STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495272	A. BUILDING ______ B. WING ______	C 02/05/2021

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E 000	Initial Comments An unannounced abbreviated Emergency Preparedness COVID-19 Focused Survey was conducted 2/2/21 through 2/5/21. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000	This plan of correction is respectfully submitted as evidence of alleged compliance. The submission is not an admission that the deficiencies existed or that we are in agreement with them. It is an affirmation that	
F 000	INITIAL COMMENTS An unannounced abbreviated COVID-19 Focused Survey was conducted 2/2/21 through 2/5/21. A complaint was investigated. Corrections 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 000	Correction to areas cited have been made and the facility is in compliance with participation requirements.	
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is,	F 580	F580 Notify of Changes (Injury/Decline/Room) 1- Resident 1 physician and responsible party notified of missed dialysis appointments on 2-5-21. 2- Residents that currently reside in the facility that receive dialysis services have the potential to be affected by this alleged deficient practice. DON/Designee will review medical records for current residents receiving dialysis to ensure physician and responsible party have been notified of missed dialysis appointments. Notification will be made for any discrepancy that is identified.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Matt B
TITLE: Administrator
(X6) DATE: 2/19/21

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

Matt B Revised 2/22/21

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F 580	Continued From page 1 a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review, and in the course of a complaint investigation, it was determined that the facility staff failed to notify the physician and	F 580	3- Procedure for physician and family notification reviewed on 2-5-21 no changes implemented at this time. Staff Development Coordinator/Designee will educate the Licensed Nursing Staff on the procedure for notifying the attending physician and responsible party of missed dialysis appointments and documenting notification in the medical record. Licensed nursing staff will document the missed appointed on the 24 hour report for review. 4- The Interdiscipinary Team will audit the 24 hour reports and nursing progress notes during clinical meeting daily Monday through Friday for missed dialysis appointments and documentation of physician and responsible party 5 days a week for 2 weeks, then 3 days a week for 2 weeks and then monthly until facility reaches 100% compliance. Results of these audits will be brought forth to the QAPI committee for review and further recommendations.	03-02-2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 580	Continued From page 2	F 580		

RR (resident representative) regarding a change in the resident's dialysis status for one of six residents in the survey sample, Resident #1. The facility staff failed to notify the physician and the RR when the resident did not receive dialysis on 1/5/21.

The findings include:

Resident #1 was admitted to the facility on 11/26/18, and most recently readmitted on 12/24/20, with diagnoses including, but not limited to: ESRD (end stage renal disease) (1) requiring dialysis (2), history of a stroke, diabetes (3) bipolar disorder (4), and morbid (extreme) obesity (5). On the most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 12/30/20, Resident #1 was coded as severely cognitively impaired for making daily decisions, having scored seven out of 15 on the BIMS (brief interview for mental status). She was coded as requiring extensive assistance of staff for bed mobility, dressing, and personal hygiene. She was coded as being completely dependent on the assistance of two staff members for transfers and bathing. She was coded as not moving from a sitting to standing position, or as walking, during the lookback period. Her only mobility device was a wheelchair. Resident #1 was coded as receiving dialysis during the lookback period.

Resident #1 was unavailable for observation during the survey. She was out for a dialysis appointment.

A review of Resident #1's clinical record revealed the following physician order dated 11/19/20: "Dialysis T-Th-Sat (Tuesday, Thursday, Saturday)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 580	Continued From page 3	F 580		

[name of community dialysis center] one time a day every Tue (Tuesday), Thu (Thursday), Sat (Saturday)." The order did not have a stop date.

Further review of Resident #1's clinical record revealed a TAR (treatment administration record) for January 2021, which documented the above physicians order for dialysis. The box for Resident #1's dialysis on 1/5/21 was blank. A review of Resident #1's nurses' notes for 1/5/21 contained no evidence that Resident #1 received dialysis that day, or that her physician or RR (resident representative) was notified.

A review of Resident #1's comprehensive care plan dated 9/23/20, documented, in part: "I need dialysis...Encourage resident to go for scheduled dialysis appointments. Resident receives dialysis every Tuesday, Thursday, and Saturday."

On 2/4/21 at 11:29 a.m., RN (registered nurse) #3 was interviewed. When asked what it means when a resident's TAR with dialysis orders 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 should be done if a resident does not receive scheduled dialysis for any reason, she stated the physician should be notified, and the resident should be rescheduled, if ordered by the physician.

On 2/4/21 at 12:01 p.m., LPN (licensed practical nurse) #2, a unit manager, was interviewed. When asked what it means when a resident's TAR with documented orders for dialysis is blank on a day the resident should have received dialysis, LPN #2 stated, "If it's not documented,

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F 580	Continued From page 4 it's not done." When asked what should be done if a resident does not receive scheduled dialysis for any reason, he stated the physician should be notified, as well as the RR (resident representative). LPN #2 stated a note should be placed in the chart, and the resident should be watched carefully for any complications from the lack of dialysis. 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, she stated it was too long ago for her to remember. When asked if there was any indication or documentation in the clinical record that Resident #1 had received dialysis on 1/5/21, LPN #2 stated there was not. When asked if there was any evidence that the physician or RR was notified that the resident did not receive dialysis, she stated there was not. On 2/4/21 at 4:30 p.m., ASM (administrative staff member) #2, the regional director of operations, and RN #1, the assistant director of nursing (ADON) were informed of these concerns. A review of the facility policy, "Care of A Resident with End-Stage Renal Disease," revealed no information related to the notification of the physician or RR if a resident does not receive dialysis for any reason. A review of the facility policy, "Change in a Resident's Condition or Status" revealed, in part: "The nurse will notify the resident's Attending Physician or physician on call when there has been ...a need to alter the resident's medical treatment significantly."	F 580		

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F 580	Continued From page 5	F 580		

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 the work your kidneys used to do. Unless you have a kidney transplant, you will need a treatment called dialysis. There are two main types of dialysis. Both types filter your blood to rid your body of harmful wastes, extra salt, and water. Hemodialysis uses a machine. It is sometimes called an artificial kidney. You usually go to a special clinic for treatments several times a week." This information was taken from the website https://medlineplus.gov/dialysis.html.

(3) "Diabetes (mellitus) is a disease in which your blood glucose, or blood sugar, levels are too high." This information is taken from the website https://medlineplus.gov/diabetes.html.

(4) "Bipolar disorder (formerly called manic-depressive illness or manic depression) is a mental disorder that causes unusual shifts in mood, energy, activity levels, concentration, and the ability to carry out day-to-day tasks." This information is taken from the website

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F 580	Continued From page 6 https://www.nimh.nih.gov/health/topics/bipolar-disorder/index.shtml. (5) "Obesity, defined as a body mass index (BMI) = 30 kg/m2, is recognized as an important risk factor. The Centers for Disease Control and Prevention (CDC) reported that obesity rates in the U.S. have increased dramatically over the last 30 years, and obesity is now epidemic in the United States (Kahn, 2009). For adults 60 years and older, the prevalence of obesity is about 37% among men and 34% among women (NHANES - National Health and Nutrition Examination Survey). Obesity may be further classified according to the NIH: Class I Obesity = BMI 30.0-34.9 kg/m² Class II Obesity = BMI 35.0-39.9 kg/m² Class III (Extreme) Obesity = BMI = 40.0 kg/m²" This information is taken from the website https://www.cms.gov/medicare-coverage-database/details/nca-tracking-sheet.aspx?NCAId=258&fromdb=true.	F 580		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95,	F 607	F607 Develop/Implement Abuse/Neglect Policies 1- Resident 1 denies abuse and neglect r/t fracture of tibia. DON will complete investigation regarding injury of unknown origin by 2-21-21. 2- Residents that acquire an injury of unknown origin have the potential to be affected by this alleged deficient practice. DON/Designee will review incident reports from 2/1/2021 to present to identify injuries of unknown origin that have not been reported. DON will report and investigate residents identified during this review.	

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F 607	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review, and in the course of a complaint investigation, it was determined that the facility staff failed to implement its policy to report an injury of unknown origin (possible abuse) as required for one of six residents in the survey sample, Resident #1. The facility staff failed to report Resident #1's broken tibia (leg) to required agencies on 12/17/20. The findings include: 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 timeframe's 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." Resident #1 was admitted to the facility on 11/26/18, and most recently readmitted on 12/24/20, with diagnoses including, but not limited to: ESRD (end stage renal disease) (1) requiring dialysis (2), history of a stroke, diabetes (3) bipolar disorder (4), and morbid (extreme) obesity (5). On the most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 12/30/20, Resident #1 was coded as being severely cognitively impaired for making daily decisions, having scored seven out of 15 on the BIMS (brief interview for mental status). She was coded as requiring the extensive assistance of staff for bed	F 607	3- Abuse Investigating and reporting policy reviewed on 2-5-21. No changes needed at this time. The Staff Development Coordinator/Designee will in-service facility staff on the Abuse Investigation and Reporting policy and to immediately notify the Administrator/Designee for prompt reporting to the state agency and initiation of investigation for allegations of abuse, neglect, misappropriation of property, mistreatment and injury of unknown origin. 4- Interdisciplinary team will audit incident reports and progress notes daily Monday through Friday in clinical meeting to ensure injuries of unknown origin have been reported and investigations initiated promptly 5 days a week for 2 weeks, then 3 days a week for 2 weeks and then monthly until facility reaches 100% compliance. Results of these audits will be brought forth to the QAPI committee for review and further recommendations.	03-02-2021

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F 607	Continued From page 8	F 607		

mobility, dressing, and personal hygiene. She was coded as being completely dependent on the assistance of two staff members for transfers and bathing. She was coded as not moving from a sitting to standing position, or as walking, during the lookback period. Her only mobility device was a wheelchair. She was coded as receiving dialysis during the lookback period.

A review of Resident #1's clinical record revealed the following progress notes:

- 12/15/2020 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) 0...Pain 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 0...Pain scale: Numerical."

- 12/17/2020 6:54 a.m. "Health Status Note. Note Text: 2 Tylenol (6) given at 6:50 am...patient 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

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F 607	Continued From page 9	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."

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F 607	Continued From page 10	F 607		

Continued From page 10

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 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, she 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

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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

F 607 Continued From page 12 F 607

the circumstances surrounding Resident #1's leg fracture. ASM #2 stated he believed there was a "minimal" document describing a facility 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 [history and physical] reflect she told them she had a fall at dialysis." The investigation contained no evidence of staff interviews. The investigation did not document 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495272	A. BUILDING ______ B. WING ______	C 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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 13	F 607		

stated, "We assumed it was during a resident transfer." When asked why the facility did not interview any staff regarding this incident, neither 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, ASM #2 stated, "We are required to submit a FRI (facility reported incident) to the state and other agencies." When asked if the facility implemented its abuse policy and submitted a FRI for Resident #1's injury of unknown origin, ASM #2 stated, "No. Not that I have seen."

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 the work your kidneys used to do. Unless you have a kidney transplant, you will need a treatment called dialysis. There are two main types of dialysis. Both types filter your blood to rid your body of harmful wastes, extra salt, and water. Hemodialysis uses a machine. It is sometimes called an artificial kidney. You usually

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495272	A. BUILDING ___ B. WING ___	C 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

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F 607	Continued From page 14	F 607		

Continued From page 14

go to a special clinic for treatments several times a week." This information was taken from the website https://medlineplus.gov/dialysis.html.

(3) "Diabetes (mellitus) is a disease in which your blood glucose, or blood sugar, levels are too high." This information is taken from the website https://medlineplus.gov/diabetes.html.

(4) "Bipolar disorder (formerly called manic-depressive illness or manic depression) is a mental disorder that causes unusual shifts in mood, energy, activity levels, concentration, and the ability to carry out day-to-day tasks." This information is taken from the website https://www.nimh.nih.gov/health/topics/bipolar-disorder/index.shtml.

(5) "Obesity, defined as a body mass index (BMI) = 30 kg/m2, is recognized as an important risk factor. The Centers for Disease Control and Prevention (CDC) reported that obesity rates in the U.S. have increased dramatically over the last 30 years, and obesity is now epidemic in the United States (Kahn, 2009). For adults 60 years and older, the prevalence of obesity is about 37% among men and 34% among women (NHANES - National Health and Nutrition Examination Survey). Obesity may be further classified according to the NIH:

Class I Obesity = BMI 30.0-34.9 kg/m^2
Class II Obesity = BMI 35.0-39.9 kg/m^2
Class III (Extreme) Obesity = BMI = 40.0 kg/m^2"
This information is taken from the website https://www.cms.gov/medicare-coverage-database/details/nca-tracking-sheet.aspx?NCAId=258&fromdb=true.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495272	A. BUILDING ______ B. WING ______	C 02/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 607	Continued From page 15 (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.html.	F 607		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.	F 609	F609 Reporting of Alleged Violations 1- Resident 1 denies abuse and neglect r/t fracture of tibia. DON will complete investigation regarding injury of unknown origin by 2-21-21. 2- Residents that acquire an injury of unknown origin have the potential to be affected by this alleged deficient practice. DON/Designee will review incident reports and progress notes from 2/1/2021 to present to identify injuries of unknown origin that have not been reported. DON will report and investigate residents identified during this review. 3- Abuse Investigating and reporting policy reviewed on 2-5-21. No changes needed at this time. The Staff Development Coordinator/Designee will in-service facility staff on the Abuse Investigation and Reporting policy and to immediately notify the Administrator/Designee for prompt reporting to the state agency and initiation	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495272	A. BUILDING ______ B. WING ______	C 02/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 609	Continued From page 16 §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review, and in the course of a complaint investigation, it was determined that the facility staff failed to report an injury of unknown origin as required for one of six residents in the survey sample, Resident #1. The facility staff failed to report Resident #1's broken tibia (leg) to required agencies on 12/17/20. The findings include: Resident #1 was admitted to the facility on 11/26/18, and most recently readmitted on 12/24/20, with diagnoses including, but not limited to: ESRD (end stage renal disease) (1) requiring dialysis (2), history of a stroke, diabetes (3) bipolar disorder (4), and morbid (extreme) obesity (5). On the most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 12/30/20, Resident #1 was coded as being severely cognitively impaired for making daily decisions, having scored seven out of 15 on the BIMS (brief interview for mental status). She was coded as requiring the extensive assistance of staff for bed mobility, dressing, and personal hygiene. She was coded as being completely dependent on the assistance of two staff members for transfers and bathing. She was coded as not moving from a	F 609	of investigation for allegations of abuse, neglect, misappropriation of property, mistreatment and injury of unknown origin. 4- Interdisciplinary team will audit incident reports and progress notes daily Monday through Friday in clinical meeting to ensure injuries of unknown origin have been reported and investigations initiated promptly 5 days a week for 2 weeks, then 3 days a week for 2 weeks and then monthly until facility reaches 100% compliance. Results of these audits will be brought forth to the QAPI committee for review and further recommendations.	03-02-2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495272	A. BUILDING ______ B. WING ______	C 02/05/2021

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F 609	Continued From page 17	F 609		

sitting to standing position, or as walking, during the lookback period. Her only mobility device was a wheelchair. She was coded as receiving dialysis during the lookback period.

A review of Resident #1's clinical record 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) 0...Pain 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 0...Pain scale: Numerical."

- 12/17/2020 6:54 a.m. "Health Status Note. Note Text: 2 Tylenol (6) given at 6:50 am...patient 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 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)

F 609 | F 609

Continued From page 18

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 (emergency room) 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."

On 2/4/21 at 11:34 a.m., ASM (administrative staff member) #4, the resident's attending

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495272	A. BUILDING ______ B. WING ______	C 02/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 609	Continued From page 19	F 609		

Continued From page 19

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495272	A. BUILDING ______ B. WING ______	C 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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 20	F 609		

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 the circumstances surrounding Resident #1's leg fracture. ASM #2 stated he believed there was a "minimal" document describing a facility

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495272	A. BUILDING ______ B. WING ______	C 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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 21	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

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	495272	A. BUILDING ______ B. WING ______	C 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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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

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	495272	A. BUILDING ______ B. WING ______	C 02/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 23	F 609		

the work your kidneys used to do. Unless you have a kidney transplant, you will need a treatment called dialysis. There are two main types of dialysis. Both types filter your blood to rid your body of harmful wastes, extra salt, and water. Hemodialysis uses a machine. It is sometimes called an artificial kidney. You usually go to a special clinic for treatments several times a week." This information was taken from the website https://medlineplus.gov/dialysis.html.

(3) "Diabetes (mellitus) is a disease in which your blood glucose, or blood sugar, levels are too high." This information is taken from the website https://medlineplus.gov/diabetes.html.

(4) "Bipolar disorder (formerly called manic-depressive illness or manic depression) is a mental disorder that causes unusual shifts in mood, energy, activity levels, concentration, and the ability to carry out day-to-day tasks." This information is taken from the website https://www.nimh.nih.gov/health/topics/bipolar-disorder/index.shtml.

(5) "Obesity, defined as a body mass index (BMI) = 30 kg/m2, is recognized as an important risk factor. The Centers for Disease Control and Prevention (CDC) reported that obesity rates in the U.S. have increased dramatically over the last 30 years, and obesity is now epidemic in the United States (Kahn, 2009). For adults 60 years and older, the prevalence of obesity is about 37% among men and 34% among women (NHANES - National Health and Nutrition Examination Survey). Obesity may be further classified according to the NIH:

Class I Obesity = BMI 30.0-34.9 kg/m²

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495272	A. BUILDING ______ B. WING ______	C 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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 24 Class II Obesity = BMI 35.0-39.9 kg/m² Class III (Extreme) Obesity = BMI = 40.0 kg/m²" This information is taken from the website https://www.cms.gov/medicare-coverage-database/details/nca-tracking-sheet.aspx?NCAId=258&fromdb=true. (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.html.	F 609		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff.	F 657	F657 Care Plan Timing and Revision 1. Resident 1's care plan was revised to reflect appropriate transfer status on 2-5-21. 2. Residents that reside in the facility that need assistance with transfers have the potential to be affected by this alleged deficient practice. Nursing Administration Team and Therapy will review residents transfer status to ensure that care plans are reflective of residents most current assistive needs and update as needed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495272	A. BUILDING ____ B. WING ____	C 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

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F 657	Continued From page 25 (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review, and in the course of a complaint investigation, it was determined that the facility staff failed to revise the comprehensive care plan to include the recommended method of safe transfer for one of six residents in the survey sample, Resident #1. The facility staff failed to update Resident #1's care plan to reflect a physical therapist's recommendation to use a mechanical lift or to complete a sliding board transfer in and out of bed when a mechanical lift was not available. The findings include: Resident #1 was admitted to the facility on 11/26/18, and most recently readmitted on 12/24/20, with diagnoses including, but not limited to: ESRD (end stage renal disease) (1) requiring dialysis (2), history of a stroke, diabetes (3) bipolar disorder (4), and morbid (extreme) obesity (5). On the most recent MDS (minimum data set), a significant change assessment with an ARD	F 657	3. Care Plan policy reviewed on 2-5-21, no revisions necessary at this time. The Staff Development Coordinator/Designee will in-service the Interdisciplinary team on initiating and revising care plans to include transfer status on all new admissions and with a change in residents transfer status. IDT will discuss transfer status changes during utilization review meeting and care plans will be revised as needed. 4. DON/Designee will randomly audit 10 newly admitted residents and current residents care plans twice weekly for 2 weeks then weekly for 3 weeks and then monthly until facility reaches 100% compliance. Results of these audits will be brought forth to the QAPI committee for review and further recommendations.	03-02-2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495272	A. BUILDING ______ B. WING ______	C 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

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F 657	Continued From page 26 (assessment reference date) of 12/30/20, Resident #1 was coded as being severely cognitively impaired for making daily decisions, having scored seven out of 15 on the BIMS (brief interview for mental status). She was coded as requiring the extensive assistance of staff for bed mobility, dressing, and personal hygiene. She was coded as being completely dependent on the assistance of two staff members for transfers and bathing. She was coded as not moving from a sitting to standing position, or as walking, during the lookback period. Her only mobility device was a wheelchair. She was coded as receiving dialysis during the lookback period. On the MDS immediately prior to 12/16/20, a quarterly assessment with an ARD of 11/23/20, Resident #1 was coded as being severely cognitively impaired for making daily decisions, having scored six out of 15 on the BIMS (brief interview for mental status). She was coded as requiring the extensive assistance of staff for bed mobility, transfers, dressing, and personal hygiene. She was coded as being completely dependent on the assistance of two staff members for toileting and bathing. She was coded as not moving from a sitting to standing position, or as walking, during the lookback period. Her only mobility device was a wheelchair. A review of Resident #1's PT (physical therapy) Discharge Summary immediately prior to 12/16/20, dated 6/5/20, revealed, in part: "DC (discharge location) = Pt (patient discharged to reside in this LTC (long term care) facility...Prognosis to Maintain CLOF (current level of functioning)=Good with consistent staff follow-through...Prior equipment to Onset:w/chair (wheelchair), Hoyer (mechanical) lift...LTG (long	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495272	A. BUILDING ____ B. WING ____	C 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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 27 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	F 657		

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F 657	Continued From page 28	F 657		

she was familiar with Resident #1's status prior to her leg fracture. OSM #5 stated Resident #1 required a mechanical lift for transfers because she was unable to bear any weight at all on her legs.

On 2/4/21 at 3:33 p.m., LPN #5, a shift supervisor, was interviewed. When asked how staff know how to safely transfer a resident, he stated, "We have it on the care plans, in the MARs (medication administration records), and TARs (treatment administration records)."

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 the staff knew how a resident should be safely transferred. RN #1 stated, "It should be in the plan of care."

On 2/5/21 at 9:30 a.m., ASM #2, ASM #3, regional clinical director, RN #1, and OSM #6, director of rehab services, were interviewed. 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, OSM #6 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495272	A. BUILDING ______ B. WING ______	C 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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 29	F 657		

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. ASM #3 stated Resident #1's care plan was not updated as it should have been with the therapist's recommendations for transfers.

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 conjunction with the rehabilitation staff, shall assess individual residents' needs for transfer assistance on an ongoing basis. Staff will document resident transferring and lifting needs in the care plan...Mechanical lifting devices shall be used for heavy lifting, including lifting and moving residents when necessary."

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495272	A. BUILDING ______ B. WING ______	C 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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 30	F 657		

your kidneys fail, you need treatment to replace the work your kidneys used to do. Unless you have a kidney transplant, you will need a treatment called dialysis. There are two main types of dialysis. Both types filter your blood to rid your body of harmful wastes, extra salt, and water. Hemodialysis uses a machine. It is sometimes called an artificial kidney. You usually go to a special clinic for treatments several times a week." This information was taken from the website https://medlineplus.gov/dialysis.html.

(3) "Diabetes (mellitus) is a disease in which your blood glucose, or blood sugar, levels are too high." This information is taken from the website https://medlineplus.gov/diabetes.html.

(4) "Bipolar disorder (formerly called manic-depressive illness or manic depression) is a mental disorder that causes unusual shifts in mood, energy, activity levels, concentration, and the ability to carry out day-to-day tasks." This information is taken from the website https://www.nimh.nih.gov/health/topics/bipolar-disorder/index.shtml.

(5) "Obesity, defined as a body mass index (BMI) = 30 kg/m2, is recognized as an important risk factor. The Centers for Disease Control and Prevention (CDC) reported that obesity rates in the U.S. have increased dramatically over the last 30 years, and obesity is now epidemic in the United States (Kahn, 2009). For adults 60 years and older, the prevalence of obesity is about 37% among men and 34% among women (NHANES - National Health and Nutrition Examination Survey). Obesity may be further classified according to the NIH:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495272	A. BUILDING ______ B. WING ______	C 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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 31 Class I Obesity = BMI 30.0-34.9 kg/m² Class II Obesity = BMI 35.0-39.9 kg/m² Class III (Extreme) Obesity = BMI = 40.0 kg/m²" This information is taken from the website https://www.cms.gov/medicare-coverage-database/details/nca-tracking-sheet.aspx?NCAId=258&fromdb=true. (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.html.	F 657		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review, and in the course of	F 689	F689 Free of Accident Hazards/Supervision/Devices 1- Resident #1 care plan updated to reflect appropriate transfer status when lift is not available. 2- Residents requiring transfers with mechanical lift have the potential to be affected by this alleged deficient practice. Nursing Administration team will collaborate with therapy to identify residents in the facility that require mechanical lift for appropriate transfer status when lift is unavailable 3- Safety and Supervision of Residents policy reviewed, on 2-5-21, no revisions necessary at this time. Staff development coordinator	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495272	A. BUILDING ______ B. WING ______	C 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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 32 a complaint investigation, it was determined that the facility staff failed to ensure a safe transfer with assistive devices to prevent accidents for one of six residents in the survey sample, (Resident #1). On 12/16/20, a facility nurse transferred Resident #1 manually from her wheelchair to her bed. Therapy recommendations were for the resident to be transferred by mechanical lift or sliding board when a mechanical lift was not available. The findings include: Resident #1 was admitted to the facility on 11/26/18, and most recently readmitted on 12/24/20, with diagnoses including, but not limited to: ESRD (end stage renal disease) (1) requiring dialysis (2), history of a stroke, diabetes (3) bipolar disorder (4), and morbid (extreme) obesity (5). On the most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 12/30/20, Resident #1 was coded as being severely cognitively impaired for making daily decisions, having scored seven out of 15 on the BIMS (brief interview for mental status). She was coded as requiring the extensive assistance of staff for bed mobility, dressing, and personal hygiene. She was coded as being completely dependent on the assistance of two staff members for transfers and bathing. She was coded as not moving from a sitting to standing position, or as walking, during the lookback period. Her only mobility device was a wheelchair. She was coded as receiving dialysis during the lookback period. On the MDS immediately prior to 12/16/20, a quarterly assessment with an ARD of 11/23/20,	F 689	development coordinator will educate nursing staff on Safety and Supervision of Residents policy and reviewing plan of care for appropriate transfer status. 4- Unit Manager/Designee will audit transfers of 9 residents per week for 2 weeks, 6 residents per week for 2 weeks until facility reaches 100% to ensure compliance with transfer status of residents requiring assistance with transfers. Results of these audits will be brought forth to the QAPI committee for review and further recommendations	03-02-2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495272	A. BUILDING ______ B. WING ______	C 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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 33	F 689		

Resident #1 was coded as being severely cognitively impaired for making daily decisions, having scored six out of 15 on the BIMS (brief interview for mental status). She was coded as requiring the extensive assistance of staff for bed mobility, transfers, dressing, and personal hygiene. She was coded as being completely dependent on the assistance of two staff members for toileting and bathing. She was coded as not moving from a sitting to standing position, or as walking, during the lookback period. Her only mobility device was a wheelchair.

A review of Resident #1's PT (physical therapy) Discharge Summary immediately prior to 12/16/20, dated 6/5/20, revealed, in part: "DC (discharge location) = Pt (patient discharged to reside in this LTC (long term care) facility...Prognosis to Maintain CLOF (current level of functioning)=Good with consistent staff follow-through...Prior equipment to Onset:w/chair (wheelchair), Hoyer (mechanical) lift...LTG (long 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.

Further review of Resident #1's clinical record

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495272	A. BUILDING ______ B. WING ______	C 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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 34	F 689		

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) 0...Pain 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 0...Pain scale: Numerical."

- 12/17/2020 6:54 a.m. "Health Status Note. Note Text: 2 Tylenol (6) given at 6:50 am...patient 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 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."

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 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. Pain is well controlled. She is to f/u (follow up) with ortho next wk."

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495272	A. BUILDING ______ B. WING ______	C 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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 36	F 689		

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, she 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. RN #3 stated, "I was told that the resident had a broken leg." When asked if she specifically knew how the resident's leg had been broken, RN #3 stated, "My understanding is that it was a one assist transfer from the wheelchair to the bed. The Hoyer lift was not used. [LPN (licensed practical nurse) #5] did it."

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. She stated the resident could not be safely transferred by one person without a lift. She stated she worked the morning after the fracture happened. She stated she did not know

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495272	A. BUILDING ______ B. WING ______	C 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

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F 689	Continued From page 37 how Resident #1's leg was broken. 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 she was familiar with Resident #1's status prior to her leg fracture. She stated Resident #1 required a mechanical lift for transfers because she was unable to bear any weight at all on her legs. 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 supervisor, was interviewed. When asked how staff know how to safely transfer a resident, LPN #5 stated, "We have it on the care plans, in the MARs (medication administration records), and TARs (treatment administration records)." He stated if the resident has been newly admitted, there should always be hospital records that can be used as a reference. He stated all staff have ways to access the EMR (electronic medical record) and can see transfer orders. 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	F 689		

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 38	F 689		

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."

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 the staff knew how a resident should be safely transferred. RN #1 stated, "It should be in the plan of care."

On 2/5/21 at 9:30 a.m., ASM #2, ASM #3, regional clinical director, RN #1, and OSM #6, director of rehab services, were interviewed. ASM #3 stated she had spoken with a facility therapist on 2/4/21, and the therapist had stated the resident sometimes refused to bear weight. When asked if that meant the resident was able to bear weight, but chose not to, ASM #3 stated, "It just means the therapist's view is that the resident chose not to bear weight." She stated that the trust level of residents varies depending on which staff member is caring for them. ASM #2 stated, "We rely on the CNAs who work with the residents 24 hours a day." When informed that a CNA familiar with Resident #1 (as well as other nurses and a therapist) had stated that that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495272	A. BUILDING ______ B. WING ______	C 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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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

F 689 Continued From page 40 F 689

conjunction with the rehabilitation staff, shall assess individual residents' needs for transfer assistance on an ongoing basis. Staff will document resident transferring and lifting needs in the care plan...Mechanical lifting devices shall be used for heavy lifting, including lifting and moving residents when necessary."

No further information was provided prior to exit.

(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 the work your kidneys used to do. Unless you have a kidney transplant, you will need a treatment called dialysis. There are two main types of dialysis. Both types filter your blood to rid your body of harmful wastes, extra salt, and water. Hemodialysis uses a machine. It is sometimes called an artificial kidney. You usually go to a special clinic for treatments several times a week." This information was taken from the website https://medlineplus.gov/dialysis.html.

(3) "Diabetes (mellitus) is a disease in which your blood glucose, or blood sugar, levels are too high." This information is taken from the website https://medlineplus.gov/diabetes.html.

(4) "Bipolar disorder (formerly called

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495272	A. BUILDING ______ B. WING ______	C 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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 41	F 689		

manic-depressive illness or manic depression) is a mental disorder that causes unusual shifts in mood, energy, activity levels, concentration, and the ability to carry out day-to-day tasks." This information is taken from the website https://www.nimh.nih.gov/health/topics/bipolar-disorder/index.shtml.

(5) "Obesity, defined as a body mass index (BMI) = 30 kg/m2, is recognized as an important risk factor. The Centers for Disease Control and Prevention (CDC) reported that obesity rates in the U.S. have increased dramatically over the last 30 years, and obesity is now epidemic in the United States (Kahn, 2009). For adults 60 years and older, the prevalence of obesity is about 37% among men and 34% among women (NHANES - National Health and Nutrition Examination Survey). Obesity may be further classified according to the NIH:

Class I Obesity = BMI 30.0-34.9 kg/m^2
Class II Obesity = BMI 35.0-39.9 kg/m^2
Class III (Extreme) Obesity = BMI = 40.0 kg/m^2"
This information is taken from the website https://www.cms.gov/medicare-coverage-database/details/nca-tracking-sheet.aspx?NCAId=258&frmdb=true.

(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495272	A. BUILDING ______ B. WING ______	C 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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 42 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.html.	F 689		
F 698 SS=E	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review, and in the course of a complaint investigation, it was determined that the facility staff failed to provide dialysis care and services for one of six residents in the survey sample, Resident #1. The facility staff failed to ensure Resident #1 received dialysis as ordered by the physician on 1/5/21; failed to provide for assessment of Resident #1's dialysis access site, and failed to provide instructions to clinical staff regarding use of the resident's right arm for all of January 2021. The findings include: Resident #1 was admitted to the facility on 11/26/18, and most recently readmitted on 12/24/20, with diagnoses including, but not limited to: ESRD (end stage renal disease) (1) requiring dialysis (2), history of a stroke, diabetes (3) bipolar disorder (4), and morbid (extreme) obesity (5). On the most recent MDS (minimum data set),	F 698	F698 Dialysis 1- Resident 1 physician orders updated to include monitoring of dialysis access site and restrictions regarding use of affected extremity. 2- Residents receiving dialysis services have the potential to be affected by this alleged deficient practice. Clinical Administration team will review medical records for residents receiving dialysis to ensure orders are reflective of dialysis appointments, location and times, monitoring dialysis access site and restrictions for vital signs, needlesticks to affected extremity. 3- Hemodialysis Access Care Policy reviewed, on 2-5-21, no revisions necessary at this time. Staff Development Coordinator/Designee will in-service Licensed Nursing Staff on Hemodialysis Access Care Policy and Dialysis communication forms to ensure orders are obtained for dialysis, monitoring of dialysis access site and restrictions for vital signs/needlesticks to affected extremity. Newly admitted residents that receive dialysis services will be reviewed in Clinical Meeting daily Monday through Friday for to ensure Dialysis orders are in place to include dialysis days and times, monitoring dialysis	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495272	A. BUILDING ______ B. WING ______	C 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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698	Continued From page 43 a significant change assessment with an ARD (assessment reference date) of 12/30/20, Resident #1 was coded as being severely cognitively impaired for making daily decisions, having scored seven out of 15 on the BIMS (brief interview for mental status). She was coded as requiring the extensive assistance of staff for bed mobility, dressing, and personal hygiene. She was coded as being completely dependent on the assistance of two staff members for transfers and bathing. She was coded as not moving from a sitting to standing position, or as walking, during the lookback period. Her only mobility device was a wheelchair. She was coded as receiving dialysis during the lookback period. Resident #1 was unavailable for observation during the survey. She was out for a dialysis appointment. A review of Resident #1's clinical record revealed the following physician order dated 11/19/20: "Dialysis T-Th-Sat (Tuesday, Thursday, Saturday) [name of community dialysis center] one time a day every Tue (Tuesday), Thu (Thursday), Sat (Saturday)." The order did not have a stop date. Further review of Resident #1's clinical record revealed a TAR (treatment administration record) for January 2021, which documented the above physician's order for dialysis. The box for Resident #1's dialysis treatment on 1/5/21 was blank. A review of Resident #1's nurses' notes for 1/5/21 contained no evidence that Resident #1 received dialysis that day, or that her physician or RR (resident representative) was notified. Further review of Resident #1's clinical record failed to reveal any physician orders or directives	F 698	dialysis access site and restrictions for vital signs/needlesticks to affected extremity. 4- DON/Designee will audit Dialysis communication forms and New admission orders 5 days a week for 2 weeks, 3 days a week for 4 weeks to ensure residents receiving dialysis have appropriate physician orders and communication with physicians/dialysis centers and responsible party.	03-02-2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495272	A. BUILDING ______ B. WING ______	C 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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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 access."

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495272	A. BUILDING ______ B. WING ______	C 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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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 guess 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495272	A. BUILDING ______ B. WING ______	C 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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698		F 698		

Continued From page 46
documented, she stated, "On the TAR."

On 2/4/21 at 4:30 p.m., ASM (administrative staff member) #2, the regional director of operations, and RN #1, the assistant director of nursing (ADON) were informed of these concerns.

On 2/5/21 at 9:30 a.m., ASM #2, RN #1, and ASM #3, the regional director of clinical services, were interviewed. ASM #3 stated she had already identified that there had not been required orders or assessments for Resident #1's dialysis access site and right arm during January 2021. She stated she had already begun steps to correct this deficiency.

A review of the facility policy, "Care of A Resident with End-Stage Renal Disease," revealed, in part: "Staff caring for residents with ESRD, including residents receiving dialysis care outside the facility, shall be trained in the care and special needs of these residents. Education and training of staff includes, specifically...The type of assessment data that is to be gathered about the resident's condition on a daily or per shift basis...the care of grafts and fistulas."

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495272	A. BUILDING ______ B. WING ______	C 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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698	Continued From page 47	F 698		

(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 the work your kidneys used to do. Unless you have a kidney transplant, you will need a treatment called dialysis. There are two main types of dialysis. Both types filter your blood to rid your body of harmful wastes, extra salt, and water. Hemodialysis uses a machine. It is sometimes called an artificial kidney. You usually go to a special clinic for treatments several times a week." This information was taken from the website https://medlineplus.gov/dialysis.html.

(3) "Diabetes (mellitus) is a disease in which your blood glucose, or blood sugar, levels are too high." This information is taken from the website https://medlineplus.gov/diabetes.html.

(4) "Bipolar disorder (formerly called manic-depressive illness or manic depression) is a mental disorder that causes unusual shifts in mood, energy, activity levels, concentration, and the ability to carry out day-to-day tasks." This information is taken from the website https://www.nimh.nih.gov/health/topics/bipolar-disorder/index.shtml.

(5) "Obesity, defined as a body mass index (BMI) = 30 kg/m2, is recognized as an important risk factor. The Centers for Disease Control and Prevention (CDC) reported that obesity rates in the U.S. have increased dramatically over the last 30 years, and obesity is now epidemic in the United States (Kahn, 2009). For adults 60 years and older, the prevalence of obesity is about 37% among men and 34% among women (NHANES -

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495272	A. BUILDING ______ B. WING ______	C 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

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F 698	Continued From page 48 National Health and Nutrition Examination Survey). Obesity may be further classified according to the NIH: Class I Obesity = BMI 30.0-34.9 kg/m² Class II Obesity = BMI 35.0-39.9 kg/m² Class III (Extreme) Obesity = BMI = 40.0 kg/m²" This information is taken from the website https://www.cms.gov/medicare-coverage-database/details/nca-tracking-sheet.aspx?NCAId=258&fromdb=true. (6) "The best type of long-term access is an AV fistula. A surgeon connects an artery to a vein, usually in your arm, to create an AV fistula. An artery is a blood vessel that carries blood away from your heart. A vein is a blood vessel that carries blood back toward your heart. When the surgeon connects an artery to a vein, the vein grows wider and thicker, making it easier to place the needles for dialysis. The AV fistula also has a large diameter that allows your blood to flow out and back into your body quickly. The goal is to allow high blood flow so that the largest amount of blood can pass through the dialyzer." This information is taken from the website https://www.niddk.nih.gov/health-information/kidney-disease/kidney-failure/hemodialysis. (7) "Your access is your lifeline. You will need to protect your access. Wash the area around your access with soap and warm water every day. Check the area for signs of infection, such as warmth or redness. When blood is flowing through your access and your access is working well, you can feel a vibration over the area. Let your dialysis center know if you can't feel the vibration." This information is taken from the website	F 698		

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F 698	Continued From page 49 https://www.niddk.nih.gov/health-information/kidney-disease/kidney-failure/hemodialysis.	F 698		
F 710 SS=D	Resident's Care Supervised by a Physician CFR(s): 483.30(a)(1)(2) §483.30 Physician Services A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. A physician, physician assistant, nurse practitioner, or clinical nurse specialist must provide orders for the resident's immediate care and needs. §483.30(a) Physician Supervision. The facility must ensure that- §483.30(a)(1) The medical care of each resident is supervised by a physician; §483.30(a)(2) Another physician supervises the medical care of residents when their attending physician is unavailable. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review, and in the course of a complaint investigation, it was determined that the facility failed to ensure the attending physician ordered required dialysis care and services for one of six residents in the survey sample, Resident #1. The facility physician failed to order assessment of Resident #1's dialysis access site, and failed to provide instructions to clinical staff regarding use of the resident's right arm for all of January 2021. The findings include:	F 710	F710 Resident's Care Supervised by Physician - Physician's Services 1- Physician orders obtained for Resident 1 for assessment of dialysis access site and restrictions related to vitals signs/needlesticks in affected extremity. 2- Residents receiving dialysis services have the potential to be affected by this alleged deficient practice. Clinical Administration team reviewed physician orders for residents receiving dialysis were reviewed, orders updated as needed to include assessment of dialysis access site and restrictions related to vital signs/needlesticks to affected extremity 3- Hemodialysis Access Care Policy reviewed, on 2-5-21, no revisions necessary at this time. Staff Development Coordinator/Designee will in-service Licensed Nursing Staff on Hemodialysis Access Care Policy and Dialysis communication forms to ensure orders are obtained for dialysis, monitoring of dialysis access site and restrictions for vital signs/needlesticks to affected extremity. Newly admitted residents that receive dialysis services will be reviewed in Clinical Meeting daily Monday through Friday to ensure Dialysis orders are in place to include dialysis days and times, monitoring dialysis access site and restrictions for vital signs/needlesticks to affected	

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F 710	Continued From page 50 Resident #1 was admitted to the facility on 11/26/18, and most recently readmitted on 12/24/20, with diagnoses including, but not limited to: ESRD (end stage renal disease) (1) requiring dialysis (2), history of a stroke, diabetes (3) bipolar disorder (4), and morbid (extreme) obesity (5). On the most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 12/30/20, Resident #1 was coded as being severely cognitively impaired for making daily decisions, having scored seven out of 15 on the BIMS (brief interview for mental status). She was coded as requiring the extensive assistance of staff for bed mobility, dressing, and personal hygiene. She was coded as being completely dependent on the assistance of two staff members for transfers and bathing. She was coded as not moving from a sitting to standing position, or as walking, during the lookback period. Her only mobility device was a wheelchair. She was coded as receiving dialysis during the lookback period. Resident #1 was unavailable for observation during the survey. She was out for a dialysis appointment. A review of Resident #1's clinical record revealed the following physician order dated 11/19/20: "Dialysis T-Th-Sat (Tuesday, Thursday, Saturday) [name of community dialysis center] one time a day every Tue (Tuesday), Thu (Thursday), Sat (Saturday)." The order did not have a stop date. Further review of Resident #1's clinical record failed to reveal any orders or directives for assessment of Resident #1's dialysis access site (AV fistula) (6) in her right arm, or for the staff not	F 710	extremity. Medical Director will be informed during QAPI meeting and will educate all Physicians and extenders of the need for dialysis site care orders. 4- DON/Designee will audit Dialysis communication forms and New admission orders 5 days a week for 2 weeks, 3 days a week for 4 weeks to ensure residents receiving dialysis have appropriate physician orders and communication with physicians/dialysis centers and responsible party.	03-02-2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 710	Continued From page 51 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 2/5/21 at 10:40 a.m., ASM (administrative staff member) #4, who is Resident #1's attending physician, was interviewed. When asked what orders should be in place for a resident who receives dialysis, ASM #4 stated, "The orders for dialysis." When asked if those orders should include anything related to assessment of the fistula, or directives for staff not to use the arm containing the fistula for blood pressures or blood draws, ASM #4 stated, "None of those things should be in place." She stated residents are receiving dialysis "every other day," so the dialysis centers are taking care of the assessments. ASM #4 stated the issue of blood pressures and blood draws only applies to "the hospitals," adding, "I've only seen those signs posted in the rooms in the hospitals. These nursing homes don't do that." ASM #4 stated, "What you're asking about is for the hospitals, not for nursing homes." On 2/5/21 at 9:30 a.m., ASM #2, ASM #2, the regional director of operations, and RN (registered nurse) #1, the ADON (assistant director of nursing), and ASM #3, the regional director of clinical services, were informed of this concern. ASM #3 stated she had already identified that there had not been required orders	F 710		

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	495272	A. BUILDING ______ B. WING ______	C 02/05/2021

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F 710	Continued From page 52	F 710		

or assessments for Resident #1's dialysis access site and right arm during January 2021. She stated she had already begun steps to correct this deficiency. ASM #3 stated the facility is responsible for having the correct orders for these items for residents who are receiving dialysis.

A review of the facility policy, "Care of A Resident with End-Stage Renal Disease," revealed, in part: "Staff caring for residents with ESRD, including residents receiving dialysis care outside the facility, shall be trained in the care and special needs of these residents. Education and training of staff includes, specifically...The type of assessment data that is to be gathered about the resident's condition on a daily or per shift basis...the care of grafts and fistulas."

A review of the facility policy, "Physician Services," revealed, in part: "The medical care of each resident is under the supervision of a Licensed Physician...The resident's attending physician participates in the resident's assessment and care planning, monitoring changes in resident's medical status, providing consultation or treatment when called by the facility, and overseeing a relevant plan of care for the resident."

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 710	Continued From page 53	F 710		

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 the work your kidneys used to do. Unless you have a kidney transplant, you will need a treatment called dialysis. There are two main types of dialysis. Both types filter your blood to rid your body of harmful wastes, extra salt, and water. Hemodialysis uses a machine. It is sometimes called an artificial kidney. You usually go to a special clinic for treatments several times a week." This information was taken from the website https://medlineplus.gov/dialysis.html.

(3) "Diabetes (mellitus) is a disease in which your blood glucose, or blood sugar, levels are too high." This information is taken from the website https://medlineplus.gov/diabetes.html.

(4) "Bipolar disorder (formerly called manic-depressive illness or manic depression) is a mental disorder that causes unusual shifts in mood, energy, activity levels, concentration, and the ability to carry out day-to-day tasks." This information is taken from the website https://www.nimh.nih.gov/health/topics/bipolar-disorder/index.shtml.

(5) "Obesity, defined as a body mass index (BMI) = 30 kg/m2, is recognized as an important risk factor. The Centers for Disease Control and Prevention (CDC) reported that obesity rates in the U.S. have increased dramatically over the last 30 years, and obesity is now epidemic in the United States (Kahn, 2009). For adults 60 years

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F 710	Continued From page 54 and older, the prevalence of obesity is about 37% among men and 34% among women (NHANES - National Health and Nutrition Examination Survey). Obesity may be further classified according to the NIH: Class I Obesity = BMI 30.0-34.9 kg/m^2 Class II Obesity = BMI 35.0-39.9 kg/m^2 Class III (Extreme) Obesity = BMI = 40.0 kg/m^2" This information is taken from the website https://www.cms.gov/medicare-coverage-database/details/nca-tracking-sheet.aspx?NCAId=258&frmdb=true. (6) "The best type of long-term access is an AV fistula. A surgeon connects an artery to a vein, usually in your arm, to create an AV fistula. An artery is a blood vessel that carries blood away from your heart. A vein is a blood vessel that carries blood back toward your heart. When the surgeon connects an artery to a vein, the vein grows wider and thicker, making it easier to place the needles for dialysis. The AV fistula also has a large diameter that allows your blood to flow out and back into your body quickly. The goal is to allow high blood flow so that the largest amount of blood can pass through the dialyzer." This information is taken from the website https://www.niddk.nih.gov/health-information/kidney-disease/kidney-failure/hemodialysis.	F 710		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the	F 880	1. The facility was unable to retroactively correct the Recreation Aide #7 related to Handwashing and Hand Hygiene. The Recreation Aide #7 was suspended pending further investigation and terminated on 2/8/2021 due to having past and ongoing education and failing to follow the facility policy on hand washing and hand hygiene.	

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	495272	A. BUILDING ______ B. WING ______	C 02/05/2021

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F 880	Continued From page 55 development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.	F 880	2. Current residents have the potentially been affected. Facility education for all facility staff occurring to ensure the safety of all residents. 3. Infection Preventionist/designee to provide education to facility staff on the Policy and Procedures for hand washing and hand hygiene, including donning and doffing of personal protective equipment. Facility staff will perform competencies for hand washing, donning and doffing of PPE with an emphasis on return demonstrations on hand hygiene. Root Cause Analysis was completed on 2-18-21 to determine that all facility staff would be provided additional education with a return demonstration to ensure proper compliance of the policy. 4. Infection Preventionist/designee to complete ten (10) observations weekly for 4 weeks for facility staff for hand hygiene and donning/doffing of personal equipment while providing activities/services. The QAPI Committee will make recommendations based upon the results of the audits to ensure compliance.	03-02-2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495272	A. BUILDING ______ B. WING ______	C 02/05/2021

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F 880	Continued From page 56	F 880		

(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, and facility document review, it was determined that the facility staff failed to follow infection control procedures to prevent the spread of infection and communicable disease on two of three hallways on the Westham Unit, hallways A and B. An activities staff member failed to wash her hands between contact with residents' curtains and other personal items while serving beverages on the Westham Unit on 2/2/21.

The findings include:

On 2/2/41 at 10:43 a.m., OSM (other staff member) #7, a recreation aide, was observed going into room #217 on Hallway B of the Westham Unit. She was wearing an isolation

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F 880	Continued From page 57 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	F 880		

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F 880	Continued From page 58 approximately the past 15 minutes, and was not observed washing her hands one time, OSM #7 stated she was not aware. On 2/2/21 at 11:30 a.m., ASM (administrative staff member) #1, the administrator, and RN (registered nurse) #1, the ADON (assistant director of nursing), were informed of these observations, and of the interview with OSM #7. ASM #1 stated, "There is nothing to say. She should have been washing her hands between each resident. At a minimum." A review of the facility policy, "Handwashing/Hand Hygiene," revealed, in part: "The facility considers hand hygiene the primary means to prevent the spread of infection...All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors...Use an alcohol based hand rub...or, alternatively soap...and water for the following situations: before and after direct contact with residents...after contact with objects...in the immediate vicinity of the resident...before and after eating or handling food...before and after assisting a resident with meals." No further information was provided prior to exit.	F 880		
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative	F 883	1. The facility notified the Resident/Resident Representative and medical provider for residents #1, #3, #4, and #5 to obtain consent, as well as educate them on the influenza and pneumococcal immunization. Documentation on the consents/declined residents has been documented in the medical record.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANTERBURY REHABILITATION & HEALTH CARE CENTER	1776 CAMBRIDGE DRIVE RICHMOND, VA 23238

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F 883	Continued From page 59 receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following:	F 883	2. All current residents were reviewed to ensure the facility offered, educated and obtained consent regarding influenza and pneumococcal immunization and that appropriate documentation completed for the resident record. 3. A Root Cause Analysis was completed on 2-15-21 to determine that a logging system needed to be obtained/monitored to ensure compliance for monitoring all vaccinations specific to Influenza, Pneumococcal and COVID, are being offered and/or declined as well ensuring education was properly provided and documented. In addition the Director of Nursing/designee to provide education to all Unit Managers and Nursing Supervisors regarding the (A) eligibility to receive the pneumococcal and influenza vaccination (B) Before receiving the vaccinations the resident or legal representative shall receive information and education regarding the benefits and potential side effects of the vaccine {unless medically contraindicated already given or refused}, and the rights to refuse the vaccination and (C) For residents who receive the vaccines the date of vaccination , lot number, expiration date, person administering and the site of vaccination will be documented in the residents medical record. 4. The Director of Nursing / designee will complete 10% of the resident population weekly for 10 weeks to ensure 100% compliance. The Director of Nursing / designee will report to the QAPI Committee monthly until the facility is in 100% compliance, and then quarterly to ensure the facility is remaining in compliance thereafter.	03-02-2021.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495272	A. BUILDING ______ B. WING ______	C 02/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 883	Continued From page 60	F 883		

(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and
(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, clinical record review and facility document review, it was determined that the facility failed to maintain and implement an immunization program for the influenza and pneumococcal vaccines for four out of five residents in the immunization record review, Residents #1, #3, #4, and #5.

The facility staff failed to ensure the medical record includes documentation that immunization status was assessed, vaccinations and education were offered, declined or provided for Residents #1, #3, #4, and #5.

The findings include:

1. The facility staff failed to evidence documentation in the clinical record that Resident #1's influenza and pneumococcal immunization status was assessed, that education and the vaccines were offered, declined or that Resident #1 had already been immunized or that the immunizations were medically contraindicated.

Resident #1 was admitted to the facility on 2/5/20 and had the diagnoses of but not limited to COVID-19, tibia fracture, high blood pressure, diabetes, end stage renal disease, dysphagia, stroke, obesity, bipolar disorder, chronic kidney

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495272	A. BUILDING ______ B. WING ______	C 02/05/2021

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F 883	Continued From page 61 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	F 883		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495272	A. BUILDING ______ B. WING ______	C 02/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 883	Continued From page 62 to the facility on 2/5/20, or during the 2020-2021 flu season. A review of the facility policy "Pneumococcal Vaccine" documented, "Residents will be offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections. 1. Residents will be assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, will be offered the vaccine series unless medically contraindicated or the resident has already been vaccinated. 2. Before receiving the pneumococcal vaccine, the resident or legal representative shall receive information and education regarding the benefits and potential side effects of the pneumococcal vaccine....Provision of such education shall be documented in the resident's medical record. 3. Pneumococcal vaccines will be administered to residents (unless medically contraindicated, already given, or refused) per physician order. 4. Residents/representatives have the right to refuse vaccination. If refused, appropriate entries will be documented in each resident's medical record indicating the date of the refusal of the pneumococcal vaccination. 5. For residents who receive the vaccines, the date of vaccination, lot number, expiration date, person administering, and the site of vaccination will be documented in the resident's medical record...." In addition, a policy for "Influenza Vaccine" documented, "All residents who have no medical contraindications to the vaccine will be offered the influenza vaccine annually to encourage and promote the benefits associated with vaccinations against influenza....1. Between October 1st and March 31st each year, the influenza vaccine shall be offered to residents unless the vaccine is	F 883		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495272	A. BUILDING ______ B. WING ______	C 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

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F 883	Continued From page 63 medically contraindicated or the resident or employee has already been immunized. 2. Prior to the vaccination, the resident (or resident's legal representative) will be provided information and education regarding the benefits and potential side effects of the influenza vaccine....Provision of such education shall be documented in the resident's or employee's medical record. 3. For those who receive the vaccine, the date of vaccination, lot number, expiration date, person administering, and the site of vaccination will be documented in the resident's/employee's medical record. 4. A resident's refusal of the vaccine shall be documented on the Informed Consent for Influenza Vaccine and placed in the resident's medical record....7. Residents may obtain their influenza vaccines from their personal physicians. Documentation of previous vaccination should be provided to the facility...." No further information was provided by the end of the survey. 2. The facility staff failed to evidence documentation in the clinical record that Resident #3's pneumococcal immunization status was assessed, that education and the vaccine were offered, or that the immunization was medically contraindicated. Resident #3 was admitted to the facility on 9/11/20 and had the diagnoses of but not limited to COVID-19, cellulitis, chronic kidney disease, depression and obesity. The quarterly MDS (Minimum Data Set) assessment with an ARD (Assessment Reference Date) of 1/11/21, coded the resident as being cognitively intact in ability to make daily life decisions. The resident was	F 883		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495272	A. BUILDING ______ B. WING ______	C 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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 883	Continued From page 64	F 883		

coded as requiring total care for bathing; supervision for transfers, dressing, toileting, and hygiene; and was independent for eating.

A review of the electronic clinical record failed to reveal any documentation of the pneumococcal immunization being administered. There was no documentation evidencing that the pneumococcal vaccine had been previously administered or was medically contradicted.

Further review failed to reveal any evidence of education and consents being offered for the pneumococcal immunization.

On 2/1/21 at 3:54 PM a request was made for the immunization record information, consents and education for Resident #3.

On 2/2/21 at 5:16 PM, a pneumococcal consent form was provided, which documented the resident refused the vaccine, and that the refusal was because the resident had received the vaccine on 2/3/20. This consent was 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 pneumococcal status was

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	495272	A. BUILDING ______ B. WING ______	C 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

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F 883	Continued From page 65	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.

No further information was provided by the end of the survey.

3. The facility staff failed to evidence documentation in the clinical record that Resident #4's pneumococcal immunization status was assessed, that the education and the vaccine was offered, that Resident #4 had already been immunized or that the immunization was medically contraindicated.

Resident #4 was admitted to the facility on 11/27/20 and had the diagnoses of but not limited to bladder cancer, chronic obstructive pulmonary disease, dysphagia, high blood pressure, and heart failure. The admission MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 12/1/20 coded the resident as being moderately impaired in ability to make daily life decisions. The resident was coded as requiring supervision for eating; extensive assistance for transfers, dressing, toileting, and hygiene; and total care for bathing.

A review of the electronic clinical record failed to reveal any documentation of the pneumococcal immunization being administered. There was no documentation evidencing the resident had been previously immunized or that the pneumococcal immunization was medically contradicted.

Further review failed to reveal any evidence of education and consent being offered for the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495272	A. BUILDING ______ B. WING ______	C 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

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F 883	Continued From page 66	F 883		

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.

On 2/2/21 at 5:16 PM, a pneumococcal consent form was provided, which documented the resident refused the vaccine, and documented that the refusal was because the resident stated he already received the vaccine. This consent was 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 pneumococcal status was 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.

No further information was provided by the end of the survey.

4. The facility staff failed to evidence documentation in the clinical record that Resident #5's influenza and pneumococcal immunization status was assessed, that education and the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495272	A. BUILDING ______ B. WING ______	C 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

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F 883	Continued From page 67 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	F 883		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495272	A. BUILDING ______ B. WING ______	C 02/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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.