minimum data set), essessment with an ARD e date) of 12/30/20,	IF (6/07)	3- Abuse Investigating and repreviewed on 2-5-21. No chang this time. The Staff Coordinator/Designee will insstaff on the Abuse Invest Reporting policy and to immediate Administrator/Designee reporting to the state agency of investigation for allegation neglect, misappropriation of mistreatment and injury of unknown origin reports and progress notes dithrough Friday in clinical meeting injuries of unknown origin reported and investigation promptly 5 days a week for 2 we days a week for 2 weeks and the until facility reaches 100% Results of these audits will be but to the QAPI committee for further recommendations.	ges meeded at Development Development vervice facility tigation and diately notify for prompt and initiation as of abuse, of property, nown origin. Indit incident aily Monday and to ensure have been s initiated eeks, then 3 aren monthly compliance. Tought forth		

PRINTED: 02/11/2021
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STATIEMENT AND PLAN O	OF IDEFICIENCIES OF CORRECTION	(IXII) PROVIDER/SUPPLIER/CLINA IDENTIFICATION NUMBER:	(XZ) MULTIPLE A BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495272	B. WING		C
	PROVIDER OR SUPPLIER BURY REHABILITATION 8	HEALTH CARE CENTER	117	TREET ADDRESS, CITY, STATE, ZIP CODE 776 CAMBRIDGE DRIVE ICHMOND, VA 23238	02/05/2021
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	was coded as being of assistance of two staff bathing. She was code sitting to standing posithe lookback period. He a wheelchair. She was dialysis during the look A review of Resident # the following progress: - 12/15/2020 at 7:45 a. bed. Awake and orients warm, dry, and pale. re No C/O (complaint of) progress: - 12/15/2020 7:10 p.m. Pathway. Vital Signs: Progress: Numerical." - 12/16/2020 9:00 a.m. Text: Resident in bed. A and place. Skin warm, or dedematous (swollen), at to Dialysis clinic this motoright arm given. Up in 12/16/2020 7:10 p.m. Pathway. Vital Signs: Progress: P	d personal hygiene. She completely dependent on the immembers for transfers and ed as not moving from a tion, or as walking, during fer only mobility device was coded as receiving toack period. It's clinical record revealed notes: In "Note Text: Resident in ed to self and place. Skin esp [respiration] unlabored. Sain or discomfort." "Nursing Daily Skilled and (Pain Level) OPain "Health Status Note. Note wake and oriented to self dry, and pale. Right arm and bruised. Resident to go wring. Medication for pain in wheelchair." "Nursing Daily Skilled and OPain Scale: "Health Status Note. Note at 6:50 ampatient left leg at knee." "Health Status Note. Late and resident room to help and resident room to help."	F 607		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES STATIENENT OF DEFICIENCIES (XII) PROVIDER/SUPPLIER/CLIVA (XZ) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING

495272

OMB NO. 0938-0391 (X3) DATE SURVEY

COMPLETED

PRINTED: 02/11/2021

FORM APPROVED

C 02/05/2021

NAME OF PROVIDER OR SUPPLIER

CANTERBURY REHABILITATION & HEALTH CARE CENTER

STREET ADDRESS, CITY, STATE ZIP CODE

1776 CAMBRIDGE DRIVE RICHMOND, VA 23238

(X4)IID	SUMMARY STATEMENT OF DEFICIENCIES	IID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(KS)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX		COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)	TAG		DATE

B WING

F 607 Continued From page 9

was not going to dialysis because her leg was hurting. Assessment of leg showed some swelling to left leg. Resident rated pain "3-4" on a scale of 1-10." Medicated with PRN (as needed) tylenol. Called MD (medical doctor) for orders to X-Ray leg. Order called into [name of mobile X-ray company]. RP (responsible party) notified. Called dialysis center to inform them that resident refused transport and request make-up treatment session. Awaiting call back."

- 12/17/2020 9:47 p.m. Health Status Note. Note Text: Received in report that pt (patient) began c/o (complain of) pain below L (left) knee last night after transferring from WC (wheelchair) to bed. Pt given Tylenol @ (at) 1822 (6:22 p.m.) and ice applied to site...Pt screams if leg is moved at all. Received call from radiology that pt has L (left) proximal tibia (leg) fx (fracture). Called MD on call. Per [name of physician] send pt to [local hospital] for evaluation. Pt, [RP], DON (director of nursing), and unit manager notified of transportation to ED (emergency department)."
- 12/18/2020 4:34 a.m. "Health Status Note, Note Text: Resident returns to unit from [hospital] with diagnosis of Left fractured knee Vital Signs stable resident rates her pain at an 8 and is given prn Tylenol."
- 12/18/2020 4:46 p.m. "Nursing Daily Skilled Pathway. Vital Signs: Pnl 7... Pain scale: Numerical."
- 12/19/2020 7:47 a.m. "MD Progress Note. Note Text: ER f/u (follow up)...Pt had a fall and was seen at [local hospital] on 12/17 for a proximal tibial fx. (fracture) Pain is well controlled. She is to f/u (follow up) with ortho (orthopedic) next wk."

F 607

	OF DEFICIENCIES OF CORRECTION	(XII) PROVIDER/SUPPLIER/CUIA IDENTIFICATION NUMBER:	(XX) WULTIPLE C	ONSTRUCTION	(K3) DAI	TIE SURVEY MPLETIED
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CANTER	1	& HEALTH CARE CENTER	11771	EET ADDRESS, CITY, STATE, ZIP C 6 CAMBRIDGE DRIVE HMOND, VA 23238		2/05/2021
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	staff member) #4, the physician, was intervie the note she wrote on #1 "had a fall," ASM # [about the fall]. It was report. Probably the note the word "fall" was a wrong was interviewed. When any circumstances sur On 2/4/21 at 11:49 a.m was interviewed. When was to be safely transfelg discovered on 12/1 Hoyer (mechanical lift). #1, prior to her injury, won her legs, she stated When asked if she kne became broken, she st her shift on 12/17/20, s was having significant prior to reposition resident started "screar obtained an order to ha X-ray, and the results c She stated, "I was told toroken leg."	m., ASM (administrative resident's attending ewed. When asked about 12/19/20 stating Resident 4 stated, "I know nothing just what I was told in urses told me." She stated ord she uses regularly. In a fall all the time." She whow the resident fell, or rounding the fall. I., RN (registered nurse) #3 in asked how Resident #1 erred prior to the broken 7/20, RN #3 stated, "A in When asked if Resident was able to bear any weight in a whow Resident #1's leg ated when she came in for the was told the resident poain. She stated she went in to assess her. She the resident, and the ming from pain." She we the resident receive an arme back on her shift. That the resident had a property is to the stated she did #1's leg was broken. CNA (certified nursing iewed. She stated she did #1's leg was broken. OSM (other staff tional therapist, was	F 607			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATISMENT OF DEFICIENCIES ((X1)) PROVIDER/SUPPLIER/CUA ((X2) MULTIPLE CONSTRUCTION (K3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 495777 B. WING 02/05/2021 INAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE CANTERBURY REHABILITATION & HEALTH CARE CENTER RICHMOND, VA 23238 ((%4)) IID SUMMARY STATEMENT OF DEFICIENCIES IID PROVIDER'S PLAN OF CORRECTION (0839) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR USC IDENTIFYING INFORMATION) TOAGE CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 607 Continued From page 11 F 607 Resident #1's leg had been broken. On 2/4/21 at 3:33 p.m., LPN #5, a shift supervisor, was interviewed. When asked if he remembered transferring Resident #1 from her wheelchair to her bed on the evening of 12/16/20, LPN #5 stated, "Yes. She was in the chair. I am strong and hefty. I got her to stand up. I picked her up, and then I set her in the bed." When asked if her leg hit anything, or was positioned inappropriately at any time, LPN #5 stated, "No." LPN #5 was informed of the results of the interviews with the therapist and other staff members, who had said that, prior to her leg fracture, Resident #1 was unable to bear any weight on her legs. LPN #5 stated, "Well she stood up for me. And she kind of pivoted so I could get her in the bed." When asked why he, as a shift supervisor, transferred a resident, he stated he could not remember, but "felt like we were short staffed." When asked if he consulted the care plan or physician orders or any other staff members before he transferred Resident #1, LPN #5 stated, "I just did the only thing I could do at the time." When asked if he knows how the resident should have been transferred, LPN #5 stated, "Right now, I can't say." When asked if he knew how Resident #1's leg had been fractured between 7:00 p.m. on 12/16/20 and 6:00 a.m. on 12/17/20, he stated he did not know. On 2/4/21 at 4:31 p.m., ASM #2, the regional director of operations, and RN #1, the ADON (assistant director of nursing) were asked how Resident #1's leg was fractured in December 2020. RN #1 stated she was not working in the facility when this incident occurred. ASM #2 stated he had just taken over as interim administrator on 2/2/21, and he was unaware of

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in the second se	fracture. ASM #2 state "minimal" document of investigation. The surthis document. A review of the facility for [Resident #1]" review of the facility for [Resident #1]" review timeline documentation in-house investigation fracture to attempt to injury." What follows in recapitulation of the pabove. Additional information interview with the residecumented as follow interviewed and deniemember, stated she freeze been mean to he When asked about the stated, 'She dropped in caused my leg to breat being put into be done to the reported that 2 per Question was re-asked ising the left and drop the answered yes againd physical] reflect shift dialysis." The investif	ted he believed there was a describing a facility received requested a copy of a document, "Investigation ealed, in part: "The following on is the result of an a following her left leg determine the cause of a word for word regress notes referenced from a following included an ident. This interview was as a "Resident was a deli about what hap head and that the company of the com	F 607	DEFICIENCY)		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

	AND PROVIDER OF DEFICIENCES ((X1)) PROVIDER SUPPLIER (UNA IDENTIFICATION INJUMBER: 495272 VAME OF PROVIDER OR SUPPLIER	(XX) MULTIPLE A. BUILDING B. WING	CONSTRUCTION	CON	TIE SURVIEY MPLETIED C	
NAME OF F	ROVIDER OR SUPPLIER			DESET ADDRESS (NOW) POPULAR NO.		2/05/2021
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	transfer." When as interview any staff in ASM #2 or RN #1 of he had been the adwould have gotten are aregiver interview occurred. When as a resident receives ASM #2 stated, "Will (facility reported in agencies." When as its abuse policy and #1's injury of unknow "No. Not that I have No further information in the properties of long-term (is when your kidney body's needs. End-called end-stage reginformation is taken https://medlineplus.stage." (2) "When your kidney have a kidney transitreatment called dialitypes of dialysis. Boyour body of harmfur water. Hemodialysis	ed it was during a resident ked why the facility did not regarding this incident, neither could answer. ASM #2 stated if diministrator at the time, he 24 or even 72 hours' worth of its around the time the injury ked what should happen when an injury of unknown origin, are are required to submit a FRI cident) to the state and other sked if the facility implemented if submitted a FRI for Resident lawn origin, ASM #2 stated, a seen." on was provided prior to exit. ey disease (ESKD) is the last chronic) kidney disease. This is can no longer support your stage kidney disease is also hal disease (ESRD)." This	F 607			

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	a week." This informal website https://medlin (3) "Diabetes (mellitus blood glucose, or blood high." This information https://medlineplus.go (4) "Bipolar disorder (finanic-depressive illne a mental disorder that mood, energy, activity the ability to carry out information is taken from https://www.nimh.nih.gorder/index.shtml. (5) "Obesity, defined as a 30 kg/m2, is recognized factor. The Centers for Prevention (CDC) reported U.S. have increase 30 years, and obesity is United States (Kahn, 20 and older, the prevalent among men and 34% a National Health and Nu Survey). Obesity may be according to the NIH: Class I Obesity = BMI 3 Class II Obesity = BMI 3 Class II (Extreme) Obe This information is takenttps://www.cms.gov/menttps://www.cms.	or treatments several times from was taken from the ephus gov/dialysis.html. i) is a disease in which your disugar, levels are too is taken from the website w/diabetes.html. ormerly called ss or manic depression) is causes unusual shifts in levels, concentration, and day-to-day tasks." This om the website ov/health/topics/bipolar-dised as an important risk Disease Control and red that obesity rates in did dramatically over the last is now epidemic in the 209). For adults 60 years ce of obesity is about 37% mong women (NHANES - trition Examination e further classified 0.0-34.9 kg/m² sity = BMI = 40.0 kg/m²"	F 607			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 02/111/2021 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATIEMENT OF DEFICIENCIES (XII) PROMIDER/SUPPLIER/CUA ((XZ)) MULTIPLE CONSTRUCTION (KS) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING COMPLETED C 495272 B. WING 02/05/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE CANTERBURY REHABILITATION & HEALTH CARE CENTER RICHMOND, VA 23238 (DX-20) III) SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (XS) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TOW/G DEFICIENCY F 607 Continued From page 15 F 607 (6) "Acetaminophen is used to relieve mild to moderate pain from headaches, muscle aches, menstrual periods, colds and sore throats, toothaches, backaches, and reactions to vaccinations (shots), and to reduce fever. Acetaminophen may also be used to relieve the pain of osteoarthritis (arthritis caused by the breakdown of the lining of the joints). Acetaminophen is in a class of medications called analgesics (pain relievers) and antipyretics (fever reducers). It works by changing the way the body senses pain and by cooling the body." This information is taken from the website https://medlineplus.gov/druginfo/meds/a681004.h F 609 Reporting of Alleged Violations F 609 F609 Reporting of Alleged Violations SS=D CFR(s): 483.12(c)(1)(4) 1- Resident 1 denies abuse and neglect r/t §483.12(c) In response to allegations of abuse, fracture of tibia. DON will complete neglect, exploitation, or mistreatment, the facility investigation regarding injury of unknown must origin by 2-21-21. 2- Residents that acquire an injury of unknown §483.12(c)(1) Ensure that all alleged violations origin have the potential to be affected by involving abuse, neglect, exploitation or alleged deficient practice. mistreatment, including injuries of unknown DON/Designee will review incident reports source and misappropriation of resident property. and progress notes from 2/1/2021 to are reported immediately, but not later than 2 present to identify injuries of unknown hours after the allegation is made, if the events origin that have not been reported. DON will that cause the allegation involve abuse or result in report and investigate residents identified serious bodily injury, or not later than 24 hours if during this review. the events that cause the allegation do not involve 3- Abuse Investigating and reporting policy abuse and do not result in serious bodily injury, to reviewed on 2-5-21. No changes needed at the administrator of the facility and to other this time. The Staff Development officials (including to the State Survey Agency and Coordinator/Designee will in-service facility adult protective services where state law provides for jurisdiction in long-term care facilities) in staff on the Abuse Investigation and accordance with State law through established Reporting policy and to immediately notify

procedures

the Administrator/Designee for prompt

reporting to the state agency and initiation

	OF DEFICIENCIES OF CORRECTION	((X1)) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(XX) MUUTIPU A BUILDING	E ODNSTRUCTION	((X3) (D/A	NO. 0938-039 TE SURVEY WPLETED
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	designated represe accordance with St. Survey Agency, with incident, and if the appropriate correction of the survey Agency with incident, and if the appropriate correction of the survey Agency complaint investing the facility staff failed unknown origin as residents in the survey facility staff failed to tibia (leg) to required the findings include Resident #1 was addit/26/18, and most in 12/24/20, with diagnostic ESRD (end stage dialysis (2), history of bipolar disorder (4), in (5). On the most received a significant change (assessment referent Resident #1 was code as significant change (assessment referent requiring the extension mobility, dressing, and was coded as being assistance of two stages assistance of two stages according to the control of the code of	ort the results of all e administrator or his or her entative and to other officials in ate law, including to the State hin 5 working days of the alleged violation is verified ive action must be taken. IT is not met as evidenced rview, facility document and review, and in the course of ration, it was determined that d to report an injury of equired for one of six vey sample, Resident #1. The report Resident #1's broken d agencies on 12/17/20.	F 609	of investigation for allegation neglect, misappropriation of mistreatment and injury of unknown the interdisciplinary team will aureports and progress notes dathrough Friday in clinical meeting injuries of unknown origin reported and investigations promptly 5 days a week for 2 weeks and the until facility reaches 100%. Results of these audits will be broad to the QAPI committee for a further recommendations.	f property, nown origin. dit incident tilly Monday og to ensure have been initiated eeks, then 3 en monthly compliance.	

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CUIA IDENTIFICATION NUMBER: 495272	(XZ) MULTI A. BUILDIN B. WING	IPLE CONSTRUCTION UG	CON	TE SURVEY MPLETTED C	
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	sitting to standing p the lookback period a wheelchair. She w dialysis during the look A review of Resider the following progre - 12/15/20 at 7:45 a bed. Awake and ori warm, dry, and pale No C/O [complaint of - 12/15/2020 7:10 p Pathway. Vital Signs scale: Numerical." - 12/16/2020 9:00 a Text: Resident in be and place. Skin warr edematous (swollen to Dialysis clinic this to right arm given. U - 12/16/2020 7:10 p. Pathway. Vital Signs Numerical." - 12/17/2020 6:54 a. Text: 2 Tylenol (6) gir continues to complai - 12/17/2020 11:27 a Entry: Note Text: We ther get ready for dial was not going to dial- murting. Assessment	position, or as walking, during it. Her only mobility device was was coded as receiving ookback period. If #1's clinical record revealed ess notes: Im. "Note Text: Resident in ented to self and place. Skin except (respiration) unlabored. off pain or discomfort." Im. "Nursing Daily Skilled is: Pnl (Pain Level) 0Pain Im. "Health Status Note. Note it. Awake and oriented to self im, dry, and pale. Right arm it.), and bruised. Resident to go morning. Medication for pain ip in wheelchair."	F 60				

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	PROVIDER OR SUPPLIER BURY REHABILITATION	STIREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238			62/05/202	02/05/2021	
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	tylenol. Called MD (n X-Ray leg. Order call X-ray company). RP Called dialysis center refused transport and session. Awaiting call - 12/17/2020 9:47 p.m Text: Received in rep c/o (complain of) paim night after transferring bed. Pt given Tylenol ice applied to site Pt all. Received call from (left) proximal tibia (le on call. Per [name of hospital] for evaluation nursing), and unit man transportation to ED (in 12/18/2020 4:34 a.m. Text: Resident returns diagnosis of Left fractures ident rates her paim Tylenol." - 12/18/2020 4:46 p.m. Pathway. Vital Signs: In Numerical." - 12/19/2020 7:47 a.m. Text: ER (emergency rehad a fall and was see 12/17 for a proximal tib well controlled. She is in (orthopedic) next wk."	nedical doctor) for orders to led into [name of mobile (responsible party) notified. In the information of t	F 609				

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 02/11/2021 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STRATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ((XZ) MULTIPLE CONSTRUCTION (XXI) DATTE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 495272 B Walling 02/05/2021 NAME OF PROVIDER OR SUPPLIER STIRRET ADDRESS, CITY, STATE, ZIP CODE CANTERBURY REHABILITATION & HEALTH CARE CENTER 1775 CAMBRIDGE DRIVE RICHMOND, VA 23238 (0X40) IID) SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ((KE)) PREFIX (EACH DERICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION TOAG REGULATORY OR USC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY F 609 Continued From page 19 F 609 physician, was interviewed. When asked about the note she wrote on 12/19/20 stating Resident #1 "had a fall," ASM #4 stated: "I know nothing [about the fall]. It was just what I was told in report. Probably the nurses told me." She stated the word 'fall' was a word she uses regularly. "Nursing home residents fall all the time." She stated she did not know how the resident fell, or any circumstances surrounding the fall. On 2/4/21 at 11:49 a.m., RN (registered nurse) #3 was interviewed. When asked how Resident #1 was to be safely transferred prior to the broken leg discovered on 12/17/20, RN #3 stated, "A Hoyer (mechanical lift). When asked if Resident #1, prior to her injury, was able to bear any weight on her legs, RN #3 stated, "No. None whatsoever." When asked if she knew how Resident #1's leg became broken, she stated when she came in for her shift on 12/17/20, she was told the resident was having significant pain. She stated she went in to Resident #1's room to assess her. She attempted to reposition the resident, and the resident started "screaming from pain." She obtained an order to have the resident receive an X-ray, and the results came back on her shift. She stated, "I was told that the resident had a broken leg." On 2/4/21 at 12:16 p.m., CNA (certified nursing assistant) #2 was interviewed. She stated she did

not know how Resident #1's leg was broken.

On 2/4/21 at 12:33 p.m., OSM (other staff member) #5, an occupational therapist, was interviewed. She stated she did not know how

Resident #1's leg had been broken.

On 2/4/21 at 3:33 p.m., LPN #5, a shift

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	RDVIDER OR SUPPLIER BURY REHABILITATION (HEALTH CARE CENTER	1177	reet address, city, state, zip odde 75 Cambridge Drive Chmond, va 23238	02/05/2021
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	remembered transferr wheelchair to her bed LPN #5 stated, "Yes. strong and hefty. I got her up, and then I set asked if her leg hit any inappropriately at any LPN #5 was informed interviews with the the members, who had sa fracture, Resident #1 weight on her legs. LP stood up for me. And so could get her in the be a shift supervisor, transstated he could not remwere short staffed." With the care plan or physic staff members before the LPN #5 stated, "I just dat the time." When ask resident should have be stated, "Right now, I caknew how Resident #1' between 7:00 p.m. on 12/17/20, he stated he on 2/4/21 at 4:31 p.m., director of operations, a (assistant director of nur Resident #1's leg was facility when this inciderated he had just taker administrator on 2/2/21, the circumstances surro	iewed. When asked if he ing Resident #1 from her on the evening of 12/16/20, she was in the chair. I am her to stand up. I picked her in the bed." When whing, or was positioned time, LPN #5 stated, "No." of the results of the rapist and other staff id that, prior to her leg was unable to bear any N #5 stated, "Well she when kind of pivoted so I d." When asked why he, as aferred a resident, he member, but "felt like we hen asked if he consulted ian orders or any other he transferred Resident #1, lid the only thing I could do led if he knows how the leen transferred, LPN #5 in't say." When asked if he is leg had been fractured 12/16/20 and 6:00 a.m. on did not know. ASM #2, the regional and RN #1, the ADON wring) were asked how ractured in December was not working in the int occurred. ASM #2 in over as interim and he was unaware of bunding Resident #1's leg he believed there was a	F 609		

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 02/111/2021 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB INO. 0938-0391 STATIEMENT OF DEFICIENCIES ((X1)) PROVIDER/SUPPLIER/GUIA (XZ) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A BUILDING COMPLETED C 495272 B. WING 02/05/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE CANTERBURY REHABILITATION & HEALTH CARE CENTER 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238 SUMMARY STATEMENT OF DEFICIENCIES (0X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (XS) PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) Continued From page 21 F 609 F 609 investigation. The surveyor requested a copy of this document. A review of the facility document, "Investigation for [Resident #1]" revealed, in part: "The following timeline documentation is the result of an in-house investigation following her left leg fracture to attempt to determine the cause of injury." What follows is word for word recapitulation of the progress notes referenced above. Additional information included an interview with the resident. This interview was documented as follows: "Resident was interviewed and denied being afraid of any staff member, stated she felt safe and that no one had ever been mean to her or hurt her in any way. When asked about the injury to her leg, she stated, 'She dropped me on my head and that caused my leg to break." When asked if she was being put into bed or transferring out of bed, she stated she was going to bed, and that is was a 'she.' When asked to tell about what happened, she reported that 2 people were using the lift. Question was re-asked if there were 2 people using the left and dropped her onto her head and she answered yes again. Hospital H&P reflect she told them she had a fall at dialysis." The investigation contained no evidence of staff interviews. The investigation did not document or contain a date, the name of the person conducting the investigation or signature.

On 2/4/21 at 4:45 p.m., the interview continued with ASM #2 and RN #1. When asked, again, how Resident #1's leg was broken, ASM #2 and RN #1 stated they did not know for sure. ASM #2 stated, "We assumed it was during a resident transfer." When asked why the facility did not interview any staff regarding this incident, neither

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 02/11/2021 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATIEMENT OF DEFICIENCIES (XII) PROVIDER/SUPPLIER/CUA (XZ) MULTIPLE CONSTRUCTION (KS) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 495272 B. WING 02/05/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE CANTERBURY REHABILITATION & HEALTH CARE CENTER 1776 CANBRIDGE DRIVE RICHMOND, VA 23238 SUMMARY STATIBMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION PREEK (EACH DEFICIENCY MUST BE PRECEDED BY FULL (CKS) PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION TVAG REGULATORY OR LISC IDENTIFYING INFORMATION) TAG CROSS-REFIERENCED TO THE APPROPRIATE DATE DEFICIENCY F 609 Continued From page 22 F 609 ASM #2 or RN #1 could answer. ASM #2 stated if he had been the administrator at the time, he would have gotten 24 or even 72 hours' worth of caregiver interviews around the time the injury occurred. When asked what should happen when a resident receives an injury of unknown origin (IUO), ASM #2 stated, "We are required to submit a FRI (facility reported incident) to the state and other agencies." When asked if the facility submitted a FRI for Resident #1's IUO, he stated, "No. Not that I have seen." A review of the facility policy, "Abuse Prevention Program," revealed, in part: "As part of the resident abuse prevention, the administration will: ...Identify and assess all possible incidents of abuse...Investigate and report any allegations of abuse within timeframes as required by federal requirements... The staff, with the physician's input as needed, will investigate alleged abuse and neglect to clarify what happened and identify possible causes." No further information was provided prior to exit.

REFERENCES

(1) "End-stage kidney disease (ESKD) is the last stage of long-term (chronic) kidney disease. This is when your kidneys can no longer support your body's needs. End-stage kidney disease is also called end-stage renal disease (ESRD)." This information is taken from the website

https://medlineplus.gov/ency/article/000500.htm.

(2) "When your kidneys are healthy, they clean your blood. They also make hormones that keep your bones strong and your blood healthy. When your kidneys fail, you need treatment to replace

STATEMENT OF DEFICIENCES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/OUA IDENTIFICATION NUMBER:	(XX) MULTIPLE OF		(x2) DALE SHEVER
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	PROVIDER OR SUPPLIER BURY REHABILITATION	N & HEALTH CARE CENTER	117776	EET ADDRESS, OITY, STATE, ZIP OO CAMBRIDGE DRIVE HMOND, VA 23238	02/05/2021 DDE
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	the work your kidne, have a kidney trans treatment called dia types of dialysis. Bo your body of harmfu water. Hemodialysis sometimes called ar go to a special clinic a week." This inform website https://medl (3) "Diabetes (mellith blood glucose, or blood glucose,	plant, you will need a lysis. There are two main with types fifter your blood to rid all wastes, extra salt, and is uses a machine. It is a artificial kidney. You usually is for treatments several times nation was taken from the ineplus.gov/dialysis.html. us) is a disease in which your bod sugar, levels are too on is taken from the website gov/diabetes.html. (formerly called ness or manic depression) is at causes unusual shifts in the levels, concentration, and at day-to-day tasks." This from the website gov/health/topics/bipolar-distributed as an important risk for Disease Control and ported that obesity rates in used dramatically over the last of is now epidemic in the 2009). For adults 60 years ence of obesity is about 37% among women (NHANES - Nutrition Examination of be further classified	F 609		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DISPLOYERS

STATIEMENT AND PLAN (TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	((XZ) MULTIF A. BUILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495272	B. WING_		C 02/05/2021
CANTER	T	& HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	0.2/05/2021
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA (DEFICIENCY)	E CONFLETION DATE
F 609	Class III Obesity = Bi Class III (Extreme) C This information is ta https://www.cms.gov e/details/nca-tracking omdb=true. (6) "Acetaminophen i menstrual periods, or toothaches, backach vaccinations (shots), Acetaminophen may pain of osteoarthritis breakdown of the linit Acetaminophen is in analgesics (pain relie reducers). It works by	MI 35.0-39.9 kg/m² Dibesity = BMI = 40.0 kg/m²" liken from the website Ifmedicare-coverage-databas g-sheet.aspx?NCAId=258&fr is used to relieve mild to neadaches, muscle aches, bids and sore throats, es, and reactions to and to reduce fever. also be used to relieve the (arthritis caused by the ng of the joints). a class of medications called vers) and antipyretics (fever changing the way the body	F 60		
F 657	senses pain and by c information is taken fr https://medlineplus.go tml. Care Plan Timing and CFR(s): 483.21(b)(2)(rom the website ov/druginfo/meds/a681004.h Revision	F 657	F657 Care Plan Timing and Revision	
	§483.21(b) Comprehe §483.21(b)(2) A comp be- (i) Developed within 7 the comprehensive as (ii) Prepared by an interior includes but is not limit (A) The attending physical A registered nurse resident. (C) A nurse aide with resident.	ensive Care Plans rehensive care plan must days after completion of sessment. erdisciplinary team, that ted to sician. with responsibility for the		1. Resident 1's care plan was revised to mappropriate transfer status on 2-5-21. 2. Residents that reside in the facility that massistance with transfers have the potento be affected by this alleged deficipractice. Nursing Administration Team Therapy will review residents transfer stato ensure that care plans are reflective residents most current assistive needs a update as needed.	eed ntial ient and itus

	(X1) PROVIDER/SUPPLIER/CUIA IDENTIFICATION NUMBER:	(XZ) MULTIPLE (CONSTRUCTION	(X3) DATE SUR) COMPLETE		
		495272	B. WING		C 02/05/2	021
	ROVIDER OR SUPPLIER BURY REHABILITATIO	N & HEALTH CARE CENTER	177	REET ADDRESS, CITY, STATE, ZIP CODE 76 CAMBRIDGE IDRIVE CHMOND, VA 23238		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES INCY MUST BE PRECEDED BY FUUL OR LSC IDENTIFYING INFORMATION)	IID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPILIDEFICIENCY)	BE CO	(KS) MPLETION DATE
F 657	the resident and the An explanation mumedical record if the and their resident in not practicable for resident's care plan (F) Other appropried disciplines as deteor as requested by (iii)Reviewed and ream after each as comprehensive an assessments. This REQUIREME by: Based on staff intereview, clinical record a complaint investive facility staff fail care plan to include safe transfer for or sample, Resident # physical therapist's mechanical lift or the transfer in and out was not available. The findings include Resident #1 was a 11/26/18, and mos 12/24/20, with diagram to the facility of the findings included to ESRD (end standialysis (2), history bipolar disorder (4) (5). On the most resident #1 was resident #1 was a findings included the findings included	racticable, the participation of the resident's representative(s) as the included in a resident's representative is determined the development of the remined the development of the remined by the resident's needs the resident. The resident revised by the interdisciplinary revised by the resident of the course of gation, it was determined that ed to revise the comprehensive the recommended method of the of six residents in the survey of the facility staff failed to 1's care plan to reflect a recommendation to use a complete a sliding board of bed when a mechanical lift	F 657	Coordinator/Designee will in-servi Interdisciplinary team on initiati revising care plans to include the status on all new admissions and change in residents transfer status will discuss transfer status of during utilization review meeting care plans will be revised as need 4. DON/Designee will randomly autilization review meeting admitted residents and of residents care plans twice weeks weeks then weekly for 3 weeks and monthly until facility reaches compliance. Results of these audilization individual process.	ie. The opment rice the ing and ransfer with a us. IDT hanges ing and ed. Idit 10 current by for 2 id then 100% its will mittee further	02-2021

STATEMENT AND PLAN (FOF DEFICIENCES OF CORRECTION	(X1) PROMIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(XZ) MULTIPLE CO A. BUILDING	ONSTRUCTION	((K3) D.A	TE SURVEY MPLETED
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	PROVIDER OR SUPPLIER BURY REHABILITATION	8 HEALTH CARE CENTER	1776	EET ADDRESS, CITY, STATE, ZIP CO CAMBRIDGE DRIVE HMOND, VA 23238		210512021
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	(assessment referent Resident #1 was concognitively impaired having scored sever interview for mental requiring the extension mobility, dressing, a was coded as being assistance of two states bathing. She was consitting to standing portion the lookback period. In a wheelchair. She was dialysis during the lookback period. In a wheelchair. She was dialysis during the lookback period. In a wheelchair was concognitively impaired in having scored six out interview for mental strequiring the extension mobility, transfers, drequiring the extension mobility. The was condependent on the assignment of the extension of the e	ded as being severely for making daily decisions, nout of 15 on the BIMS (brief status). She was coded as ive assistance of staff for bed and personal hygiene. She completely dependent on the aff members for transfers and ded as not moving from a sition, or as walking, during Her only mobility device was as coded as receiving okback period. ately prior to 12/16/20, a at with an ARD of 11/23/20, led as being severely for making daily decisions, at of 15 on the BIMS (brief status). She was coded as are assistance of staff for bed essing, and personal ded as being completely sistance of two staff and bathing. She was from a sitting to standing g, during the lookback lity device was a wheelchair. #1's PT (physical therapy) mmediately prior to 0, revealed, in part: "DC Pt (patient discharged to	F 657			

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 02/111/2021 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIVA (XZ) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (KB) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A BUILDING 495272 B. WING 02/05/2021 NAME OF PROVIDER OR SUPPLIER STIREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE CANTERBURY REHABILITATION & HEALTH CARE CENTER RICHMOND, VA 23238 SUMMARY STATEMENT OF DEFICIENCIES (0X40) IID PROVIDERS PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EXI) PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COME FINAN REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY F 657 Continued From page 27 F 657 term goal) Discontinue on 6/5/20 Pt will complete a sliding board transfer with minimal assistance X 1 for functional transfers in and OOB (out of bed when Hoyer lift not available) - Discharge Mod (moderate) to max (maximum) A (assistance) X1." A review of Resident #1's comprehensive care plan dated 9/23/20 revealed, in part: "I have an ADL (activities of daily living) self-care performance deficit......I require 1 person assist with transfers." This item was documented as being cancelled on 12/18/20. This care plan contained no information related to transfer by sliding board or mechanical lift for Resident #1. On 2/4/21 at 12:16 p.m., CNA (certified nursing assistant) #2 was interviewed. She stated she was familiar with Resident #1, and had worked with her many times prior to her leg fracture in December 2020. She stated that, as long has she had cared for Resident #1, Resident #1 had required two people to transfer her with a mechanical lift, and that she could not bear any weight on her legs. CNA #2 stated the resident could not be safely transferred by one person without a lift On 2/4/21 at 12:20 p.m., LPN #3 was interviewed. When asked how she knew how to safely transfer a resident, LPN #3 stated, "They usually have an actual order written. It should be in the plan of care."

On 2/4/21 at 12:33 p.m., OSM (other staff member) #5, an occupational therapist, was interviewed. She stated the physical therapist who had worked with Resident #1 in June 2020 was no longer working at the facility. She stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CUIA IDENTIFICATION NUMBER:	(X2) MULTIPLE OF	ONSTRUCTION	((K3) IDA	TTE SURVEY MPLETED
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	PRÖVIDER OR SUPPLIER BURY REHABILITATION	N & HEALTH CARE CENTER	117776	EET ADDRESS, CITY, STATE, ZIP CI CAMBRIDGE DRIVE HMOND, WA 23238		2/05/2021
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	she was familiar with her leg fracture. Os required a mechanic she was unable to be legs. On 2/4/21 at 3:33 pusupervisor, was intestaff know how to sastated, "We have it of MARs (medication at TARs (treatment addirector of operation (assistant director of the staff knew how at transferred. RN #1 splan of care." On 2/5/21 at 9:30 a.m. regional clinical director of rehab sen #3 stated the facility tell us about safe transfer directors of the staff knew how at transferred. RN #1 splan of care." On 2/5/21 at 9:30 a.m. regional clinical director of rehab sen #3 stated the facility tell us about safe transfer for Resi on the formed the floor staff religional clinical directors of the safe transfer for Resi on the floor staff religional clinical directors as the floor staff religional clinical directors of the safe transfer for Resi on the floor staff religional clinical directors as the floor staff religional clinical directors of the safe transfer for Resi on the floor staff religional clinical directors of the safe transfer for Resi on the floor staff religional clinical directors of the safe transfer for Resi on the safe transfe	th Resident #1's status prior to M #5 stated Resident #1 cal lift for transfers because pear any weight at all on her m., LPN #5, a shift previewed. When asked how afely transfer a resident, he can the care plans, in the administration records), and ministration records)." m., ASM #2, the regional s, and RN #1, the ADON in ursing) were asked how a resident should be safely tated, "It should be in the m., ASM #2, ASM #3, ctor, RN #1, and OSM #6, vices, were interviewed. ASM relies on the therapy staff to insfers. She stated the y important part of the team.	F 657			

STATEMENT AND PLAN O	OF DEFICIENCIES IF CORRECTION	(X1) PROVIDER/SUPPLIER/OLIA IDENTIFICATION INUMBER.	(XX) MULTIPLE (C	ONSTRUCTION	(EXI)	TE SURVEY WPUETED	
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	PROVIDER OR SUPPLIER BURY REHABILITATION	& HEALTH CARE CENTER	STIREET ADDRESS, CITY, STATE, ZIP GODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238				
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	morning meetings, a be updated. She state manager and educate communicating with the about what the residence recommendations for the state of the facility of	and then the care plan should led at that time, the unit ion staff should be the rest of the floor staff ent needed. ASM #3 stated an was not updated as it the therapist's transfers. If policy, "Safe Lifting and nets." revealed, in part: iity, comfort and medical reporated into goals and he safe lifting and moving of any of residents shall be iible. Nursing staff, in ehabilitation staff, shall dents' needs for transfer oing basis. Staff will ensferring and lifting needs hanical lifting devices shall any, including lifting and en necessary." If was provided prior to exit. disease (ESKD) is the last ronic) kidney disease. This can no longer support your age kidney disease is also disease (ESRD)." This	F 657				

STATEMENT AND PLAN C	OF IDEFICIENCIES OF CORRECTION	((X11) PROVIDER/SUPPLIER/CUIA IDENTIFICATION NUMBER:	((X2) MUUTIF A. BUILDING	LE CONSTRUCTION	(KS) DATE SURVEY COMPLETED
		495272	B. WING_		C 02/05/2024
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	your kidneys fail, you the work your kidney have a kidney trans treatment called dia types of dialysis. Bo your body of harmful water. Hemodialysis sometimes called ar go to a special clinic a week." This inform website https://medl (3) "Diabetes (mellith blood glucose, or blood gl	plant, you will need a lysis. There are two main with types fifter your blood to nid all wastes, extra salt, and is uses a machine. It is a artificial kidney. You usually is for treatments several times nation was taken from the ineplus.gov/dialysis.html. us) is a disease in which your god sugar, levels are too on is taken from the website gov/diabetes.html. (formerly called ness or manic depression) is at causes unusual shifts in the levels, concentration, and at day-to-day tasks." This from the website gov/health/topics/bipolar-dis as a body mass index (BMI) nized as an important risk or Disease Control and corted that obesity rates in sed dramatically over the last or is now epidemic in the 2009). For adults 60 years ence of obesity is about 37% among women (NHANES - Nutrition Examination to be further classified	F 65		

STATIENERIT OF DEFICIENCIES AND PLAN OF CORRECTION		(XXI) PROVIDER/SUPPLIER/CUIA ((XX) IDENTIFICATION NUMBER: A.E.		UE (COMSTRUCTION)		(XX) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER BURY REHABILITATION I	& HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238		/05/2021	
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F 657	This information is tak https://www.cms.gov/h	30.0-34.9 kg/m² 35.0-39.9 kg/m² pesity = BMI = 40.0 kg/m²"	F 657				
F 689 SS=D	moderate pain from he menstrual periods, col toothaches, backache vaccinations (shots), a Acetaminophen may a pain of osteoarthritis (a breakdown of the lining Acetaminophen is in a analgesics (pain reliev reducers). It works by senses pain and by coinformation is taken from https://medlineplus.gov.tml. Free of Accident Hazar CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure §483.25(d)(1) The residual free of accident hazar free of accidents. This REQUIREMENT by: Based on staff interview	s, and reactions to and to reduce fever. also be used to relieve the arthritis caused by the g of the joints). class of medications called ers) and antipyretics (fever changing the way the body oling the body." This om the website aldruginfolmeds/a681004.h ards/Supervision/Devices?) e that -dent environment remains ards as is possible; and ident receives adequate ance devices to prevent is not met as evidenced	F 689	F689 Free of Hazards/Supervision/Devices 1- Resident #1 care plan update appropriate transfer status not available. 2- Residents requiring trans mechanical lift have the pot affected by this alleged practice. Nursing Administr will collaborate with therapy residents in the facility th mechanical lift for appropria status when lift is unavailable 3- Safety and Supervision of Re reviewed, on 2-5-21, no revisi	when lift is sfers with ential to be I deficient ration team of to identify hat require ate transfer esidents policy		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(XX) MULTIPLE CONSTRUCTION A. BUILDING			(K3) DATE SURVEY COMPLETED	
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		& HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238 ID PROVIDER'S PLAN OF COR		DE	/05/2021	
PREFIX		OF MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI	IX (EACH CORRECTIVE ACTIO	IN SHOULD BE E APPROPRIATE	(MS) COMPLETION DATE	
	a complaint investigathe facility staff failed with assistive devices one of six residents in (Resident #1). On 12/transferred Resident wheelchair to her bedwere for the resident in mechanical lift or sliding mechanical lift was not the findings include: Resident #1 was admitted that the findings include: Resident #1 was admitted that the findings include: Resident #1 was admitted that the findings include: Resident #1 was admitted to ESRD (end stage ridialysis (2), history of bipolar disorder (4), ard (5). On the most recers a significant change as (assessment reference Resident #1 was code cognitively impaired for having scored seven of interview for mental start requiring the extensive mobility, dressing, and was coded as being consistence of two staff bathing. She was code sitting to standing position the lookback period. He a wheelchair. She was dialysis during the look. On the MDS immediate.	tion, it was determined that to ensure a safe transfer is to prevent accidents for in the survey sample, 16/20, a facility nurse 17. Therapy recommendations to be transferred by ing board when a obtavailable. Interest to the facility on executly readmitted on sees including, but not limited renal disease) (1) requiring a stroke, diabetes (3) and morbid (extreme) obesity int MDS (minimum data set), seessment with an ARD in the date) of 12/30/20, and as being severely in making daily decisions, but of 15 on the BIMS (brief atus). She was coded as a assistance of staff for bed in personal hygiene. She completely dependent on the members for transfers and an action, or as walking, during er only mobility device was coded as receiving aback period.	F	development coordinato nursing staff on Safety a of Residents policy and re care for appropriate trans 4- Unit Manager/Designed transfers of 9 residents per we until facility reaches 10 compliance with transl residents requiring ass transfers. Results of these brought forth to the QAPI review and further recomi	and Supervision viewing plan of sifer status. e will audit over week for 2 weeks 0% to ensure fer status of sistance with e audits will be committee for	03-02-2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/DU/ IDENTIFICATION NUMBER 495272		(X1) PROVIDER/SUPPLIER/CUPA IDENTIFICATION NUMBER	((X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATIE SURVEY COMPLETIED C	
		495272					
	PROVIDER OR SUPPLIER BURY REHABILITATIO	ON & HEALTH CARE CENTER	1776	EET ADDRESS, CITY, STATE, ZIP OO CAMBRIDGE DRIVE HMOND, VA 23238		2/05/2021	
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	Resident #1 was o cognitively impaire having scored six of interview for mental requiring the extensional properties of the contained on the amembers for toileting coded as not moving position, or as walk period. Her only moderate of the coded as not moving position, or as walk period. Her only moderate of the coded as not moving position, or as walk period. Her only moderate of functioning of the code of the c	oded as being severely d for making daily decisions, but of 15 on the BIMS (brief all status). She was coded as sive assistance of staff for bed dressing, and personal coded as being completely assistance of two staff and and bathing. She was and from a sitting to standing and, during the lookback abbility device was a wheelchair. In #1's PT (physical therapy) by immediately prior to by 20, revealed, in part: "DC by Pt (patient discharged to cong term care) o Maintain CLOF (current by a Good with consistent staff by requipment to Onset: w/chair by (mechanical) lift LTG (long and on 6/5/20 Pt will complete befer with minimal assistance X befers in and OOB (out of bed davailable) - Discharge Mod dimaximum) A (assistance) It #1's comprehensive care revealed, in part: "I have an	F 689				

OF DEFICIENCIES F CORRECTION	((X1) PROVIDER/SUPPLIER/CUIA IDENTIFICATION NUMBER:				(KS) DATE SURVEY COMPLETED	
	495272	B. WING_			02/05/2021	
ROVIDER OR SUPPLIER BURY REHABILITATION (& HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238		2/05/2021	
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revealed the following - 12/15/20 at 7:45 a.m bed. Awake and orien warm, dry, and pale. If No C/O (complaint of) - 12/15/2020 7:10 p.m Pathway. Vital Signs: scale: Numerical." - 12/16/2020 9:00 a.m Text: Resident in bed. and place. Skin warm, edematous (swollen), to Dialysis clinic this m to right arm given. Up in the right arm given. Up in 12/16/2020 7:10 p.m. Pathway. Vital Signs: f Numerical." - 12/17/2020 6:54 a.m. Text: 2 Tylenol (6) give continues to complain in 12/17/2020 11:27 a.m Entry: Note Text: Went ther get ready for dialys was not going to dialys thurting. Assessment of swelling to left leg. Resiscale of 1-10.' Medicate tylenol. Called MD (medicate ylenol. Called MD (medicate	progress notes: n. "Note Text: Resident in fed to self and place. Skin resp (respiration) unlabored. pain or discomfort." n. "Nursing Daily Skilled Pnl (Pain Level) 0Pain n. "Health Status Note. Note Awake and oriented to self dry, and pale. Right arm and bruised. Resident to go forning. Medication for pain in wheelchair." "Nursing Daily Skilled Pnl 0Pain scale: "Health Status Note. Note in at 6:50 ampatient in left leg at knee." n. "Health Status Note. Late into resident room to help is. Resident stated she is because her leg was leg showed some ident rated pain '3-4" on a ed with PRN (as needed) dical doctor) for orders to	F 6				
	ROVIDER OR SUPPLIER SURY REHABILITATION A SUMMARY STI (EACH DEFICIENCE REGULATORY OR II Continued From page revealed the following - 12/15/20 at 7:45 a.m. bed. Awake and orien warm, dry, and pale. r No C/O (complaint of) - 12/15/2020 7:10 p.m. Pathway. Vital Signs: scale: Numerical." - 12/16/2020 9:00 a.m. Text: Resident in bed. and place. Skin warm, edematous (swollen), to Dialysis clinic this m to right arm given. Up - 12/16/2020 7:10 p.m. Pathway. Vital Signs: If Numerical." - 12/17/2020 6:54 a.m. Text: 2 Tylenol (6) give continues to complain i - 12/17/2020 11:27 a.m. Entry: Note Text: Went her get ready for dialys was not going to dialys muting. Assessment of swelling to left leg. Res scale of 1-10.' Medicate ylenol. Called MD (med C-Ray leg. Order called C-ray company). RP (re Called dialysis center to Called dialysis center to	ROVIDER OR SUPPLIER SURY REHABILITATION & HEALTH CARE CENTIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 34 revealed the following progress notes: - 12/15/20 at 7:45 a.m. "Note Text: Resident in bed. Awake and oriented to self and place. Skin warm, dry, and pale. resp (respiration) unlabored. No C/O (complaint of) pain or discomfort." - 12/15/2020 7:10 p.m. "Nursing Daily Skilled Pathway. Vital Signs: Pnl (Pain Level) 0Pain scale: Numerical." - 12/16/2020 9:00 a.m. "Health Status Note. Note Text: Resident in bed. Awake and oriented to self and place. Skin warm, dry, and pale. Right arm edematous (swollen), and bruised. Resident to go to Dialysis clinic this morning. Medication for pain to right arm given. Up in wheelchair." - 12/16/2020 7:10 p.m. "Nursing Daily Skilled Pathway. Vital Signs: Pnl 0Pain scale: Numerical." - 12/17/2020 6:54 a.m. "Health Status Note. Note Text: 2 Tylenol (6) given at 6:50 ampatient continues to complain in left leg at knee." - 12/17/2020 11:27 a.m. "Health Status Note. Late Entry: Note Text: Went into resident room to help her get ready for dialysis. Resident stated she was not going to dialysis because her leg was nurting. Assessment of leg showed some swelling to left leg. Resident rated pain "3-4" on a scale of 1-10.' Medicated with PRN (as needed) ylenol. Called MD (medical doctor) for orders to C-Ray leg. Order called into [name of mobile C-ray company]. RP (responsible party) notified. Called dialysis center to inform them that resident	ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 34 revealed the following progress notes: - 12/15/20 at 7:45 a.m. "Note Text: Resident in bed. Awake and oriented to self and place. Skin warm, dry, and pale. resp (respiration) unlabored. No C/O (complaint of) pain or discomfort." - 12/15/2020 7:10 p.m. "Nursing Daily Skilled Pathway. Vital Signs: Pnl (Pain Level) 0Pain scale: Numerical." - 12/16/2020 9:00 a.m. "Health Status Note. Note Text: Resident in bed. Awake and oriented to self and place. Skin warm, dry, and pale. Right arm edematous (swollen), and bruised. Resident to go to Dialysis clinic this morning. Medication for pain to right arm given. Up in wheelchair." - 12/16/2020 7:10 p.m. "Nursing Daily Skilled Pathway. Vital Signs: Pnl 0Pain scale: Numerical." - 12/17/2020 6:54 a.m. "Health Status Note. Note Text: 2 Tylenol (6) given at 6:50 ampatient continues to complain in left leg at knee." - 12/17/2020 11:27 a.m. "Health Status Note. Late Entry: Note Text: Went into resident room to help her get ready for dialysis. Resident stated she was not going to dialysis because her leg was nurting. Assessment of leg showed some swelling to left leg. Resident rated pain "3-4" on a scale of 1-10.' Medicated with PRN (as needed) tylenol. Called MD (medical doctor) for orders to C-Ray leg. Order called into [name of mobile C-ray company]. RP (responsible party) notified. Called dialysis center to inform them that resident	### A. BUILDINIS ### ### A. BUILDINIS ### ### ### A. BUILDINIS ### ### ### A. BUILDINIS ### ### ### ### ### ### ### ### ### #	### ### ### ### ### ### ### ### ### ##	

PRINTED: 02/11/2021 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCES (IXII) PROVIDER/SUPPLIER/GUA (XZ) MULTIPLE CONSTRUCTION (KB) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED C 495272 B. WING 02/05/2021 NAME OF PROVIDER OR SUPPLIER STIREET ADDRESS, CITY, STATE ZIP CODE 1776 CAMBRIDGE DRIVE CANTERBURY REHABILITATION & HEALTH CARE CENTER RICHMOND, VA 23238 (0X41) IID) SUMMARY STATEMENT OF DEFICIENCIES 100 PROVIDER'S PLAN OF CORRECTION ((KS)) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREEK (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY F 689 Continued From page 35 F 689 - 12/17/2020 9:47 p.m. Health Status Note. Note Text: Received in report that pt (patient) began c/o (complain of) pain below L (left) knee last night after transferring from WC (wheelchair) to bed. Pt given Tylenol @ (at) 1822 (6:22 p.m.) and ice applied to site...Pt screams if leg is moved at all. Received call from radiology that pt has L (left) proximal tibia (leg) fx (fracture). Called MD on call. Per [name of physician] send pt to [local hospital] for evaluation. Pt, [RP], DON (director of nursing), and unit manager notified of

Tylenol."

Numerical."

transportation to ED [emergency department]."

- 12/18/2020 4:46 p.m. "Nursing Daily Skilled Pathway. Vital Signs: Pnl 7....Pain scale:

- 12/19/2020 7:47 a.m. "MD Progress Note. Note Text: ER f/u (follow up)...Pt had a fall and was seen at [local hospital] on 12/17 for a proximal tibial fx. Pain is well controlled. She is to f/u

On 2/4/21 at 11:34 a.m., ASM (administrative staff member) #4, the resident's attending physician, was interviewed. When asked about the note she wrote on 12/19/20 stating Resident #1 "had a fall," ASM #4 stated, "I know nothing [about the fall]. It was just what I was told in report. Probably the nurses told me." She stated the word 'fall' was a word she uses regularly. "Nursing home residents fall all the time." She

(follow up) with ortho next wk."

 12/18/2020 4:34 a.m. "Health Status Note. Note Text: Resident returns to unit from [hospital] with diagnosis of Left fractured knee Vital Signs stable resident rates her pain at an 8 and is given pro

STATEMENT AND PLAN (OF DEFICIENCIES OF CORRECTION	(XXII) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION	(X3) DATE		
		495272	B. WING				
	PROVIDER OR SUPPLIER BURY REHABILITATION	& HEALTH CARE CENTER	STIREET ADDRESS, CITY, STATE, ZIP CODE 17776 CAMBRIDGE DRIVE RICHMOND, VA 23238			02/05/2021	
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	stated she did not kind any circumstances sure of the control of t	ow how the resident fell, or unrounding the fall. m., RN (registered nurse) #3 en asked how Resident #1 sferred prior to the broken 17/20, RN #3 stated, "A stated, "A stated, "A stated if Resident was able to bear any weight d, "No. None whatsoever." ew how Resident #1's leg stated when she came in for she was told the resident pain. She stated she went om to assess her. She in the resident, and the aming from pain." She ave the resident receive an came back on her shift. RN hat the resident had a sed if she specifically knew had been broken, RN #3 ding is that it was a one e wheelchair to the bed. Used. [LPN (licensed lit." a., CNA (certified nursing viewed. She stated she ent #1, and had worked ior to her leg fracture in tated that, as long has she #1, Resident #1 had	F 689				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER.		AS TOUR STREET, MAN	(%3) MULTIPLE CONSTRUCTION A. BUILDING		
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(IX4) IID PIREHIX TIAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF OR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE IDEFICIENCY)	IN SHOULD BE COMPLETION DATE
F 689	When asked how she a resident, LPN #3 str		F 68	9	
	interviewed. She state who had worked with was no longer working she was familiar with her leg fracture. She sa mechanical lift for traunable to bear any we	m., OSM (other staff pational therapist, was ed the physical therapist Resident #1 in June 2020 g at the facility. She stated Resident #1's status prior to stated Resident #1 required ansfers because she was eight at all on her legs. She we how Resident #1's leg			
	staff know how to safe #5 stated, "We have it MARs (medication adr TARs (treatment admistated if the resident hithere should always be used as a reference ways to access the EM record) and can see the first of the remembered transher wheelchair to her to 12/16/20, LPN #5 state chair. I am strong and I picked her up, and the When asked if her leg positioned inappropria	iewed. When asked how ely transfer a resident, LPN on the care plans, in the ministration records), and nistration records)." He as been newly admitted, e hospital records that can e. He stated all staff have MR (electronic medical ansfer orders. When asked sferring Resident #1 from bed on the evening of ed, "Yes. She was in the hefty. I got her to stand up. en I set her in the bed."			

AND PLAN OF CORRECTION		(XT) PROVIDER/SUPPLIER/CUIA IDENTIFICATION NUMBER: 495272	(XZ) MULDI A. BUILDI B. WING	TIPLE CONSTRUCTION	(KR) DATE SURVEY COMPLETED C
CANTER		ON & HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP C 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	02/05/2021 CODE
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ti ti	fracture, Resident is weight on her legs. stood up for me. As could get her in the a shift supervisor, the stated he could not were short staffed." I just the time." When it resident should have stated, "Right now. On 2/4/21 at 4:31 p. director of operation (assistant director of operation (assistant director of the staff knew how attransferred. RN #1 splan of care." On 2/5/21 at 9:30 a. regional clinical director of rehab ser #3 stated she had splan of 2/4/21, and the timesident sometimes when asked if that no bear weight, but contained the trust level of the trust level of the trust level of the resident staff member 2 stated, "We rely of the residents 24 hour hat a CNA familiar weight as the contained and the trust level of the residents 24 hour hat a CNA familiar weight.	ith the therapist and other staff I said that, prior to her leg I said that, prior to her leg I was unable to bear any LPN #5 stated, "Well she and she kind of pivoted so I bed." When asked why he, as ransferred a resident, he remember, but "felt like we When asked if he consulted visician orders or any other re he transferred Resident #1, st did the only thing I could do asked if he knows how the re been transferred, LPN #5	IF 6		

FORM APPROVED CENTIERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATISMENT OF DEFICIENCIES (0K11) PIROVIDER/SUPPLIER/CUIA (XZ) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER COMPLETED A BUILDING C MOSTO B. WING 02/05/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE ZIP CODE 1776 CAMBRIDGE DRIVE CANTERBURY REHABILITATION & HEALTH CARE CENTER RICHMOND, VA 23238 SUMMARY STATEMENT OF DEFICIENCIES (0X40) IID PROVIDER'S PLAN OF CORRECTION (%5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TIAG DATE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 689 | Continued From page 39 F 689 Resident #1 could not bear weight on her legs. and always required a mechanical lift for transfers, none of the interviewees commented. RN #2 stated, "We do not need an order to use a [mechanical] lift." ASM #3 stated the facility relies on the therapy staff to tell us about safe transfers. She stated the therapy staff is a very important part of the team, and the floor staff rely on therapy recommendations for a safe transfer for all residents. OSM #6 was asked to review the 6/6/20 PT Discharge Summary referenced above. When asked what this document says about a safe transfer for Resident #1 prior to 12/16/20. she stated, "To use a [mechanical] lift. That was [the physical therapist's] recommendation to be used at all times." When asked the process for communicating the therapist's recommendation for a safe transfer to all staff caring for a resident, ASM #3 stated the therapist's evaluations and recommendations should be discussed at the morning meetings, and then the care plan should be updated. She stated at that time, the unit manager and education staff should be communicating with the rest of the floor staff about what the resident needed. She stated Resident #1's care plan was not updated as it should have been with the therapist's recommendations for transfers. When asked if Resident #1 was safely transferred by LPN #5 on 12/16/20, ASM #2 and ASM #3 stated, "No. She was not." A review of the facility policy, "Safe Lifting and Movement of Residents," revealed, in part: "Resident safety dignity, comfort and medical condition will be incorporated into goals and decisions regarding the safe lifting and moving of

residents. Manual lifting of residents shall be eliminated when feasible. Nursing staff, in

PRINTED: 02/11/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(XII) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(XZ) IMIULI (A. (BLUILIOI	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER BURY REHABILITATION	& HEALTH CARE CENTER	STIREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, WA 23238		02/05/2021 CODE
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	conjunction with the assess individual resassistance on an one document resident trin the care plan Me be used for heavy lift moving residents who have a kidney stage of long-term (c) is when your kidneys body's needs. End-st called end-stage renainformation is taken finttps://medlineplus.go. (2) "When your kidney your blood. They also your bones strong an your kidneys fail, you the work your kidneys have a kidney transplit treatment called dialystypes of dialysis. Both your body of harmful water. Hemodialysis usometimes called an ago to a special clinic for a week." This informative is informative website https://medlinesolood.	rehabilitation staff, shall sidents' needs for transfer going basis. Staff will ansferring and lifting needs chanical lifting devices shall ting, including lifting and en necessary." In was provided prior to exit. In was	F6	589	

	ENIT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIFILE CONSTRUCTION (X2) MULTIFILE (X2)		TACI (EX)	TE SURVEY			
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	PROVIDER OR SUPPLIER BURY REHABILITATION (B HEALTH CARE CENTER	STREET ADDRESS, OITY, STATE, ZIP CODE 177/6 CAMBRIDGE DRIVE RICHMOND, VA 23238				
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F 689	a mental disorder that mood, energy, activity the ability to carry out information is taken fr	ess or manic depression) is causes unusual shifts in levels, concentration, and day-to-day tasks." This	F 689				
	= 30 kg/m2, is recognificator. The Centers for Prevention (CDC) reporting U.S. have increased 30 years, and obesity United States (Kahn, 2 and older, the prevaled	orted that obesity rates in ed dramatically over the last is now epidemic in the 2009). For adults 60 years note of obesity is about 37% among women (NHANES - utrition Examination					
	This information is take https://www.cms.gov/n	35.0-39.9 kg/m² esity = BMI = 40.0 kg/m²"					
	moderate pain from he menstrual periods, col- toothaches, backaches vaccinations (shots), a Acetaminophen may a pain of osteoarthritis (a breakdown of the lining Acetaminophen is in a	s, and reactions to nd to reduce fever. Iso be used to relieve the arthritis caused by the					

	OF DEFICIENCIES FOORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		((X2) MULTIPLE CONSTRUCTION A. BUILDING	
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NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	02/05/2021
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((%4) IID IPREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FUUL SC IDENTIFYING INFORMATION)	IID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 689	reducers). It works by senses pain and by crinformation is taken from https://medfineplus.go.tml.	changing the way the body poling the body." This	F 689		
SS=E	S483.25(I) Dialysis. The facility must ensurequire dialysis receive with professional standomprehensive person the residents' goals and This REQUIREMENT by: Based on staff interview, clinical record a complaint investigating the facility staff failed to services for one of six sample, Resident #1. ensure Resident #1 reby the physician on 1/5 assessment of Resider and failed to provide in regarding use of the resident #1 was admitted to the provide in the findings include: Resident #1 was admitted to the sample of the resident #1 was admitted to the physician of the resident #1 was admitted to the physician of the resident #1 was admitted to the physician of the resident #1 was admitted to the physician of the resident #1 was admitted to the physician of the resident #1 was admitted to the physician of the physician of the physician was admitted to the physician of the physicia	e such services, consistent dards of practice, the n-centered care plan, and ad preferences. is not met as evidenced ew, facility document review, and in the course of on, it was determined that o provide dialysis care and residents in the survey. The facility staff failed to ceived dialysis as ordered 6/21; failed to provide for int #1's dialysis access site, istructions to clinical staff sident's right arm for all of ted to the facility on ently readmitted on es including, but not limited enal disease) (1) requiring	F 698	Licensed Nursing Staff on Hemod	ite and ifected ive the illeged iration is for orders ments, lialysis signs, ewed, it this oment ervice ialysis ialysis ialysis ialysis ialysis rs are ialysis vital emity. eceive linical for to iclude

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	PROVIDER OR SUPPLIER BURY REHABILITATION	& HEALTH CARE CENTER	17	TREET ADDRESS, CITY, STATE, ZIP CODE 176 CAMBRIDGE DRIVE ICHMOND, VA 23238		02/05/2021
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F 698	a significant change a (assessment reference Resident #1 was code cognitively impaired if having scored seven interview for mental strequiring the extensive mobility, dressing, and was coded as being consistance of two staft bathing. She was code sitting to standing post the lookback period. It a wheelchair. She was dialysis during the lookback period. It a wheelchair. She was dialysis during the survey. She appointment. A review of Resident if the following physician "Dialysis T-Th-Sat (Tu (name of community day every Tue (Tuesda (Saturday)." The order Further review of Resident #1's dialysis blank. A review of Resident #1's dialysis that of Resident representations.	assessment with an ARD be date) of 12/30/20, ed as being severely for making daily decisions, out of 15 on the BIMS (brief tatus). She was coded as re assistance of staff for bed dipersonal hygiene. She completely dependent on the fill members for transfers and led as not moving from a sition, or as walking, during her only mobility device was as coded as receiving likback period. The clinical record revealed in order dated 11/19/20: lesday, Thursday, Saturday) lialysis center] one time a lay), Thu (Thursday), Saturdid not have a stop date. In did not have a stop date. In dent #1's clinical record ment administration record) che documented the above lialysis. The box for treatment on 1/5/21 was lident #1's nurses' notes for vidence that Resident #1 day, or that her physician or	F 698	dialysis access site and restrict vital signs/needlesticks to extremity. 4- DON/Designee will audit communication forms and admission orders 5 days a weeks, 3 days a week for 4 weeks, 3 days a week for 4 wensure residents receiving dialy appropriate physician order communication with physicians centers and responsible party.	Dialysis New ek for 2 veeks to sis have s and	: 03-02-2021

PRINTED: 02/11/2021 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATIEMENT OF DEFICIENCIES (XII) PROVIDER/SUPPLIER/CUIA (XZ) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND FLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 495272 B. WING 02/05/2021 NAME OF PROVIDER OR SUPPLIER STIREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE CANTERBURY REHABILITATION & HEALTH CARE CENTER RICHMOND, VA 23238 (X4) IID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION TOAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 698 Continued From page 44 F 698 for staff for the assessment of Resident #1's dialysis access site (AV [arteriovenous] fistula) in her right arm, or for the staff not to use Resident #1's right arm for blood pressures, blood draws, or IV (intravenous) access. The TAR for January 2021 contained no documentation regarding these assessments or directives. A review of Resident #1's comprehensive care plan dated 9/23/20 revealed, in part: "I need dialysis...Check and change dressing daily at access site. Document." On 2/4/21 at 11:29 a.m., RN (registered nurse) #3 was interviewed. RN #3 was asked what it means when a resident's TAR with documented physician orders for dialysis is blank on a day the resident should have received dialysis. RN #3 stated it must mean the resident did not receive dialysis that day. When asked what she would include on daily basis in documentation for a resident who received dialysis, RN #3 stated she would sign the dialysis off on the TAR, and she would write a progress note stating the resident had been out for dialysis. When asked what facility assessments should be done for residents receiving dialysis, RN #3 stated, "We should be checking for bruit and thrill (vibration in the access site) (7) and whether it's showing any signs of infection." When asked if staff should be aware of which arm is used for dialysis, she stated it is important not to use the arm with dialysis access for blood pressures or IV sticks. When asked why this is important, RN #3 stated,

"We don't want to do anything to ruin that

On 2/4/21 at 12:01 p.m., LPN (licensed practical nurse) #2, a unit manager, was interviewed.

PRINTED: 09/11/2021 FORM APPROVED CENTIERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES ((X1)) IPROVIDER/SUPPLIER/CLIA (XZ) MULTIPLE CONSTRUCTION (KB) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 495272 B. WING 02/05/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE CANTERBURY REHABILITATION & HEALTH CARE CENTER RICHMOND, VA 23238 ((米4))间 SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX COMPLETION TUNG REGULATORY OR USC IDENTIFYING INFORMATIONA TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 698 Continued From page 45 F 698 When asked what it means when a resident's TAR is blank on a day the resident should have received dialysis, LPN #2 stated, "If it's not documented, it's not done." He stated the nurse should write a note saying something about a resident being out for dialysis. When asked about assessments the facility staff conduct for resident who receive dialysis, LPN #2 stated, "We should be looking for bleeding, infection, bruit, and thrill." When asked if there should be orders or instructions for which arm to use for blood pressures and IV sticks, LPN #2 stated, "Yes, absolutely." When asked if he could locate any such assessments or orders for Resident #1 in January 2021, LPN #2 stated he could not. On 2/4/21 at 12:20 p.m., LPN #2, who worked with Resident #1 on 1/5/21, was interviewed. When asked if she remembered whether or not Resident #1 received dialysis on 1/5/21, LPN #2 stated it was too long ago for her to remember. When asked about assessments and documentation for residents receiving dialysis, LPN #2 stated, "I usually write a note." When asked what assessments she performs on residents receiving dialysis, she stated: "I quess vital signs before they go, and when they get back." When asked if she knew of any restrictions regarding the use of the same arm in which a resident receives dialysis, LPN #2 stated, "I think blood pressures. We are supposed to use the other arm for blood pressures." On 2/4/21 at 2:20 p.m., LPN #4 was interviewed. When asked what assessments should be completed for residents who receive dialysis. LPN

#4 stated, "The dialysis site, infection, patency. What their blood pressure is. If they have bruit and thrill." When asked where that assessment is

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(XZ) MULTIPLE O	ONSTRUCTION	(K3) DATE SURVEY COMPLETED
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	member) #2, the regice and RN #1, the assist (ADON) were informe. On 2/5/21 at 9:30 a.m. #3, the regional direct interviewed. ASM #3 stidentified that there has or assessments for Resiste and right arm during stated she had already this deficiency. A review of the facility with End-Stage Renal. "Staff caring for resident residents receiving dial facility, shall be trained needs of these resident of staff includes, specific assessment data that is resident's condition on basisthe care of graft. No further information of the stage of long-term (chrosis when your kidneys capacity's needs. End-stage called end-stage renal conformation is taken from	ed, "On the TAR." ASM (administrative staff onal director of operations, ant director of mursing d of these concerns. ASM #2, RN #1, and ASM or of clinical services, were stated she had already and not been required orders esident #1's dialysis access any January 2021. She y begun steps to correct policy, "Care of A Resident Disease," revealed, in part: ints with ESRD, including lysis care outside the lin the care and special sts. Education and training fically The type of s to be gathered about the a daily or per shift is and fistulas." was provided prior to exit. Ilisease (ESKD) is the last onic) kidney disease. This am no longer support your se kidney disease is also disease (ESRD)." This	F 698		

CENTERS FOR MEDICARE & MEDICAID SERVICES

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San San Principal Control of Cont	ROVIDER OR SUPPLIER BURY REHABILITATION	& HEALTH CARE CENTER	STREET ADDRESS, OITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238				
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F 698	Continued From page		F 69	98			
	your blood. They also your bones strong an your kidneys fail, you the work your kidneys have a kidney transpl treatment called dialy types of dialysis. Both	sis. There are two main types filter your blood to rid wastes, extra salt, and					
	sometimes called an go to a special clinic f a week." This informa	artificial kidney. You usually or treatments several times tion was taken from the eplus gov/dialysis.html.					
	blood glucose, or bloo	 is a disease in which your of sugar, levels are too n is taken from the website ov/diabetes.html. 					
	a mental disorder that mood, energy, activity the ability to carry out information is taken fr	ess or manic depression) is causes unusual shifts in levels, concentration, and day-to-day tasks." This					
	= 30 kg/m2, is recognificator. The Centers for Prevention (CDC) reported U.S. have increased 30 years, and obesity United States (Kahn, 2) and older, the prevale	is a body mass index (BMI) ized as an important risk in Disease Control and corted that obesity rates in ed dramatically over the last is now epidemic in the 2009). For adults 60 years ince of obesity is about 37% among women (NHANES -					

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	National Health an Survey). Obesity maccording to the NI Class II Obesity = I Class II Obesity = I Class III (Extreme) This information is https://www.cms.gre/details/nca-trackiomdb=true. (6) "The best type of fistula. A surgeon cousually in your arm, artery is a blood veriform your heart. An carries blood back is surgeon connects a grows wider and this the needles for dialy large diameter that and back into your trained back into your access with soap and Check the area for swarmth or redness. It through your access well, you can feel a syour dialysis center in the property of t	id Nutrition Examination hay be further classified IH: BMI 30.0-34.9 kg/m² BMI 35.0-39.9 kg/m² Obesity = BMI = 40.0 kg/m²° taken from the website ow/medicare-coverage-databas ng-sheet.aspx?NCAld=258&fr of long-term access is an AV connects an artery to a vein, to create an AV fistula. An ssel that carries blood away vein is a blood vessel that toward your heart. When the an artery to a vein, the vein icker, making it easier to place lysis. The AV fistula also has a allows your blood to flow out body quickly. The goal is to w so that the largest amount brough the dialyzer." This from the website iih.gov/health-information/kidn	F 698				

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	OF DEFICIENCIES IF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(XX) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER BURY REHABILITATION	& HEALTH CARE CENTER	11	STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE SICHMOND, VA 23238	1	
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	ey-disease/kidney-fai Resident's Care Supi CFR(s): 483.30(a)(1) §483.30 Physician Se A physician must pen recommendation that a facility. Each reside care of a physician. assistant, nurse pract specialist must provid immediate care and r §483.30(a) Physician The facility must ensu §483.30(a)(1) The me is supervised by a ph §483.30(a)(2) Anothe medical care of reside physician is unavailab This REQUIREMENT by: Based on staff intervi review, clinical record a complaint investigat the facility failed to en ordered required dialy one of six residents in Resident #1. The facil assessment of Reside and failed to provide i	a.gov/health-information/kidn illure/hemodialysis. ervised by a Physician (2) ervices sonally approve in writing a an individual be admitted to ent must remain under the A physician, physician itioner, or clinical nurse de orders for the resident's needs. Supervision. The physician supervises the ents when their attending ole. The is not met as evidenced lew, facility document review, and in the course of ion, it was determined that sure the attending physician resis care and services for	F 698	F710 Resident's Care Supervises Physician - Physician's Services 1- Physician orders obtained for Resider assessment of dialysis access sit restrictions related to signs/needlesticks in affected extremi 2- Residents receiving dialysis services has potential to be affected by this adeficient practice. Clinical Administ team reviewed physician order residents receiving dialysis were revorders updated as needed to it assessment of dialysis access sitt restrictions related to signs/needlesticks to affected extremi 3- Hemodialysis Access Care Previewed, on 2-5-21, no revisinecessary at this time. Development Coordinator/Designees in-service Licensed Nursing Staff Hemodialysis Access Care Policy Dialysis communication forms to en orders are obtained for dial monitoring of dialysis access site restrictions for vital signs/needlest to affected extremity. Newly admiresidents that receive dialysis servicely will be reviewed in Clinical Meeting of Monday through Friday to ensibility be reviewed in Clinical Meeting of Monday through Friday to ensibility of the plays orders are in place to inclinicallysis access site and restrictions vital signs/needlesticks to affected signs/needlesticks signs/needlesticks to affected signs/needles	at 1 for e and vitals ity. eve the alleged tration s for iewed, nclude e and vital ity folicy sions Staff e will on and sure ysis, and ticks tted frices daily sure ude ring for	

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CANTER		& HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, WA 23238		
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i i i i i i i i i i i i i i i i i i i	Resident #1 was adm 11/26/18, and most in 12/24/20, with diagnot to: ESRD (end stage dialysis (2), history of bipolar disorder (4), a (5). On the most rece a significant change a (assessment reference Resident #1 was code cognitively impaired in having scored seven interview for mental s requiring the extensive mobility, dressing, and was coded as being of assistance of two stafe bathing. She was code sitting to standing pose the lookback period. He a wheelchair. She was dialysis during the look Resident #1 was unave during the survey. She appointment. A review of Resident # the following physician 'Dialysis T-Th-Sat (Tue name of community di day every Tue (Tuesda Saturday)." The order Further review of Resident Further review of Resident sessesment of Resider Further review of Resider	mitted to the facility on ecently readmitted on oses including, but not limited renal disease) (1) requiring a stroke, diabetes (3) and morbid (extreme) obesity and Morbid (extreme) obesity and MOS (minimum data set), assessment with an ARD oc date) of 12/30/20, and as being severely or making daily decisions, out of 15 on the BIMS (brief tatus). She was coded as a assistance of staff for bed dipersonal hygiene. She completely dependent on the fill members for transfers and an anot moving from a action, or as walking, during aller only mobility device was a coded as receiving a coded a	F 710	extremity. Medical Director wi informed during QAPI meeting an educate all Physicians and extende the need for dialysis site care order 4- DON/Designee will audit Di communication forms and admission orders 5 days a week weeks, 3 days a week for 4 wee ensure residents receiving dialysis appropriate physician orders communication with physicians/di centers and responsible party.	nd will ers of rs. ialysis New for 2 eks to have and

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F 710	to use Resident #1's in pressures, blood draw access. The TAR for documentation regard directives. A review of Resident in plan dated 9/23/20 re	ight arm for blood vs, or IV (intravenous) January 2021 contained no ling these assessments or #1's comprehensive care vealed, in part: "I need	F	710			
	On 2/5/21 at 10:40 a.i staff member) #4, who physician, was intervitorders should be in placetives dialysis. ASM dialysis." When asked include anything relate fistula, or directives for	thange dressing daily at at." m., ASM (administrative of is Resident #1's attending ewed. When asked what ace for a resident who if those orders should ed to assessment of the restaff not to use the arm or blood pressures or blood					
	draws, ASM #4 stated should be in place." S receiving dialysis "eve dialysis centers are tall assessments. ASM #4 pressures and blood of hospitals," adding, "I'v posted in the rooms in nursing homes don't di "What you're asking all for nursing homes." On 2/5/21 at 9:30 a.m.	"None of those things he stated residents are ry other day," so the king care of the stated the issue of blood raws only applies to "the e only seen those signs the hospitals. These o that." ASM #4 stated, bout is for the hospitals, not					
	director of clinical servicencern. ASM #3 state	the ADON (assistant and ASM #3, the regional ices, were informed of this					

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	OF IDERICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(XX) MULTIPLE C	ONSTRUCTION	((K3)) (DAT	VO. 0938-039 TE SURVEY WPLETED
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	PROVIDER OR SUPPLIER BURY REHABILITATION (8. HEALTH CARE CENTER	177	GET ADDRESS, CITY, STATE, ZIP CODE 6 CAMBRIDGE DRIVE HMOND, VA 23238		2/05//2021
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F710	or assessments for Resite and right arm during stated she had alread this deficiency. ASM # responsible for having these items for resider dialysis. A review of the facility	esident #1's dialysis access ing January 2021. She ly begun steps to correct f3 stated the facility is the correct orders for	F 710			
	"Staff caring for reside residents receiving dia facility, shall be trained needs of these resider of staff includes, speci	ents with ESRD, including alysis care outside the d in the care and special and training ficallyThe type of is to be gathered about the a daily or per shift				
	each resident is under Licensed PhysicianTi physician participates i assessment and care p changes in resident's in consultation or treatme facility, and overseeing the resident." No further information verseeing the distance of long-term (chrois when your kidneys care is when your kidneys care in the case of long-term (chrois when your kidneys) and long-term (chrois when your kidneys).	part: "The medical care of the supervision of a he resident's attending in the resident's olanning, monitoring nedical status, providing int when called by the a relevant plan of care for was provided prior to exit. Isease (ESKD) is the last onic) kidney disease. This is no longer support your e kidney disease is also				

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CUIA IDENTIFICATION NUMBER.		(XZ) MULTIPLE A. BUILDING_	CONSTRUCTION	((KS) DATE SURVEY COMPLETED		
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F 710	imformation is taken https://medfineplus (2) "When your kid your blood. They a your bones strong your kidneys fail, you the work your kidneys fail, you the work your kidney transtreatment called distypes of dialysis. Be your body of harming water. Hemodialysis sometimes called a go to a special clinical week." This information website https://medineplus (3) "Diabetes (melliplood glucose, or be high." This information is information depressive if a mental disorder the ability to carry of information is taken https://www.nimh.norder/index.shtml. (5) "Obesity, define = 30 kg/m2, is reconfactor. The Centers Prevention (CDC) of the U.S. have incression years, and obes	in from the website i.gov/ency/article/000500.htm. Ineys are healthy, they clean iso make hormones that keep and your blood healthy. When ou need treatment to replace eys used to do. Unless you splant, you will need a alysis. There are two main oth types filter your blood to rid ul wastes, extra salt, and is uses a machine. It is an artificial kidney. You usually of for treatments several times mation was taken from the flineplus.gov/dialysis.html. tus) is a disease in which your lood sugar, levels are too tion is taken from the website gov/diabetes.html. or (formerly called finess or manic depression) is not causes unusual shifts in vity levels, concentration, and out day-to-day tasks." This	F 710			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(XZ) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
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BACK A CONTRACTOR	PROVIDER OR SUPPLIER RBURY REHABILITATION	& HEALTH CARE CENTER	1177	REET ADDRESS, CITY, STATE, ZIP CODE 75 CAMBRIDGE DRIVE CHMOND, VA 23238	02/05/2021
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F 710	and older, the preval among men and 34% National Health and Survey). Obesity ma according to the NIH Class I Obesity = BM Class II Obesity = BM Class III (Extreme) O This information is ta https://www.cms.gov.e/details/nca-tracking omdb=true.	lence of obesity is about 37% among women (NHANES - Nutrition Examination y be further classified : If 30.0-34.9 kg/m² All 35.0-39.9 kg/m² All about the website approximation of the website coverage-databas approximation in the website approximation of the website approxima	F710		
F 880 SS=D	fistula. A surgeon con usually in your arm, to artery is a blood vess from your heart. A vei carries blood back too surgeon connects an grows wider and thick the needles for dialysi large diameter that all and back into your boo allow high blood flow so of blood can pass throinformation is taken from https://www.niddk.nih.ey-disease/kidney-failunfection Prevention & CFR(s): 483.80(a)(1)(3) §483.80 Infection Continue facility must established in provide a stage of the provide a stage of the surgeon of the surgeo	gov/health-information/kidn ure/hemodialysis. Control 2)(4)(e)(f) trol lish and maintain an id control program	F 880	1. The facility was unable to retroal correct the Recreation Aide #7 related Handwashing and Hand Hygiene Recreation Aide #7 was suspepending further investigation terminated on 2/8/2021 due to hip past and ongoing education and it to follow the facility policy on washing and hand hygiene.	ated to . The ended and naving

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F 880	development and trandiseases and infection program. The facility must estal and control program (a minimum, the follow \$483.80(a)(1) A syste reporting, investigating and communicable distaff, volunteers, visitor providing services und arrangement based upconducted according accepted national stall \$483.80(a)(2) Written procedures for the probut are not limited to: (i) A system of surveill possible communicable disease in the facility; (ii) When and to whom communicable disease reported; (iii) Standard and transto be followed to preven the procedures in the facility; (iii) When and to whom communicable disease reported; (iii) Standard and transto be followed to preven the procedure; (iv) When and how iso resident; including but (A) The type and duradepending upon the inivolved, and (B) A requirement that	prevention and control blish an infection prevention IPCP) that must include, at a ring elements: In for preventing, identifying, and controlling infections seases for all residents, and other individuals der a contractual pon the facility assessment to §483.70(e) and following indards; Istandards, policies, and agram, which must include, all ance designed to identify the diseases or can spread to other In possible incidents of e or infections should be used for a not limited to:	F 88	3.	provide education to facility staff of Policy and Procedures for hand was and hand hygiene, including dorand doffing of personal prote equipment. Facility staff will per competencies for hand was donning and doffing of PPE with emphasis on return demonstration hand hygiene. Root Cause Analysis completed on 2-18-21 to determine all facility staff would be provadditional education with a redemonstration to ensure processing the processing of	to n the shing naining ective form hing, h an as on as was e that wided eturn roper to eekly hand of widing nittee upon	03-02-2021

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	(v) The circumstand must prohibit employed disease or infected contact with resident contact will transmit (vi) The hand hygien by staff involved in contact will transmit (vi) The hand hygien by staff involved in contact will transmit (vi) The hand hygien by staff involved in contact will enter the corrective actions to \$483.80(a)(4) A systidentified under the corrective actions to standard transport linens so a infection. §483.80(a)(4) A systidentified under the facility will conduit transport linens so a infection. §483.80(f) Annual restriction. §483.80(f) Annual restriction.	prese under which the facility by es with a communicable skin lesions from direct and the lesions from direct at the disease; and the procedures to be followed direct resident contact. Item for recording incidents facility's IPCP and the liken by the facility. Idle, store, process, and as to prevent the spread of the lesion and as to prevent the spread of the lesion and the lesion control at the spread of infection and the spread of the spread of infection and the spread of the spread of infection and the spread to wash her hands residents' curtains and while serving beverages on 2/2/21.	F 880			

PRINTED: 02/11/2021 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DERICIENCIES (X1)) PROVIDERISUPPLIERICHA (X2) MULTIPLE CONSTRUCTION (MS) DATE SURWEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER COMPLETED A BUILDING 495272 IR WING 02/05/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, OITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE CANTERBURY REHABILITATION & HEALTH CARE CENTER RICHMOND, VA 23238 SUMMARY STATEMENT OF DEFICIENCIES (X4) (D) PROVIDER'S PLAN OF CORRECTION (OKS) PRIFICK (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION REGULATORY OR USC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 880 | Continued From page 57 F 880 gown, face mask and face shield. She was not wearing gloves, and she delivered a newsletter to a resident. She touched the resident's overbed table and privacy curtain. She exited room #217, removed her gown, but did not sanitize her hands. OSM #7 picked up a newsletter from her cart, and took into room #218. She touched the privacy curtain and overbed table. When she exited the room, she did not sanitize her hands. She pushed her cart, containing newsletters and supplies for making cups of hot tea for the residents, on to the adjacent hallway (Hallway A) on Westham. Without putting on gloves, she delivered a newsletter to the resident in room #211. She touched the resident's overbed table. When she exited the room, she did not sanitize her hands. She again touched the cart handle as she rolled the cart further down the hallway. She picked up a newsletter and delivered it to a resident in room #210. She returned to her cart, picked up a rack containing various types of tea bags, and brought the rack into room #210. OSM #7 showed the rack with tea bags to the resident. and then returned the rack to the cart. Without wearing gloves, she made a cup of hot tea and gave it to the resident in room #210. She did not sanitize her hands when she exited room #210. On 2/2/21 at 11:00 a.m., OSM #7 was interviewed. When asked what kinds of things she was doing to prevent the spread of infection from resident to resident, she stated she was wearing a mask and face shield, and that sometimes she also wore an isolation gown into a

resident's room. OSM #7 stated, "I don't need gloves." OSM #7 was asked when she should wash her hands. OSM #7 stated, "I wash hands after every resident." When asked if she was aware that she had been observed for

STATEMENT OF IDEFICIENCIES AND PLAN OF CORRECTION		(X11) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(XZ) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED C		
		495272	B. WING_	02/05/2021			
	PROVIDER OR SUPPLIER BURY REHABILITATIO	N & HEALTH CARE CENTER	STIRBET ADDRESS, CITY, STATE, ZIP CODE 1775 CAMERIDGE DRIVE RICHMOND, VA 23238				
(X4) IID PREFIX TAG	(EACH DERIOIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	IID IPREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DERICIENCY)	ULD BE COMPLETION		
F 880	approximately the pobserved washing is stated she was not On 2/2/21 at 11:30 staff member) #1, til (registered nurse) # director of nursing), observations, and of ASM #1 stated, "The should have been weach resident. At a stated review of the facility hand hygiene," revealed, hand hygiene the present the spread of infection handwashing/hand is prevent the spread of personnel, residents based hand rubor, water for the following direct contact with residentbefore and reside	past 15 minutes, and was not mer hands one time, OSM #7 aware. a.m., ASM (administrative me administrator, and RN 11, the ADON (assistant were informed of these of the interview with OSM #7. Here is nothing to say. She washing her hands between minimum." Ity policy, "Handwashing/Hand in part: "The facility considers imary means to prevent the All personnel shall follow the mygiene procedures to help of infections to other and visitorsUse an alcohol alternatively soapand ag situations: before and after esidentsafter contact with	F 880				
F 883 SS=E	Influenza and Pneum CFR(s): 483.80(d)(1) §483.80(d) Influenza immunizations §483.80(d)(1) Influenza policies and procedu (i) Before offering the	and pneumococcal	F 883	The facility notified Resident/Resident Represental medical provider for residents # and #5 to obtain consent, as educate them on the influe pneumococcal immunization. Documentation consents/declined residents h documented in the medical reco	1,#3,#4, well as nza and on the as been		

CENTERS FOR MEDICARE & MEDICAID SERVICES

SIMILEMENT OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING_	(X2) MULTIPLE CONSTRUCTION A. BUILDING				
		495272	B. WING		02/05/2021		
	ROVIDER OR SUPPLIER BURY REHABILITATIO	N & HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 11776 CAMBRIDGE DRIVE RICHMOND, VA 23238				
((X4) IID PIREFIX TIAG	(EACH DEFICIE	STATIEMENT OF DEPICIENCIES NCY MUST BE PRECEDED BY FULL OR USC IDENTIFYING IMPORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR (DEFICIENCY)	BE COMPLETION		
F 883	receives education potential side effect (ii) Each resident is immunization Octol annually, unless the contraindicated or timmunized during the community (iv) The resident's indocumentation that following: (A) That the resident was provided educant potential side of immunization; and (B) That the resident immunization or dictimmunization or dictimmunization due to refusal. §483.80(d)(2) Pneumust develop policit that- (i) Before offering the immunization; (ii) Each resident is immunization; (iii) Each resident is immunization, unless the opportunity (iv) The resident's medically contrained already been immunity (iv) The resident's medically contrained al	regarding the benefits and ts of the immunization; offered an influenza ber 1 through March 31 e immunization is medically the resident has already been this time period; the resident's representative to refuse immunization; and nedical record includes indicates, at a minimum, the art or resident's representative ation regarding the benefits effects of influenza and edical contraindications or immunication or medical contraindications or immococcal disease. The facility es and procedures to ensure the pneumococcal resident or the resident's existence of the immunication is icated or the resident has	F 883	 All current residents were revierensure the facility offered, educate obtained consent regarding influent pneumococcal immunization and appropriate documentation complete the resident record. A Root Cause Analysis was complete 15-21 to determine that a logging needed to be obtained/monitored to compliance for monitoring all vaccinspecific to Influenza, Pneumococco COVID, are being offered and/or decided well ensuring education was provided and documented. In addit Director of Nursing/designee to education to all Unit Managers and its Supervisors regarding the (A) eligible receive the pneumococcal and in vaccination (B) Before receiving vaccinations the resident or representative shall receive informatic education regarding the benefit potential side effects of the vaccine medically contraindicated already girefused), and the rights to refuse vaccination and (C) For resident receive the vaccines the date of vaccination and (C) For resident receive the vaccines the date of vaccination and (C) For resident receive the vaccines the date of vaccination and (C) For resident receive the vaccines the date of vaccination and (C) For residents of the receive the vaccines of Nursing (D) designed complete 10% of the resident population. The Director of Nursing (D) designed complete 10% of the resident population. The Director of Nursing complete 10% of the resident population. The Director of Nursing complete 10% of the resident population, and then quarterly to the facility is in compliance, and then quarterly to the facility is remaining in compliance. 	ted and haza and d that eted for ed on 2-system ensure inations cal and dined as properly cion the provide Nursing collity to fluenza g the legal con and s and (unless even or see the s who contains the collination person con will enedical ete will collination 100% sing / mittee 100% ensure		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION INUMBER: 49527.2	(XX) MUUTIPLE CONSTRUCTION A. BUILDING B. WING			THE SURVIEW MPLETED C			
CANTER	-	N & HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE			02/05/2021			
(X4) IID IPREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED				OF CORRECTION (%5) ACTION SHOULD BE COMPLETIC DATE DATE ENCY)		
	(A) That the resided was provided eduction and potential side of immunization; and (B) That the resider pneumococcal immunization or the pneumococcal immunization or This REQUIREMENT by: Based on staff interest and facility documentation or immunization proposed that the facility failed an immunization proposed that the facility failed an immunization proposed that the facility staff failed are immunization proposed that the facility staff failed record includes door status was assessed were offered, declined that is influenced and prostatus was assessed were offered and prostatus was assessed was assessed that is influenced and prostatus was assessed was assessed to the facility staff failed that is influenced and prostatus was assessed was assessed was assessed to the facility staff failed that is influenced and prostatus was assessed was assessed was assessed was assessed to the fail of the facility staff failed that is influenced and prostatus was assessed was assessed was assessed was assessed to the fail of the fail	ation regarding the benefits effects of pneumococcal effects or did not receive effects. It is not met as evidenced effects of eview effects effects of effects o	F &	383					

FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (XII) PROVIDER/SUPPLIER/CUA (XZ) MULTIPLE CONSTRUCTION (X3) DATTE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A BUILDING C 495272 B. WING 02/05/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE CANTERBURY REHABILITATION & HEALTH CARE CENTER RICHMOND, VA 23238 (0X40) IO SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (033) (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR USC IDENTIFYING INFORMATION) DATE TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 883 | Continued From page 61 F 883 disease, pacemaker, atrial fibrillation, and pressure sore. The significant change MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 12/30/20 coded the resident as being cognitively impaired in ability to make daily life decisions. A review of the electronic clinical record failed to reveal any documentation of any influenza or pneumococcal immunizations being administered Further review failed to reveal any evidence of education and consents being offered for influenza and pneumococcal immunizations. On 2/1/21 at 1:23 PM a request was made for the immunization record information, consents and education for Resident #1. None were provided. On 2/3/21 at 8:40 AM in a phone interview with ASM #2 (Administrative Staff Member - Regional Director of Operations) and RN #1 (Registered Nurse - the Assistant Director of Nursing), when asked about the consent and education for the immunizations. ASM #2 stated that he did not know if they were previously offered or not as the facility was not able to find any documentation. On 2/4/21 at 10:00 AM in a phone interview with RN #1, she stated that she does not have documented immunization information for Resident #1, RN #1 stated that the resident (Resident #1) gets her immunizations at dialysis. She stated that she has requested the

documentation twice from the dialysis center and it has not been provided. RN #1 had no evidence that Resident #1's immunization status was addressed by the facility at the time of admission

PRINTED: 02/11/2021

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		((X11) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION	(XS) DATE SURVEY COMPLETED	
		495272	B. WING			00	C 2/05/2021
	PROVIDER OR SUPPLIER BURY REHABILITATION	8 HEALTH CARE CENTER		1776	et address, city, state, zip oode Cambridge drive MOND, VA 23238	1 02	210312024
(X4) IID PREFIX TAG	(EACH DEFICIEN	STATISMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FUUL R LISC IDENTIFYING INFORMATION)	PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEPICIENCY)	BE .	((XS)) COMPLETION DATE
	to the facility on 2/5/ flu season. A review of the facility Vaccine" documented pneumococcal vaccine pneumococcal vaccine pneumococcal vaccine pneumococcal vaccine pneumococcal vaccines medicated, will be officuntess medically conhas already been vathe pneumococcal vaccine pneumococcal vaccine pneumococcal vaccine pneumococcal vaccine pneumococcal vaccines (unless medication regarding side effects of the provaccine Provision documented in the repneumococcal vaccine pneumococcal vaccines already given, or reference and the side of vaccine pneumococcal vaccine receive the vaccines number, expiration documented in each indicating the date of pneumococcal vaccine receive the vaccines number, expiration dand the site of vaccine the resident's medication, a policy for documented, "All resicontraindications to the influenza vaccine and promote the benefits against influenza	ty policy "Preumococcal ed, "Residents will be offered ines to aid in preventing coccal infections. 1. sessed for eligibility to receive accine series, and when ered the vaccine series intraindicated or the resident accine, the resident or legal receive information and the benefits and potential neumococcal of such education shall be esident's medical record. 3. ines will be administered to edically contraindicated, used) per physician order. 4. atives have the right to refuse ed, appropriate entries will be resident's medical record of the refusal of the nation. 5. For residents who the date of vaccination, lot ate, person administering, nation will be documented in	F	383			

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CUIA IDENTIFICATION NUMBER:	A. BUILDI	TIPLE CONSTRUCTION NG		TE SURVEY MPLETED
		495272	B. WING_		0	2/05/2021
	ROVIDER OR SUPPLIER BURY REHABILITATION	& HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP C 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238		
(%4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FUUL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFID TAG	PROVIDERS PLAN OF IX (EACH CORRECTIVE ACT) CROSS-REFERENCED TO TO DEFICIENCE	ION SHOULD BE HEAPPROPRIATE	((KS)) COMPLETION DATE
F 883	employee has alread to the vaccination, the representative) will be education regarding to side effects of the influence who receive the vaccination, lot number administering, and the documented in the record. 4. A resident be documented on the Influenza Vaccine and medical record	rated or the resident or by been immunized. 2. Prior e resident (or resident's legal e provided information and the benefits and potential luenza vaccineProvision all be documented in the re's medical record. 3. For e vaccine, the date of recr, expiration date, person e site of vaccination will be resident's/employee's medical to refusal of the vaccine shall be informed Consent for diplaced in the resident's residents may obtain their own their personal physicians.	F &	383		
	#3's pneumococcal in assessed, that educa offered, or that the imcontraindicated. Resident #3 was adm 9/11/20 and had the ofto COVID-19, cellulitis depression and obesi (Minimum Data Set) a (Assessment Referenthe resident as being	clinical record that Resident nmunization status was tion and the vaccine were munization was medically				

STATIEMENT OF DEFICIENCIES AND PLAIN OF CORRECTION		(XII) PROVIDER/SUPPLIER/CUM IDENTIFICATION NUMBER:	(IX2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495272	B. WING	B. WING			
	PROVIDER OR SUPPLIER BURY REHABILITATION	& HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP COL 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	DE	02/05/2021	
((X4) IID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTION SHOUL)				
	coded as requiring to supervision for transf Inygiene; and was ind A review of the electroreveal any document immunization being a documentation evider vaccine had been presented immunization and conserpneumococcal immunization record in education and conserpneumococcal immunization for Resident Con 2/2/21 at 5:16 PM form was provided, which was because the residuation on 2/3/20. The 2/2/21, the date the enthe surveyor. On 2/3/21 at 8:40 AM ASM #2 (Administrative Director of Operations Nurse - the Assistant It asked about the conserpneumolizations, ASM # know if they were previously was not able to Con 2/4/21 at 10:00 AM	tal care for bathing; ers, dressing, toileting, and lependent for eating. onic clinical record failed to ation of the pneumococcal dministered. There was no noing that the pneumococcal eviously administered or was d. to reveal any evidence of nts being offered for the nization. a request was made for the nization. a request was made for the normation, consents and at #3. , a pneumococcal consent hich documented the accine, and that the refusal dent had received the ais consent was dated vidence was requested by in a phone interview with the Staff Member - Regional) and RN #1 (Registered Director of Nursing), when ent and education for the 2 stated that he did not riously offered or not as the find any documentation. I in a phone interview with she had no evidence that	F 863				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		((X1)) PROVIDER/SUPPLIER/CUVA IDENTIFICATION INUMBER:	(X2) WILLTIPLE CONSTRUCTION A. BUILDING			(X3) DATIE SURVEY COMPLETED	
		495272	B. WING			C	
	ROVIDER OR SUPPLIER BURY REHABILITATION	& HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238		2/05/2021	
((X4)IID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		IID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(AS) COMPLETION DATE	
F 883	Continued From page 65 addressed at the time of admission or that the resident was offered the vaccine at the time of admission. She stated it should have been addressed at time of admission.		F 863				
	No further informatio the survey.	n was provided by the end of					
	#4's pneumococcal in assessed, that the ed	clinical record that Resident mmunization status was ducation and the vaccine was t #4 had already been e immunization was					
	11/27/20 and had the to bladder cancer, ch disease, dysphagia, I heart failure. The ad Data Set) with an AR Date) of 12/1/20 code moderately impaired decisions. The reside supervision for eating	nitted to the facility on diagnoses of but not limited ronic obstructive pulmonary nigh blood pressure, and mission MDS (Minimum D (Assessment Reference ed the resident as being in ability to make daily life ent was coded as requiring; extensive assistance for pileting, and hygiene; and					
	reveal any documenta immunization being a documentation evider previously immunized immunization was me Further review failed I	onic clinical record failed to ation of the pneumococcal dministered. There was no noting the resident had been or that the pneumococcal dically contradicted.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		((X1)) PROVIDER/SUPPLIER/GLIA IDENTIFICATION INUMBER:	(XZ) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495272	MIN PROPERTY.			C	
NUMBER OF P	ROVIDER OR SUPPLIER	455212	B. WATNIG			02/05/2021	
		& HEALTH CARE CENTER		STIREET ADDRESS, CITY, STATE, ZR 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	CODE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		IAD IAREHI TAG	(EACH CORRECTIVE A) OROSS-REFERENCED TO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 883	Continued From page 66 pneumococcal immunization. On 2/1/21 at 3:54 PM a request was made for the immunization record information, consents and education for Resident #4.		F	883			
	form was provided, wi resident refused the vi that the refusal was b he already received the	raccine, and documented ecause the resident stated ne vaccine. This consent date the evidence was					
	ASM #2 (Administrative Director of Operations Nurse - the Assistant asked about the constimutions, ASM # know if they were pre-	in a phone interview with we Staff Member - Regional and RN #1 (Registered Director of Nursing), when ent and education for the stated that he did not viously offered or not as the find any documentation.					
	RN #1, she stated that the resident's pneumo addressed at the time	of admission or that the ne vaccine at the time of d it should have been					
	the survey. 4. The facility staff fail documentation in the c #5's influenza and pne	was provided by the end of ed to evidence clinical record that Resident umococcal immunization that education and the					

PRINTED: 00/H1/2021 FORM APPROVED CENTIERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEPICIENCIES (XII) PROVIDER/SUPPLIER/CLI/A (XZ) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER COMPLETED A BUILDING C 495272 B. WING 02/05/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE CANTERBURY REHABILITATION & HEALTH CARE CENTER RICHMOND, VA 23238 (CX40) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (XS) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE/ACTION SHOULD BE TOAG REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG CROSS-REFERENCED TO THE APPROPRIATE DERICIENCY F 883 Continued From page 67 F883 vaccines were offered, that Resident #1 had previously been immunized or that the immunizations were medically contraindicated. Resident #5 was admitted to the facility on 11/25/20 and had the diagnoses of but not limited to dysphagia, dementia, and COVID-19. The admission MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 12/2/20 coded the resident as being severely impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing and hygiene; and extensive assistance for all other areas of activities of daily living. A review of the electronic clinical record failed to reveal any documentation of any influenza or pneumococcal immunizations being administered. There was no documentation evidencing that the resident had been previously immunized or that the immunizations were medically contradicted. Further review failed to reveal any evidence of education and consents being offered for influenza and pneumococcal immunizations. On 2/1/21 at 3:54 PM a request was made for the immunization record information, consents and education for Resident #5. On 2/2/21 at 5:16 PM, a pneumococcal consent form was provided, which documented the vaccine was refused, and that the refusal was because the resident representative was unsure if

the resident already received the vaccine. This consent was dated 2/2/21, the date the evidence was requested by the surveyor. An influenza consent form was also provided, which

PRINTED: 02/11/2021 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES ((X1)) PROVIDER/SUPPLIER/OLIA (KZ) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A BUILDING COMPLETED 495272 B. WING 02/05/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE CANTERBURY REHABILITATION & HEALTH CARE CENTER RICHMOND, VA 23238 (0K4th IIII) SUMMARY STATEMENT OF DEFICIENCIES MD PROVIDER'S PLAN OF CORRECTION (0X3) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREEN (EACH CORRECTIVE ACTION SHOULD BE COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TVAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 883 Continued From page 68 F 883 documented that the vaccine was refused and documented that the reason it was refused was because the resident representative was unsure if the resident already had it. This was also dated 2/2/21, the date the evidence was requested by the surveyor. On 2/3/21 at 8:40 AM in a phone interview with ASM #2 (Administrative Staff Member - Regional Director of Operations) and RN #1 (Registered Nurse - the Assistant Director of Nursing), when asked about the consent and education for the immunizations, ASM #2 stated that he did not know if they were previously offered or not as the facility was not able to find any documentation. On 2/4/21 at 10:00 AM in a phone interview with RN #1, she stated that she had no evidence that the resident's immunization status was addressed at the time of admission or that the resident was offered immunizations at the time of admission. She stated it should have been addressed at time of admission. No further information was provided by the end of the survey.