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

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| F 000 | INITIAL COMMENTS<br><br>An unannounced Medicare/Medicaid abbreviated survey was conducted 10/19/2021 through 10/22/2021. Six complaints (VA00053345- substantiated with no deficiency, VA00050914- unsubstantiated with no deficiency, VA00053250- unsubstantiated with unrelated deficiency, VA00050891- unsubstantiated with unrelated deficiency, VA00053202- Substantiated with no deficiency, VA00053152- unsubstantiated with no deficiency), were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements.<br><br>The census in this 190 certified bed facility was 175 at the time of the survey. The survey sample consisted of nine current resident reviews and six closed record reviews. | F 000 | | |
| F 558 SS=D | Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3)<br><br>§483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, resident interview, 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 maintain the call bell in a position accessible to the resident for one of nine current residents in the survey sample, Resident #12. | F 558 | SS=D CRR(s): 483.10(e)(3)<br><br>Resident #12 at the time of finding was provided with a call cord within reach and clipped to bed linen for security.<br>Residents who reside at Canterbury Health and Rehabilitation have the potential to be affected by this practice. | 10/18/21 |

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

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.

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| F 558 | Continued From page 1<br>On 10/19/21, Resident #12 was observed without a functioning call bell and no hand bell was observed on Resident #12's side of the room or within reach of the resident.<br><br>The findings include:<br><br>Resident #12 was admitted to the facility with diagnoses that included but were not limited to Parkinson's disease (1) and major depressive disorder (2). Resident #12's most recent MDS (minimum data set) assessment, an annual assessment with an ARD (assessment reference date) of 10/2/2021, coded Resident #12 as scoring an 11 on the brief interview for mental status (BIMS) scale, 11- being moderately impaired for making daily decisions. Section G coded Resident #12 as requiring extensive assistance of one staff member for bed mobility, transfers and extensive assistance of two or more staff members for toileting and personal hygiene. Section G coded Resident #12 as not having any impairment in the upper extremities.<br><br>The comprehensive care plan for Resident #12 dated 12/10/2020 documented in part, "I have an ADL (activities of daily living) Self Care Performance Deficit r/t (related to) Activity Intolerance, Disease Process, impaired mobility related to Parkinson's, right sided weakness with tremors. Date Initiated: 12/10/2020."<br><br>On 10/19/2021 at approximately 4:45 p.m., an observation was made of Resident #12 in their room. Resident #12 was observed lying in bed with the head of bed elevated and overbed table to the right of the bed. The call bell unit located on the wall between Resident #12's bed and their roommate's bed was observed to without any call | F 558 | The Administrator/Designee completed a 100% audit to ensure all residents have a functioning call bell within their reach.<br>Ambassador rounds will be made daily by the Department Head team, to include checking call bell placement.<br><br>The DON/Designee will accomplish a monthly audit for the next three months to ensure ongoing compliance with this process.<br>The findings from the audit will be presented to the QAPI committee monthly for review and recommendation.<br>Compliance Date: ____________ | 10/18/21 |

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| F 558 | Continued From page 2<br>bell cords attached to it. When asked if they had a call bell, Resident #12 and their roommate both stated that it was broken. Resident #12 stated that they did not have a call bell so their roommate went out to get staff when needed. A hand bell was observed on the dresser beside the television of Resident #12's roommate. No hand bell was observed on Resident #12's side of the room or in reach of Resident #12.<br><br>Additional observation on 10/19/2021 at approximately 5:40 p.m., revealed the same as above. On 10/20/2021 at approximately 8:50 a.m., Resident #12 was observed in bed with the overbed table in front of them. Call bell cords with push button ends were observed attached to the call bell unit between Resident #12's bed and their roommate's bed. Resident #12 stated that staff had put the cords in that morning but they did not work. A hand bell was observed on top of Resident #12's overbed table. Resident #12 stated that someone had put it there the night before.<br><br>On 10/20/2021 at approximately 10:20 a.m., an interview was conducted with LPN (licensed practical nurse) #2, unit manager. LPN #2 stated that they were aware of Resident #12's call light being broken but they were not sure how long it had been out. LPN #2 stated that they had provided both residents in the room with hand bells to use until the call bell could be repaired. LPN #2 stated that the company had been into repair the call bell previously and that maintenance was aware that they needed to come back. LPN #2 was made aware of the observations on 10/19/2021 of Resident #12 in bed without a hand bell available and stated that she knew that Resident #12 had one. | F 558 | | |

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| F 558 | Continued From page 3 | F 558 | | |

On 10/20/2021 at approximately 2:40 p.m., an interview was conducted with OSM (other staff member) #5, maintenance director. OSM #5 stated that staff enter work orders for them to complete repairs within the facility, including call bell repairs. OSM #5 stated that they had the vendor out to repair the call bell in Resident #12's room on 5/4/2021 and had a current work order in for them to come to look at it again which he had entered that morning. OSM #5 stated that they were not aware of any call bell problems prior to the morning of 10/20/2021 when Resident #12's roommate had flagged him down when he walked past.

On 10/20/2021 at approximately 12:43 p.m., a request was made to ASM (administrative staff member) #2, the director of nursing for the facility policy on call bells and all information on repairs for the call bell in Resident #12's room.

On 10/20/2021 at approximately 2:40 p.m., ASM #1, the administrator and OSM #5, maintenance director provided the completed work order dated 5/4/2021 from the vendor which documented repairs completed on the call bell in Resident #12's room. An active work order was provided requesting repairs to Resident #12's room call bell was provided. OSM #5 stated that he had submitted it that morning.

The facility policy, "Answering the Call Light" dated April 2016 documented in part, "...Report all defective call lights to the nurse supervisor promptly..."

On 10/20/2021 at approximately 6:20 p.m., ASM #1, the administrator was made aware of the

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| F 558 | Continued From page 4 | F 558 | | |

above concern.

On 10/21/2021 at 11:30 a.m., CNA (certified nursing assistant) #4, LPN #2 and ASM #1 presented the following. CNA #4 stated that they worked with Resident #12 frequently and they displayed frequent behaviors of throwing items from their overbed table onto the floor, including their hand bell. CNA #4 stated that the call bell had been out for approximately two to three weeks now and Resident #12 had the hand bell which they were continually picking up off of the floor. CNA #4 stated that they rounded on Resident #12 frequently and made sure the hand bell was in reach when they were there. CNA #4 stated that Resident #12 had been displaying these behaviors recently.

On 10/21/2021 at 11:57 a.m., an interview was conducted with ASM #2, the director of nursing. ASM #2 stated that staff should document any behaviors Resident #12 was displaying and they should be monitoring them for continuing displaying of the behavior. A request was made to ASM #2 for any documentation of the behavior reported on 10/21/2021 by CNA #4.

On 10/21/2021 at 1:02 p.m., LPN #2 provided an updated care plan dated 10/21/2021 and stated that they had updated the care plan to include the behaviors reported by CNA #4. LPN #2 stated that they were not aware of any behaviors prior to CNA #4 reporting them during the interview on 10/21/2021 at 11:30 a.m.

On 10/21/2021 at approximately 4:45 p.m., ASM #1 was made aware of the continued concern.

No further information was presented prior to exit.

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| F 558 | Continued From page 5<br><br>References:<br><br>1. Parkinson's disease<br>A type of movement disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/parkinsonsdisease.html.<br><br>2. Major depressive disorder<br>Major depression is a mood disorder. It occurs when feelings of sadness, loss, anger, or frustration get in the way of your life over a long period of time. It also changes how your body works. This information was obtained from the website: https://medlineplus.gov/ency/article/000945.htm. | F 558 | | |
| F 658 SS=D | Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)<br><br>§483.21(b)(3) Comprehensive Care Plans<br>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br>(i) Meet professional standards of quality.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, clinical record review, facility document review and in the course of a complaint investigation it was determined facility staff failed to follow professional standards of practice for medication administration for one of two current residents observed during medication administration, Resident #13.<br><br>The facility staff failed to observe Resident #13 take their medications prior to leaving the room. | F 658 | **SS=D CFR (s): 483.21 (b) (3) (i)**<br><br>A Self-Administration of Medication evaluation was completed for resident #13.<br><br>Residents who have the ability to self-administer their medications have the potential to be affected by this practice. DON/Designee completed an audit on current residents to identify need for Self Administration of Medication Evaluation. | 11/12/21 |

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| F 658 | Continued From page 6<br>Resident #13 was not assessed to safely self-administer their medications and for medications to be left unattended at the bedside.<br><br>The findings include:<br><br>Resident #13 was admitted to the facility with achondroplasia (1) and dysphagia (2). Resident #13's most recent MDS (minimum data set), a quarterly assessment with an ARD (Assessment Reference Date) of 8/30/2020 coded Resident #13 as scoring an 15 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 15- being cognitively intact for making daily decisions.<br><br>On 10/20/2021 at 8:56 a.m., an observation of medication administration for Resident #13 was conducted with LPN (licensed practical nurse) #1. LPN #1 prepared medications to administer to Resident #13 including Aspirin 81 mg (milligram) one tablet, Baclofen 10 mg one tablet, Potassium Chloride 10 meq (millequivalent) one tablet, and Gabapentin 300 mg one tablet. LPN #1 entered Resident #13's room with the medication and placed the medication on the over bed table in front of Resident #13. Resident #13 was observed sitting in bed with the head of bed elevated eating breakfast. LPN #1 was observed telling Resident #13 that they had their medications for them and would come back later with a snack and then proceeded to leave the room and returned to the medication cart. LPN #1 failed to observe Resident #13 take the medication prior to exiting the room. LPN #1 proceeded to move their cart across the hallway to the next room.<br><br>On 10/20/2021 at 9:20 a.m., an interview was | F 658 | The DON/Designee will complete education on licensed nursing staff on safe medication administration practices to include safely allowing resident to self-administer medications. | 11/18/21 |

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| F 658 | Continued From page 7<br>conducted with LPN #1. LPN #1 stated that Resident #13 was a slow eater and never took the medication until after he finished breakfast. LPN #1 stated that they always left the medication for him to take when he was finished with his breakfast. LPN #1 stated that they always went back in later to make sure he had taken the medication and to bring him a snack. LPN #1 stated that they were going back to the room at that time to make sure he had taken the medication. LPN #1 stated that they thought Resident #13 was assessed and able to self-administer his medications.<br><br>Review of the physician's orders failed to evidence an order for self administration of medications prior to the observation on 10/20/2021 at 8:56 a.m.<br><br>The comprehensive care plan failed to evidence a care plan regarding self administration of medications created prior to the observation on 10/20/2021 at 8:56 a.m.<br><br>Resident #13's clinical record failed to evidence documentation of a completed assessment for self-administration of medications prior to the observation on 10/20/2021 at 8:56 a.m.<br><br>On 10/20/2021 at approximately 12:43 p.m., a request was made to ASM (administrative staff member) #2, the director of nursing for the facility policy on self administration of medications and for any self-administration assessment for Resident #13.<br><br>On 10/20/2021 at approximately 2:30 p.m., ASM #1, the administrator provided a "Medication Self-Administration Safety Screen" for Resident | F 658 | An audit will be completed by the DON/Designee monthly x 3 months on monitoring of safe medication administration practices with regards to self- administration of medication.<br>The findings from the audit will be presented to the QAPI committee monthly for review and recommendation. | 11/18/21 |

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| F 658 | Continued From page 8<br>#13 dated 10/20/2021 at 9:58 a.m. ASM #1 was asked for an assessment performed prior to the observation on 10/20/2021 at 8:56 a.m.<br><br>On 10/20/2021 at approximately 5:53 p.m., an interview was conducted with LPN #4. LPN #4 stated that staff were supposed to always stay with the resident to watch them take the medication. LPN #4 stated that they did this to ensure that they were not hoarding the medications or choking on them. LPN #4 stated that they were not sure of the process for self-administration of medications because they had never worked with a resident who wanted to do this and always stayed by their side until the medication was gone.<br><br>On 10/19/2021 at approximately 11:45 a.m., a request was made to ASM #1 and ASM #2 for any nursing standard of practice that the facility followed. On 10/20/2021 at approximately 11:38 a.m., ASM #1 provided a copy of the front cover of "Fundamentals of Nursing, Ninth Edition, Potter/Perry."<br><br>The facility policy "Self-Administration of Medications" dated December 2016 documented in part, "Residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so...As part of their overall evaluation, the staff and practitioner will assess each resident's mental and physical abilities to determine whether self-administering medications is clinically appropriate for the resident..."<br><br>According to "Fundamentals of Nursing, Eighth Edition, Potter/Perry, pg. 582," it documented in | F 658 | | |

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| F 658 | Continued From page 9 part, "...Assess the patient's ability to self-administer medications, determine whether a patient should receive a medication at a given time, administer medications correctly, and closely monitor their effects..."<br><br>On 10/20/2021 at approximately 6:20 p.m., ASM #1, the administrator was made aware of the findings.<br><br>No further information was presented prior to exit.<br><br>References:<br><br>1. Achondroplasia is a form of short-limbed dwarfism. The word achondroplasia literally means "without cartilage formation." Cartilage is a tough but flexible tissue that makes up much of the skeleton during early development. However, in achondroplasia the problem is not in forming cartilage but in converting it to bone (a process called ossification), particularly in the long bones of the arms and legs. Achondroplasia is similar to another skeletal disorder called hypochondroplasia, but the features of achondroplasia tend to be more severe.<br><br>2. Dysphagia: A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html. | F 658 | | |
| F 842 SS=D | Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)<br><br>§483.20(f)(5) Resident-identifiable information.<br>(i) A facility may not release information that is resident-identifiable to the public.<br>(ii) The facility may release information that is | F 842 | SS=D CFR(s): 483.20 (f)(5)<br>A statement was obtained from the C N A staff members who still employed at Canterbury Health and Rehabilitation that were assigned to resident #3 during the times of 11/8/2020 day shift and | 11/18/21 |

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| F 842 | Continued From page 10<br>resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.<br><br>§483.70(i) Medical records.<br>§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-<br>(i) Complete;<br>(ii) Accurately documented;<br>(iii) Readily accessible; and<br>(iv) Systematically organized<br><br>§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-<br>(i) To the individual, or their resident representative where permitted by applicable law;<br>(ii) Required by Law;<br>(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;<br>(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.<br><br>§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. | F 842 | 11/9/2020 stating their usual care flow with resident #3. Residents who reside at Canterbury Health and Rehabilitation have the potential to be affected by this practice.<br><br>Point of Care review/monitoring will be accomplished daily with Morning Clinical Meeting to ensure ADL documentation including turning and repositioning and care provided is completed. Education will be completed by DON/Designee for C N A staff member on completing documentation on turning and repositioning and care provided each shift. | 11/18/21 |

| 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 10/22/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| F 842 | Continued From page 11 | F 842 | | 11/18/21 |

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, clinical record review, and in the course of a complaint investigation, it was determined that the facility staff failed to ensure a complete and accurate clinical record for one of 15 residents in the survey sample; Resident #3.

The facility staff failed to document ADL (activity of daily living care) including turning and repositioning and care provided to Resident #3, between an entry on the morning of 11/8/20, and an entry on the evening of 11/9/20.

The findings include:

Resident #3 was admitted to the facility on 6/4/18

**Provider's Plan of Correction:**

The DON/Designee will complete a monthly audit x 3 months on the completion of Point of Care documentation of turning and repositioning and care provided to the residents during the shift. The findings from the audit will be submitted to the QAPI committee form review and recommendation.

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| F 842 | Continued From page 12 | F 842 | | |

and expired on 11/27/20 at the facility. The resident had the diagnoses of but not limited to chronic respiratory failure, chronic kidney disease, anxiety, depression, cerebrovascular disease, hemiplegia, Parkinson's disease, diabetes, high blood pressure, vascular dementia with behaviors, and dysphagia. The quarterly MDS (Minimum Data Set) assessment with an ARD (Assessment Reference Date) of 9/17/20 coded Resident #3 as severely cognitively impaired in ability to make daily life decisions. The resident was coded as requiring total care for all areas of activities of daily living. The resident was coded as not being ambulatory.

A review of the clinical record revealed the following on the November 2020 ADL (Activities of Daily Living) record as part of a compliant investigation. This review revealed the following:

CNA #5 (Certified Nursing Assistant) documented a bed bath on 11/8/20 at 10:41 AM; a skin check on 11/8/20 at 10:41 AM documented no areas, and for "turned and repositioned" 11/8/20 day shift documented, "N/NA" (no/not applicable) at 10:43 AM.

There was no CNA documentation for evening and night shift on 11/8/20 and day shift 11/9/20. The next CNA documentation was evening shift on 11/9/20 as follows:

A CNA (unidentified) documented a bed bath 11/9/20 evening shift at 7:58 PM, a skin check 11/9/20 at 7:58 PM documented an open area, and for "turned and repositioned" 11/9/20 at 8:01 PM documented, "Y" for "yes."

The concern was identified that CNA #5 had

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| F 842 | Continued From page 13<br>documented on 11/8/20 day shift that the resident was not turned and repositioned, then the next time a CNA documented care, was evening shift on 11/9/20 with an open area. The three shifts in between the two times of documentation were all left blank with no CNA documentation.<br><br>The CNA that documented on 11/8/20 (CNA #5) was interviewed on 10/22/21 at 9:20 AM. CNA #5 stated, "The only thing I would put no for is that if he was up in the wheel chair which was his normal routine. He was incontinent. I would have gotten him up during the shift to change him and clean him. I probably documented "No" because he was in the wheel chair and I considered turning and repositioning as a "in bed" task." It was also noted that her documentation was early in the shift, and therefore did not reflect care provided later in the shift that included turning and repositioning, etc.<br><br>Interviews were also conducted with the CNAs from evening and night shift of 11/8/20 and day shift of 11/9/20 who did not document any care on their shifts.<br><br>On 10/22/21 at 8:25 AM CNA #4, who cared for the resident on 11/8/20 evening and night shifts, was interviewed. CNA #4 stated, "I usually document every day, I don't know what happened there. But I definitely provided him care. You really had to with him because he was always doing things like taking his clothes off, and required incontinent care. He would have been provided incontinent care several times, redressed several times and his skin would have been observed for any areas. I did not report any areas because there wasn't any to report. I don't know what happened regarding the | F 842 | | |

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| F 842 | Continued From page 14<br>documentation."<br><br>On 10/22/21 at 9:38 AM CNA #6, who cared for the resident on 11/9/20 day shift, was interviewed. CNA #6 stated, regarding his skin, "It was just light red, not opened. I reported to the nurse, put incontinent cream on, turned and repositioned. He liked to be up in the chair." She did not know why it wasn't documented.<br><br>On 10/21/21 at 4:43 PM, ASM #1 (Administrative Staff Member) the Administrator, and ASM #2, the Director of Nursing, were made aware of the findings. No further information was provided by the end of the survey. | F 842 | | |