PRINTED: 01/23/2022 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	Service Super-Supe	3) DATE SURVEY COMPLETED
		495272	B. WING		C
NAME OF P	ROVIDER OR SUPPLIER	A CO - 50000 C 50000 C		STREET ADDRESS, CITY, STATE, ZIP CODE	01/13/2022
CANTEDE	NOV DEMARK ITATION	LIEALTH CARE CENTER		1776 CAMBRIDGE DRIVE	
CANTERE	BURT REHABILITATION (R HEALTH CARE CENTER		RICHMOND, VA 23238	
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
E 000	Initial Comments		E 00	0	14
F 000	survey was conducted	reconstruction (# Sections to section)	F 00	0	
F 550 SS=D	An unannounced Me survey was conducted One complaint was in (VA00054015 - substate required for compliant Federal Long Term Calife Safety Code survey. The census in this 19 time of the survey. The	dicare/Medicaid standard d 1/11/22 through 1/13/22. vestigated during the survey antiated). Corrections are ce with 42 CFR Part 483 are - Requirements. The ey/report will follow. D bed facility was 177 at the e survey sample consisted reviews and seven closed cise of Rights	F 55		
	self-determination, an access to persons and outside the facility, incertain this section. §483.10(a)(1) A facility with respect and dignity resident in a manner appromotes maintenance.	ht to a dignified existence, d communication with and d services inside and cluding those specified in by must treat each resident ty and care for each and in an environment that e or enhancement of his or gnizing each resident's ty must protect and	CF Re me dig Cer imp	Sist SS=D Resident Rights/Exercise of Rights (R(s): 483.10(a)(1)(2)(b)(1)(2) Sident #327 Foley Catheter was covered by stembers on 1/12/2022 to maintain the resident inified manner. Stiffied Nursing assistant #2 was educated on the portance of closing the restroom door while eting residents to ensure the provision of priving the provision of priving the residents.	t in a
ABORATORY	DIRECTOR'S OR PROVIDER/S	UPPLIER 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.

FORM CMS-2567(02-99) Previous Versions Obsolete

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	5 5		CONSTRUCTION	82.0	SURVEY PLETED
		*****		1300			С
		495272	B. WING			01	/13/2022
	PROVIDER OR SUPPLIER BURY REHABILITATION &	& HEALTH CARE CENTER		1	TREET ADDRESS, CITY, STATE, ZIP CODE 776 CAMBRIDGE DRIVE LICHMOND, VA 23238		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 550	§483.10(a)(2) The factor access to quality care severity of condition, or must establish and mapractices regarding traprovision of services of the residents regardless of the resident has the rights as a resident of or resident of the Unit. §483.10(b)(1) The factor resident can exercise interference, coercion from the facility. §483.10(b)(2) The resident can exercise interference, coercion from the facility. §483.10(b)(2) The resident from the facility rights and to be supposed exercise of his or her is subpart. This REQUIREMENT by: Based on observation interview and clinical rights determined that the facility for two of 62 residents #32. 1. The facility staff failed #327's urinary cathete Urine in the catheter be hall while Resident #33.	regardless of diagnosis, or payment source. A facility aintain identical policies and ansfer, discharge, and the under the State plan for all of payment source. If Rights. Fight to exercise his or her the facility and as a citizen ed States. Illity must ensure that the his or her rights without, discrimination, or reprisal Ident has the right to be percion, discrimination, and y in exercising his or her orted by the facility in the rights as required under this Is not met as evidenced In, resident interview, staff eccord review, it was cility staff failed to provide sidents in the survey 27 and #171. The dot of maintain Resident in a dignified manner. The gray assistant) #2 failed to and a gray assistant) #2 failed to and	F	Heapra all I ma priv Urin rev The edu Nui Cat dig Dig The edu Nui duri Uni auco mo are Fin DO	sidents who reside at Canterbury Rehab & althcare have the risk of being affected by ctice. A 100% random audit was accompresidents to ensure that they are being intained in a dignified manner, and provivacy is also maintained. The Catheter Care policy was reviewed, isions needed. Staff Development Coordinator/Designersing Assistants, and TNA staff on the Uricheter Care Policy and need for provision inity with resident care needs. The Staff Development Coordinator/Designersing and TNA staff on the provision of proving and the Licensed Nursing staff, Certified and the Licensed Nursing staff, Certified are sident to the provision of proving resident care needs. The Managers/designee will complete a randit of residents weekly x 4 weeks and the provision of proving the proving the provision of proving the proving the proving the proving the provision of proving the proving the proving the proving the proving the proving the proving	y this y this olished o sion of no ee ed nary of I. ee ed rivacy ndom en es needs rivacy.	f

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION		SURVEY PLETED
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NAME OF B		495272	B. WING_			01/	/13/2022
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CANTERE	BURY REHABILITATION 8	HEALTH CARE CENTER			6 CAMBRIDGE DRIVE		
				RIC	CHMOND, VA 23238		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 550	Continued From page	2	F 5	550			
	bathroom while toileting #171 personal care. observed exposed to unclothed from the war	the open doorways					
	The findings include:						
	12/29/21. Resident # but were not limited to paralysis and high blo #327's admission min with an assessment recoded the resident as	od pressure. Resident imum data set assessment eference date of 1/5/22, being cognitively intact.					
	Review of Resident #: revealed a physician's urinary catheter.	327's clinical record corder dated 12/30/21 for a					
	observed lying in bed. catheter bag was observame and was located was facing the door. covered and urine in the from the hall. At this the	/22 at 1:49 p.m., Resident #327 was ad lying in bed. The resident's urinary repair bag was observed attached to the bed and was located on the side of the bed that ing the door. The catheter bag was not a land urine in the catheter bag was visible a hall. At this time, another resident was ad in the hall outside of the room door.					
	observed lying in bed. catheter bag was observed and was located was facing the door. covered and urine in the from the hall. At this that asked how she felt about stated, "I don't feel good	od if people can see it."					
	Resident #327's comp	rehensive care plan dated	il e				1

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		405272	D. WING				С
NAME OF F	IROVIDED OD ALIDDU IED	495272	B. WING			01	/13/2022
W. AG. 193 C. 201 W. C. W. C. 201	PROVIDER OR SUPPLIER BURY REHABILITATION 8	HEALTH CARE CENTER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 550	12/31/21 failed to doc regarding dignity for the catheter bag. On 1/12/22 at 2:09 p.r. conducted with RN (restated urinary cathete over them. RN #3 state expose to the world the (urinary catheter). It's have dignity at all time. On 1/12/22 at 5:15 p.r. staff member) #1 (the (the director of nursing above concern. The facility policy titled failed to document information 2. Resident #171 was 4/27/21, with the diagred dementia, diabetes, hid depression. The most Data Set) was a quarted ARD (Assessment Ref Resident #171 was cocognitively impaired in decisions. The resider total care for bathing, it extensive assistance for and dressing; supervise coded as incontinent or on the state of the catheter of the cat	ument information ne resident's urinary m., an interview was egistered nurse) #3. RN #3 r bags should have a cover ted, "You don't want to e patient has a Foley personalized. They should es as much as possible." m., ASM (administrative administrator) and ASM #2 g) were made aware of the I, "Catheter Care, Urinary" ormation regarding dignity ags. was presented prior to exit. admitted to the facility on loses of but not limited to gh blood pressure, and recent MDS (Minimum erly assessment with an ference Date) of 1/6/22. ded as being severely ability to make daily life in was coded as requiring hygiene, and toileting; or transfers, bed mobility ion for eating; and was	F	550			

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A. BUILDING		STATEMENT	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	0/014/11/2		OMB N	NO. 0938-039
ANAME OF PROVIDER OR SUPPLIER CANTERBURY REHABILITATION & HEALTH CARE CENTER RICHMOND, VA. 22328 STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA. 22328 RICHMOND, VA. 22328 SIMMARY STATEMENT OF DEFICIENCIES (FACI) DEFICIENCY MUST BE PRECEDED BY FULL TAG FS 50 Continued From page 4 Int the bathroom door and the door to the room open, Resident #171's wheelchair was placed in the doorway of the bathroom. After assisting the resident in the bathroom, CNA #2 assisted Resident #171 into the wheelchair. Observation revealed Resident #171 was underseased from the waist up, and was exposed to the open doorway of the room. At this limit, CNA #2 was then observed putting a shirt on Resident #171. On 1/1/2/22 at 9:42 AM an interview was conducted with CNA #2. When asked about providing privacy during care, she stated that cutalins and doors should be closed. When asked if the door to the room for Resident #171 was closed when she was providing her assistance to the bathroom and then dressing her, CNA #2 stated no. When asked if the residents dignity was maintained, she stated that it was not. On 1/1/12/22 at 1:10 PM ASM #1 (Administrative Staff Member; the Administrator) stated they do not have a policy on the provision of privacy and dignity during care. On 1/1/12/22 at approximately 5:30 PM at the end of day meeting, ASM #1 and ASM #2 (Administrator and Director of Nursing, respectively, were made aware of the findings. No further information was provided by the end of the survey. Self-Determination. The resident has the right to and the facility must				IDENTIFICATION NUMBER:				
ANTERBURY REHABILITATION & HEALTH CARE CENTER PREFIX SUMMARY STATEMENT OF DEPOSITIONS (EACH DERICIENCY MUST BE PRECEDED by PILL) REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (CROSS-REPERSIVE AC	l			495272	B. WING_		١.	
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPICIENCY MUST BE RECEDED BY FULL RECOULD THE RECOULT THE RECOULD THE RECOULT THE RECOULD THE RECOULT THE RECOULD THE RECOULD THE RECOULD THE RECOULT THE RECOULD THE RECOULT THE REC				HEALTH CARE CENTER		1776 CAMBRIDGE DRIVE	1 0	1/13/2022
left the bathroom door and the door to the room open. Resident #171's wheelchair was placed in the doorway of the bathroom. After assisting the resident in the bathroom, CNA #2 assisted Resident #171 into the wheelchair. Observation revealed Resident #171 into the wheelchair. Observation revealed Resident #171 was undressed from the waist up, and was exposed to the open doorway of the room. At this time, CNA #2 was then observed putting a shirt on Resident #171. On 1/12/22 at 9:42 AM an interview was conducted with CNA #2. When asked about providing privacy during care, she stated that curtains and doors should be closed. When asked if the door to the room for Resident #171 was closed when she was providing her assistance to the bathroom and then dressing her, CNA #2 stated no. When asked if the resident's dignity was maintained, she stated that it was not. On 1/13/22 at 1:10 PM ASM #1 (Administrative Staff Members) was maintained, she stated they do not have a policy on the provision of privacy and dignity during care. On 1/12/22 at approximately 5:30 PM at the end of day meeting, ASM #1 and ASM #2 (Administrative Staff Members) the Administrator and Director of Nursing, respectively, were made aware of the findings. No further information was provided by the end of the survey. F 561 SS=E Self-Determination. The resident has the right to and the facility must.		PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI	BE	COMPLETION
		F 561 SS=E ST	left the bathroom door open. Resident #171's the doorway of the bathresident in the bathroom Resident #171 into the revealed Resident #171 waist up, and was exported for the room. At this time observed putting a shirt observed putting a shirt of the room. At this time observed putting a shirt of the room. At this time observed putting a shirt of the room, as the conducted with CNA #2 providing privacy during curtains and doors show asked if the door to the was closed when she we assistance to the bathroom her, CNA #2 stated no. resident's dignity was must was not. On 1/13/22 at 1:10 PM A Staff Member, the Admirant have a policy on the dignity during care. On 1/12/22 at approximate of day meeting, ASM #1 (Administrative Staff Member, and Director of Nursing, resident by the end of the obself-Determination CFR(s): 483.10(f) Self-determination of the resident has the right in the resident has the right.	and the door to the room wheelchair was placed in hroom. After assisting the m, CNA #2 assisted wheelchair. Observation 1 was undressed from the beed to the open doorway e, CNA #2 was then t on Resident #171. an interview was . When asked about care, she stated that ald be closed. When room for Resident #171 as providing her from and then dressing When asked if the aintained, she stated that ask #1 (Administrative histrator) stated they do provision of privacy and ately 5:30 PM at the end and ASM #2 hibers) the Administrator respectively, were made of further information was e survey. B) ation. It to and the facility must		F561 SS=E Self-Determination	2/8	/2022

١	STATEMENT	OF DEFICIENCIES	(V1) PROMPERIOUS (FEB. 1971)	T		OMR N	O. 0938-039°
	A ANO	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	LE CONSTRUCTION		E SURVEY PLETED
l	Old concentration with the second		495272	B. WING		1	C
l	NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 01	/13/2022
L	CANTER	BURY REHABILITATION &	HEALTH CARE CENTER		1776 CAMBRIDGE DRIVE RICHMOND, VA 23238		
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E ATE	(X5) COMPLETION DATE
	find the state of	through support of resinot limited to the rights (1) through (11) of this \$483.10(f)(1) The residuactivities, schedules (in waking times), health coare services consister assessments, and plan applicable provisions of \$483.10(f)(2) The residuactivities about aspects of facility that are significal significant with members of the concommunity activities both facility. \$483.10(f)(8) The residual provisions of the concommunity activities both facility. \$483.10(f)(8) The residual provisions and community activities both facility. \$483.10(f)(8) The residual provisions, and community activities activities activities activities. This REQUIREMENT is activities activity document review, eview it was determined.	dent choice, including but specified in paragraphs (f) section. I ent has a right to choose including sleeping and are and providers of health at with his or her interests, of care and other if this part. I ent has a right to make of his or her life in the int to the resident. I ent has a right to interact infinity and participate in the inside and outside the interest in the interest in the inside and outside the interest in the survey	Res Hea prac ensi Acco revis Educ Coor Certi prefe Show ensur weekl ensur Findin DON/I	f sident # 162 was provided a shower after s post Covid status and moved from the (nd d by this to ment g staff, esident r to s to	

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A' '.AN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI	PLE CONSTRUCTION G	(X3) DAT	(X3) DATE SURVEY COMPLETED	
		495272	B. WING			С	
1	PROVIDER OR SUPPLIER RBURY REHABILITATION 8	HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	01	1/13/2022	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
I S S S S S S T C C C	The findings include: Resident #162 was addiagnoses that include hemiplegia [1], muscle pressure Resident #162's most data set), a quarterly as (assessment reference coded Resident #162 a interview for mental starts, 15, 15 - being cognitive decisions. Resident #1 requiring extensive assis members for activities of totally dependent of one On 01/112022 at approxinterview was conducted When asked if staff assis #162 stated that they are on Wednesdays and Sat	mitted to the facility with d but were not limited to: weakness and high blood recent MDS (minimum seessment with an ARD date) of 12/29/2021, as scoring a 15 on the brief tus (BIMS) of a score of 0 ely intact for making daily 62 was coded as stance of two staff f daily living and being staff member for bathing. Imately 1:56 p.m., an a with Resident # 162. It with showers, Resident e scheduled for showers furdays. Resident #162 to get them twice a week stated it was her east wice a week but getting it done. She ponge baths. When owers as scheduled to stated that they plan for Resident # 162 ented in part, "Focus. I daily living] Self Care to lititated: 07/08/2021."	F 56				

STATEME!	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		495272	B. WING_			С	
CANTE	F PROVIDER OR SUPPLIER RBURY REHABILITATION 8	vegadears		STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238		01/13/2022	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
	The facility's "Kardex" 01/22/2022 documented Hygiene. I require total hygiene care." Under "BATHING: total care." A review of Resident # September 1, 2021 threevealed that Resident shower on 09/04/2021, 09/22/2021, 10/27/202 11/27/2021. On 01/12/2022 at approinterview was conducted practical nurse] # 5, united describe the procedu LPN # 5 stated, "Resided day and we use a dry significant was severy Wednesday and Sto 11:00 p.m. shift." Whe # 162 receiving showers stated that there were time fused a shower. When	for Resident # 162 dated and in part, "Personal al assistance with personal "BATHING" it documented, "162's shower sheets dated ough December 31, 2021 # 162 did receive a 09/08/2021, 09/15/2021, 1, 11/10/2021 and on "Distinct of the property of the prope	F 56				

AN C	F OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495272	B. WING				С	
	PROVIDER OR SUPPLIER BURY REHABILITATION 8	HEALTH CARE CENTER		1770	REET ADDRESS, CITY, STATE, ZIP CODE 6 CAMBRIDGE DRIVE CHMOND, VA 23238	(01/13/2022	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	N
t s v C C irr s re d. A	Resident # 162's show always work the 3:00 p. When asked about Rea a shower CNA # 1 stat give [Resident # 162] a day because another s and we were short staff requires two staff for trawould give her a showed did. He wasn't happy a okay." On 01/13/2022 at approinterview was conducted practical nurse] # 5, uniterviewing Resident # 16 September 2021 throug 5 was asked why Resid showers on the dates list stated, "I can't answer when a conducted nursing assistant] # 3. When asked why a resident stated, "Residents get a When asked why a resident stated, "We can't always we don't have enough stated."	rers because they didn't o.m. to 11:00 p.m. shift. sident # 162 not receiving ed, "One day we couldn't is shower on her shower taff member had called out fed and [Resident # 162] ansfers. I told her we er the following day and we shout it but said it was eximately 8:15 a.m. and with LPN [licensed to manager. After 62's shower sheets dated in December 2021, LPN # ent # 162 did not receive sted above. LPN # 5 shy." Eximately 11:22 a.m. and with CNA [certified When asked to describe not showers CNA # 3 bed bath every day." ent would not receive a ed shower day CNA # 3 give showers because aff." Imately 12:30 p.m. an with ASM [administrative for of nursing. After ets for Resident # 162 rough December 2021, Resident # 162 did not ath on the dates listed	FS	561				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	CO POSSESSION AND AND AND AND AND AND AND AND AND AN	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495272	B. WING			C /13/2022	
	ROVIDER OR SUPPLIER BURY REHABILITATION 8	HEALTH CARE CENTER	-1	STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	1 00	TGIZUZZ	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	**** II	BE	(X5) COMPLETION DATE	
F 561	ASM # 2 stated yes. On 01/13/2022 at app (administrative staff mand ASM # 2, director aware of the findings. No further information Complaint deficiency Reference: [1] Also called: Hemip Quadriplegia. Paralys function in part of your something goes wrong pass between your bracan be complete or paboth sides of your bod one area, or it can be information was obtain https://medlineplus.go/ Safe/Clean/Comfortab/ CFR(s): 483.10(i)(1)-(3) §483.10(i) Safe Environ The resident has a right comfortable and home but not limited to receive supports for daily living The facility must provide \$483.10(i)(1) A safe, condelike environment, use his or her personal possible.	roximately 2:15 p.m., ASM nember) #1, administrator of nursing were made was provided prior to exit. legia, Palsy, Paraplegia, sis is the loss of muscle r body. It happens when g with the way messages ain and muscles. Paralysis urtial. It can occur on one or ly. It can also occur in just widespread This ned from the website: v/paralysis.html. le/Homelike Environment 7) soment. not to a safe, clean, elike environment, including ving treatment and g safely.	F 5	F584 SS=D Safe/Clean/Comfortable/FEnvironment CFR (s): 483.10(i)(1)-(7) The dry tan substance underneath the statube feeding pump pole in resident #426' cleaned at the time of the survey. Residents who reside at Canterbury Rehal Health have the potential of being affecte practice. Administrator/Designee complete in each resident's room to ensure that A scomfortable, homelike environment. Home Environment Policy reviewed no revinecessary.	o and d by this ed rounds afe, clean,	s	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		405272				С	
		495272	B. WING		01	/13/2022	
	ROVIDER OR SUPPLIER BURY REHABILITATION 8	L HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRICIENCY)	BE	(X5) COMPLETION DATE	
F 584	Continued From page	10	F 58	4			
	physical layout of the independence and do (ii) The facility shall exthe protection of the reor theft.	ices safely and that the facility maximizes resident es not pose a safety risk. Rercise reasonable care for esident's property from loss	p E	Canterbury staff were educated on the im f keeping the resident room floors clean roviding a Safe/Clean/Comfortable/Homnvironment.	and elike		
	services necessary to and comfortable interior		2 i ho	monthly x fortable,	ľ		
	§483.10(i)(3) Clean be in good condition; §483.10(i)(4) Private of	ed and bath linens that are	Findings from the audit will be presented to DON/Designee and submitted to QAPI mon review and recommendation.				
		cified in §483.90 (e)(2)(iv);					
	§483.10(i)(5) Adequate levels in all areas;	e and comfortable lighting					
	levels. Facilities initiall	able and safe temperature y certified after October 1, temperature range of 71 to					
	sound levels. This REQUIREMENT by: Based on observation	is not met as evidenced , staff interview and clinical					
	staff failed to maintain environment for one of sample, Resident #426	62 residents in the survey 6. The facility staff failed to loor in Resident #426's					
	The findings include:						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	8 8	LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		495272	B. WING				C
**************************************	ROVIDER OR SUPPLIER BURY REHABILITATION 8	& HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP COL 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	DE	<u> 01/</u>	/13/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	FIX (EACH CORRECTIVE ACTIO	N SHOULD BI E APPROPRIA		(X5) COMPLETION DATE
	Resident #426 was addiagnoses that include anoxic brain damage failure (2). Resident # (minimum data set), a an ARD (assessment 10/21/2021, coded the impaired for making d coded Resident #426 assistance of two or mand total assistance of personal hygiene, toile On 1/11/2022 at approbservation was made room. Resident #426 receiving a tube feeding pump. Resident #426 open and non-verbal. Resident #426's bed robserved to contain an material located on the stainless steel tube fee was observed to be approbable. Resident #426's bed robserved to be approbable, was dry and stainless steel tube fee was observed to be approbable, was dry and stainless steel tube fee was observed to be approbable, was dry and stainless steel tube fee was observed to be approbable. On 1/12/2022, at 2:00 conducted with LPN (li LPN #6 stated that how large spills but any sm by the nursing staff at the LPN #6 observed the action of the stated that how large spills but any sm by the nursing staff at the LPN #6 observed the action of the stated that how large spills but any sm by the nursing staff at the LPN #6 observed the action of the stated that how large spills but any sm by the nursing staff at the LPN #6 observed the action of the stated that how large spills but any sm by the nursing staff at the LPN #6 observed the action of the stated that how large spills but any sm by the nursing staff at the LPN #6 observed the action of the stated that how large spills but any sm by the nursing staff at the LPN #6 observed the action of the stated that how large spills but any sm by the nursing staff at the large spills but any sm by the nursing staff at the large spills but any sm by the nursing staff at the large spills but any sm by the nursing staff at the large spills but any sm by the nursing staff at the large spills but any sm by the nursing staff at the large spills but any sm by the nursing staff at the large spills but any sm by the nursing staff at the large spills but any sm by the nursing staff at the large spills but any sm by the	dmitted to the facility with ed but were not limited to (1) and congestive heart #426's most recent MDS a quarterly assessment with reference date) of a resident as being severely aily decisions. Section G as requiring total more staff with bed mobility of one staff member for eting, dressing and eating. Eximately 12:30 p.m., an eximately six by six suck to the floor. The area of dried tan-colored eximately six by six suck to the floor. The area of 1/11/2022 The area	F	584			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION		SURVEY PLETED
		495272	B. WING				C /13/2022
	ROVIDER OR SUPPLIER BURY REHABILITATION 8	HEALTH CARE CENTER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	1 01.	110/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 584	happened. LPN #6 stappeared to be tube for the floor and dried upshould not have been clean and did not appstated that they would On 1/12/2022 at approrequest was made to member) #1, the administrative and nonelike environment On 1/13/2022 at 1:10 the facility did not have comfortable, homelike On 1/12/2022 at approximation and ASN were made aware of the No further information References: 1. Anoxic brain damas Not enough oxygen gen information was obtain https://www.nlm.nih.go.001435.htm 2. Congestive heart facts A condition in which the blood to meet the body does not mean that you about to stop working.	ated that the substance beeding that had spilled on LPN #6 stated that it there and the floor was not lear homelike. LPN #6 I take care it at that time. Describe the floor was not lear homelike. LPN #6 I take care it at that time. Describe the facility stated that lear in the floor the facility staining a clean, comfortable, in the floor manner. Describe the floor was not learn, and the floor that learn that learn the floor that learn that floor the floor is learn the floor that learn that your heart is it the way it should. It can	F	584			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	8 /8		CONSTRUCTION		SURVEY PLETED
		40.5070		-			С
a company and a		495272	B. WING			01	/13/2022
STOREST CONTRACTOR OF	PROVIDER OR SUPPLIER BURY REHABILITATION 8	HEALTH CARE CENTER		1	TREET ADDRESS, CITY, STATE, ZIP CODE 776 CAMBRIDGE DRIVE RICHMOND, VA 23238		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 584 F 623 SS=E	information was obtain https://medlineplus.go Notice Requirements CFR(s): 483.15(c)(3)-\$483.15(c)(3) Notice It Before a facility transformed resident, the facility modified in the resident representative(s) of the reasons for the modified in the reasons for the modified in the reasons for the modified in the reasons discharge in the reside accordance with paragraph (c)(5) of this \$483.15(c)(4) Timing of (i) Except as specified (c)(8) of this section, the discharge required unimade by the facility at resident is transferred (ii) Notice must be many before transfer or discited (A) The safety of individual to the endangered under this section; (B) The health of individual transferred (ii) Notice must be many before transfer or discited (C) The resident's health of individual transferred (II) Notice must be many before transfer or discited (C) The resident's health of individual transferred (II) Notice must be many before transfer or discited (C) The resident's health of individual transferred (II) Notice must be many before transferred (III) Notice must	ned from the website: v/heartfailure.html Before Transfer/Discharge (6)(8) pefore transfer. ers or discharges a ust- and the resident's e transfer or discharge and ove in writing and in a they understand. The py of the notice to a office of the State udsman. s for the transfer or ent's medical record in graph (c)(2) of this section; the the items described in s section. of the notice. in paragraphs (c)(4)(ii) and the notice of transfer or der this section must be least 30 days before the or discharged. de as soon as practicable	F 6 V p # V p V p # V p	vritt vritt vrovi omb vritt vrovi 15. vritt vritt	F623 Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) ten notification of hospital transfer was ided to the Resident Representative for resident to the Resident Representative and udsman for resident #149. ten notification of hospital transfer was ided to the Resident Representative for resident resident R	esident esident	2/8/2022

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STATEMENT	OF DEFICIENCIES		T			OWR I	<u>vo. 0938-0391</u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		TE SURVEY MPLETED
		495272	B. WING				C
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 0	1/13/2022
CANTED					1776 CAMBRIDGE DRIVE		
CANTER	BURY REHABILITATION 8	HEALTH CARE CENTER			RICHMOND, VA 23238		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		,			
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 623 Continued From page 14 under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs,			F	523		Control Street Ann	
	required by the resider	nt's urgent medical needs,	R	esid	lents who resident at Canterbury Rehal	and	
	under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30		H	ealti	hcare who are transferred to the hospi	tal havo	1
1	days.	resided in the facility for 30	th	e po	otential to be affected by this practice.	An audit	
	days.		w	as co	ompleted of the last 30 days of residen	+	
	§483.15(c)(5) Contents	s of the notice. The written	tra	ansf	fers to the hospital to ensure a written	L	
	notice specified in para	agraph (c)(3) of this section	no	tific	cation was provided to the Resident		,
	must include the follow	ring:	Re	pre	sentative and/or Ombudsman. Resider		κ.
İ	(i) The reason for trans	sfer or discharge;	Re	pres	sentative and/or Ombudsman who did	IL	
1	(ii) The effective date o	f transfer or discharge;	red	ceive	e the letter of these transfers will be se	not	
	(iii) The location to which	ch the resident is	inf	orm	nation accordingly.	nt the	1
	transferred or discharge	eo; resident's appeal rights,			action accordingly.		
	including the name add	dress (mailing and email),	Tra	ins/	Discharge Policy reviewed no revisions		1
	and telephone number	of the entity which	neo	cess	ary.		1
	receives such requests	; and information on how			ation was provided by the		l I
	to obtain an appeal forr	n and assistance in	A	dmir	nistrator/Designee to the Social Service		
	completing the form and	d submitting the appeal	De	epar	rtment on the requirements for Notice		
	hearing request;		Re	aui	rements Before Transfer/Discharge.	of	
	(V) The name, address	(mailing and email) and		.,	rements before transfer/Discharge.		
	telephone number of the Long-Term Care Ombud	deman	Int	erd	lisciplinary Toam more bear 111		
	(vi) For nursing facility r	esidents with intellectual	of	Moi	lisciplinary Team members will review a	s part	1
	and developmental disa		ho	snit:	rning Clinical residents who transfer to	the	1
	disabilities, the mailing a		the	Po	al and if written notification was provid	ed to	
t	elephone number of the	agency responsible for	200	4:+	sident Representative and/or Ombudsr	nan. An	l.
t	he protection and advo	cacy of individuals with	Dir	אונ א	will be completed by the Social Service		ł
	developmental disabilitie	es established under Part	Dir	ecto	or/Designee weekly x 4 weeks and then		
	of the Developmental	Disabilities Assistance	mo	nthi	ly x 2 months of all residents who were		
a	and Bill of Rights Act of	2000 (Pub. L. 106-402,	trai	nste	erred to the hospital and that a written		1
0	codified at 42 U.S.C. 150	001 et seq.); and	not	писа	ation was provided to the Resident		1
(vii) For nursing facility re	esidents with a mental	Rep	rese	entative and/or Ombudsman.		
	lisorder or related disab	nines, the mailing and					1
a	email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder		Find	lings	s from the audit will be presented to th	e	
a			וטט	V/De	esignee and submitted to QAPI monthly	for	
	, -:aaaalo v	a mortal disolder	revi	ew a	and recommendation.	.5.	

	STATEMENT A AN O	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY MPLETED	
			495272	B. WING				С	
Ì	NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT	TE, ZIP CODE	0	1/13/2022	
-	CANTER	BURY 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 PREFI TAG	X (EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BE SED TO THE APPROPRIAT FICIENCY)	ΓE	(X5) COMPLETION DATE	ŀ
	1 t s # 1 v F tr	established under the for Mentally III Individu §483.15(c)(6) Changes If the information in the effecting the transfer or must update the recipie as practicable once the becomes available. §483.15(c)(8) Notice in In the case of facility clethe administrator of the written notification prior to the State Survey Age State Long-Term Care the facility, and the residuel as the plan for the relocation of the resider 483.70(I). This REQUIREMENT is by: Based on staff interview and facility document rethat the facility staff faile notification was provided Representative and/or Ctransfer for five of 62 resisample; Residents #97, #177. The findings include:	Protection and Advocacy als Act. Is to the notice. In notice changes prior to a discharge, the facility ents of the notice as soon a updated information advance of facility closure posure, the individual who is facility must provide to the impending closure ency, the Office of the Ombudsman, residents of dent representatives, as transfer and adequate hts, as required at § is not met as evidenced with the wide of the Resident	F	623				

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١	STATEMENT	OF DEFICIENCIES	(X4) PROMPERIOUS (FR. 17.17.	7		OMB	NO. 0938-0391
		OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	198 (198)	TIPLE CONSTRUCTION		ATE SURVEY OMPLETED
Į			495272	B. WING_			C
I	NAME OF	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE		01/13/2022
-	CANTER		HEALTH CARE CENTER		1776 CAMBRIDGE DRIVE RICHMOND, VA 23238		
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	F 623	11/11/21 and had the of to fall with fractures of dysphagia, depression The most recent MDS an admission assessm (Assessment Reference resident was coded as impaired in ability to match the resident was code bathing; extensive assidessing, toileting, and assistance for transfers and was incontinent of	diagnoses of but not limited the tibia and ribs, in insomnia and dementia. (Minimum Data Set) was tent with an ARD te Date) of 11/29/21. The being severely cognitively ake daily life decisions. If as requiring total care for stance for bed mobility, hygiene; limited is; supervision for eating; bowel and bladder.	F 6	23		
		note dated 11/17/21 at "Received order to send (emergency room) due blood cells) and Rednes attempted to reach Surg Seen by NP (nurse practisent out." A review of the "SNF/NF Form" dated 11/17/21 at	to elevated WBC (white ss to incision site. Writer geon office. Message left. citioner) resident will be to Hospital Transfer and the nurses notes in the eveal any evidence that a e hospital transfer was representative.				
		conducted with OSM #3 Social Services Director been at the facility since sending written notification representative at this or	(Other Staff Member) the . She stated that she has 12/8/21 but has not been ons to the resident any facility she has ever 3:19 PM OSM #3 followed her staff regarding ent before she started.				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		91
		Section Co.	A. BUILD	ING_		CON	C	
		495272	B. WING			0	1/13/2022	
	PROVIDER OR SUPPLIER BURY REHABILITATION 8	HEALTH CARE CENTER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE	N
	Staff Member, the Adn not have a policy on he requirements. On 1/12/22 at approximation of day meeting, ASM # (Administrative Staff Mand Director of Nursing aware of the findings. provided by the end of 2. The facility staff faile notification was provided Resident #149's reside Resident #149's hospital Resident #149 was admitted diagnoses of but no obstructive pulmonary of obsessive compulsive of left femur necrosis, high alcohol abuse. The moderately impaired in a decisions. The resident moderately impaired in a decisions. The resident total care for bathing; explored the provision for eating; a incontinent of bowel and A nurse's note dated 12/4 nurse's nurse	ASM #1 (Administrative ninistrator) stated they did pospital transfer mately 5:30 PM at the end at and ASM #2 embers) the Administrator of respectively, were made No further information was the survey. and to evidence that written and to the Ombudsman and the representative for the fall transfer on 12/9/21. Initted on 10/27/20 and had at limited to stroke, chronic disease, depression, alisorder, pressure injury, a blood pressure, and st recent MDS (Minimum ant change assessment ent Reference Date) of was coded as being ability to make daily life was coded as requiring stensive care for transfers, bygiene and toileting; and was coded as a bladder.	F	623				

CANTERBURY REHABILITATION & HEALTH CARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER CANTERBURY REHABILITATION & HEALTH CARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	С		
CANTERBURY REHABILITATION & HEALTH CARE CENTER 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	1/13/2022		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE		
blood in stool last night. Unwitnessed fall out of bed a short time ago, very large hematoma to right forehead and top of head. Neurocheck [neurological check] normal but due to size will send to ED (emergency department) for evaluation, to rule out subdural hematoma, and for rectal bleeding" A nurse's note dated 12/9/21 at 1:44 PM documented, "Resident being sent to (name of emergency room) ER for eval (evaluation), RR (resident representative) made aware." A review of the "SNF/NF [skilled nursing facility/hursing facility] to Hospital Transfer Form" dated 12/9/21 and the nurses notes in the clinical record falled to reveal any evidence that a written notification of the hospital transfer was provided to the resident representative and Ombudsman. On 1/12/22 at 2:59 PM, an interview was conducted with OSM #3 (Other Staff Member) the Social Services Director. She stated that she has been at the facility since 12/8/21 but has not been sending written notifications to the resident representative at this or any facility she has ever been at. OSM #3 stated that normally the discharge list is printed and emailed to the Ombudsman. On 1/12/22 at 3:19 PM OSM #3 followed up after checking with other staff regarding notifications that were sent before she started. She stated that the facility had not been doing written notifications to the Resident Representatives. A list of resident discharges dated 9/1/21 through 1/12/22 was provided that was faxed to the Ombudsman on 1/11/1/2. Resident #149's transfer on 12/9/21 was not listed. OSM #3 stated that it was because he was not discharged. The facility was not tracking			

STATEMENT OF DEFICIENCIES 'LAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
	495272	B. WING			С		
NAME OF PROVIDER OR SUPPLIER CANTERBURY REHABILITATION 8	HEALTH CARE CENTER		STREET ADDRESS, CITY, STA 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	TE, ZIP CODE	01/13/202	<u> 22 </u>	
PREFIX (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENCE	PLAN OF CORRECTION TIVE ACTION SHOULD BE SED TO THE APPROPRIA SFICIENCY)	COMPI	(5) LETION ATE	
back to the facility with facility discharge. On 1/13/22 at 1:10 PM Staff Member, the Adm not have a policy on he requirements. On 1/12/22 at approximation of day meeting, ASM # (Administrative Staff Member of Nursing aware of the findings. It is provided by the end of start of the findings of transfer to the finding of the	mbudsman hospital the emergency room and rout a hospital admission or I ASM #1 (Administrative ninistrator) stated they did respital transfer That is a state of the state o	F 6					

	STATEMENT	STATEMENT OF DEFICIENCIES ' PLAN OF CORRECTION ()	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	The second	(X3) DATE SURVEY	
] ,,,,,	. Johnsonon	IDENTIFICATION NUMBER:	A. BUILDING			OMPLETED	
			495272	B. WING			C	
1	NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		01/13/2022	
ŀ	ALEXANDER LANCE		HEALTH CARE CENTER	1	1776 CAMBRIDGE DRIVE RICHMOND, VA 23238			
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE	(X5) COMPLETION DATE	
	r C a re	Continued From page personal hygiene; super 10/27/21 at 8:00, documents been admitted to the foot ulcer." On 1/11/22 at 5:00 PM, written RP notification of the An interview was conducted by the progress note. " An interview was conducted by the written RP notification, not been doing the writted to not having consist the progress note." An interview was conducted by the progress note. " An interview was conducted by the progress note of the p	ervision in eating. I progress note dated mented in part, "Resident he hospital for treatment of a request was made for for Resident #13. Icted on 1/12/22 at 3:20 aff member) #3, the social nasked who provides the OSM #3 stated, "We have en notification to the RP stent social services staff, and documenting that in cted on 1/13/22 at 8:15 rector of nursing, who nything with written RP ASM (administrative staff strator and ASM #2, the made aware of the above ASM #1, the red on on thave any policy ements."	F 623	DEFICIENCY)	RIATE	DATE	
	R (1	No further information was provided prior to exit. References: (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and						
	С	hapman, page 120.						

STATE	MENT OF DEFICIENCIES AN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	0.0000000000000000000000000000000000000) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		495272	B. WING			С		
	OF PROVIDER OR SUPPLIER TERBURY REHABILITATION 8	HEALTH CARE CENTER		17	STREET ADDRESS, CITY, STATE, ZIP CODE 776 CAMBRIDGE DRIVE RICHMOND, VA 23238	1 0	1/13/2022	
PRE TA	FIX (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E ATE	(X5) COMPLETION DATE	
F	Non-Medical Reader, Chapman, page 160. (3) Barron's Dictionary	21 of Medical Terms for the 5th edition, Rothenberg and of Medical Terms for the 5th edition, Rothenberg and	F	523				
	limited to: chronic obst [COPD] (chronic non-reasthma (recurrent epist breathing) (2) and oster changes in the joints) (3 Resident #15's most reset) assessment, a qual assessment reference of the resident as scoring (brief interview for ment the resident was cogniting. Functional Status, corequiring extensive assistransfers, dressing, toile hygiene; supervision in the in bathing. A review of the (interven care transfers) Transfer documented in part, "Transfer documented in part, "Transfer documented of the nursing part of the care transfers) as the company of the nursing part of the care transfers of the care transf	to the Resident/RP Resident #15. itted to the facility on that included but were not cructive pulmonary disease exersible lung disease) (1), odes of difficulty in parthritis (degenerative 3). cent MDS (minimum data rterly assessment, with an date of 10/12/21, coded 15 out of 15 on the BIMS al status) score, indicating vely intact. MDS Section oded the resident as stance in bed mobility, ting and personal ceating/total dependence tions to reduce acute Form V5 dated 11/27/21, ansfer to hospital." progress note dated cumented in part, "Patient						

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 01/23/2022 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING_ COMPLETED C 495272 B. WING NAME OF PROVIDER OR SUPPLIER 01/13/2022 STREET ADDRESS, CITY, STATE, ZIP CODE CANTERBURY REHABILITATION & HEALTH CARE CENTER 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) COMPLETION CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 623 Continued From page 22 F 623 attempts to get off bed, combative, called 911, sent patient to the hospital. Called family member and notified of patient's status and reason for sending the resident out." On 1/11/22 at 5:00 PM, a request was made for written RP notification for Resident #15. An interview was conducted on 1/12/22 at 3:20 PM with OSM (other staff member) #3, the social services director. When asked who provides the written RP notification, OSM #3 stated, "We have not been doing the written notification to the RP due to not having consistent social services staff. We were calling the RP and documenting that in the progress note." An interview was conducted on 1/13/22 at 8:15 AM with ASM #2, the director of nursing, who stated, "We do not do anything with written RP notification or bed hold." On 1/13/22 at 2:15 PM, ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the above concerns. No further information was provided prior to exit. References: (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 120. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and

Chapman, page 50.

Chapman, page 420.

(3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and

PRINTED: 01/23/2022 FORM APPROVED

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA (X2) MU				OMB	NO. 0938-039
PLAN O	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILE		CONSTRUCTION		ATE SURVEY OMPLETED
		495272	B. WING				С
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 0	01/13/2022
CANTER		HEALTH CARE CENTER		177	76 CAMBRIDGE DRIVE CHMOND, VA 23238		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	CO. 10 10 10 10 10 10 10 10 10 10 10 10 10	PROVIDER'S PLAN OF CORRECTION X (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
	5. The facility staff failed notification of transfer of (responsible party) for Resident #177 was add 10/26/20 with diagnosed not limited to: cerebrow (hemorrhage or blockathe brain leads to a lacing mellitus (inability of instathe body) (2) and congection (circulatory congestion water by the kidneys) (3) Resident #177's most reduced the resident as see BIMS (brief interview for indicating the resident was reduced the resident as reduced the resident mobility and reduced the resident as reduced the resident as reduced the resident mobility and reduced the resident as reduced the resident as reduced the resident mobility and reduced the resident mobility and reduced the resident as reduced the	ed to provide written to the Resident/RP Resident #177. mitted to the facility on es that included but were ascular accident ge of the blood vessels of k of oxygen) (1), diabetes ulin to function normally in estive heart failure and retention of salt and B). ecent MDS (minimum an annual assessment, erence date of 9/26/21, coring 10 out of 15 on the mental status) score, vas moderately cognitively G- Functional Status, equiring extensive ty, transfers, dressing.	F	623	DEFICIENCY)		
AAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAA	facility and insisting respended in the facility and insisting res	orogress note dated ocumented in part, scrotal edema, er extremities. No [Sic.] ther respiratory distress per normal self. daughter sident be sent to im seen here by one of is alert and oriented per aplaint of pain voiced."					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DA	ATE SURVEY OMPLETED	9
		495272	B. WING			С	
	PROVIDER OR SUPPLIER BURY REHABILITATION &	HEALTH CARE CENTER	1	STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	<u> C</u>	01/13/2022	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC 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 () N C (3 N C (3 N C (3 N C)	10/19/21 at 12:06 PM, "Resident transferred to non-emergent." On 1/12/22 at 5:00 PM written RP notification of the services director. When written RP notification, not been doing the written RP notification, not been doing the writted ue to not having consist We were calling the RP the progress note." An interview was conducted and with ASM #2, the director of the doing the doing the RP the progress note." On 1/13/22 at 2:15 PM, member) #1, the administing director of nursing were concerns. No further information was references: 1) Barron's Dictionary of Son-Medical Reader, 5th Chapman, page 111. 2) Barron's Dictionary of Son-Medical Reader, 5th Chapman, page 160. 3) Barron's Dictionary of Son-Medical Reader, 5th Chapman, page 160. 3) Barron's Dictionary of Son-Medical Reader, 5th Chapman, page 160.	documented in part, o hospital via stretcher a request was made for for Resident #177. acted on 1/12/22 at 3:20 aff member) #3, the social in asked who provides the OSM #3 stated, "We have sen notification to the RP stent social services staff, and documenting that in acted on 1/13/22 at 8:15 rector of nursing, who hything with written RP ASM (administrative staff strator and ASM #2, the made aware of the above as provided prior to exit. Medical Terms for the redition, Rothenberg and Medical Terms for the edition, Rothenberg and	F 623				

PRINTED: 01/23/2022 FORM APPROVED

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	Language Control	10. 0938-039
A' ANO	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING _		'E SURVEY MPLETED	
11			==		Scottosco, ii Stowaniani	
		495272	B. WING		C	
NAME OF F	PROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CO	DDE I U	1/13/2022
CANTER	RURY REHARM ITATION O	HEALTH CARE CENTER		76 CAMBRIDGE DRIVE	-	
		HEALIN CARE CENTER	RI	CHMOND, VA 23238		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID I	PROVIDER'S PLAN OF O	COPPECTION	T
PREFIX TAG	(EACH DEFICIENC) REGULATORY OR L	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION	ON SHOULD BE	(X5) COMPLETION
0.220.00		- TOTAL THE IN CHIMATION	TAG	CROSS-REFERENCED TO THE DEFICIENCY		DATE
						
F 625	Continued From page	25	F 625			
F 625	Notice of Bed Hold Po	licy Before/Upon Trnsfr	F 625			
SS=D	CFR(s): 483.15(d)(1)(2	2)		S=D Notice of Bed Hold Poli		: 2/8/2022
			Transf	cy Before/Upon	: 2/8/2022	
	§483.15(d) Notice of b	ed-hold policy and return-	Transi	-1		
	8483 15/d\/1\ Notice b	efore transfer. Before a	CFR(s):	15(d)(1)(2)		
	nursing facility transfer	s a resident to a hospital or		(-/(-/(-/		
	the resident goes on th	erapeutic leave, the	The Be	d Hold Notice was provided	to	
1	nursing facility must pre	ovide written information to	residen	t/resident representative #1	2 and 415	
	the resident or resident	representative that		,	.5, and #15.	
	specifies-		Resider	t #177 was discharged from	Cantorbury	
	(i) The duration of the s	state bed-hold policy, if	Rehab a	and Healthcare on 10/19/202	21	
	any, during which the return and resume resi	esident is permitted to		1011 107 157 202	-4.	
	return and resume residuality;	dence in the nursing	Residen	ts who reside at Canterbury	Rehab and	
		ment policy in the state	Healthc			
1	plan, under § 447.40 of	this chapter, if any:	the pote	are who are transferred to the children are transferred to the affected by this partial to be affected by the partial to be a	ractice. An audit	
	(iii) The nursing facility's	s policies regarding	was con	ł		
	bed-hold periods, which	must be consistent with	to the h			
	paragraph (e)(1) of this	section, permitting a	hold not			
	resident to return; and	alfinal to the second of the second	resident	netice	1	
	of this section.	cified in paragraph (e)(1)	were giv	s who did not have bed hold en this notice.	notice provided	
				and House.		
	§483.15(d)(2) Bed-hold	notice upon transfer. At	Bed Holo	Policy reviewed no revision	S Decorrany	1
t	he time of transfer of a	resident for		7	s necessary.	ŀ
ŀ	nospitalization or therap	eutic leave, a nursing	Education	n was provided by the		
1	acility must provide to the	ne resident and the	Administ	rator/Designee to the Licens	ed Nursina	ı
	esident representative	written notice which	Staff, Adr	nissions and Social Service D	ca Marshig	1
0	pecifies the duration of lescribed in paragraph (d(1) of this section	the requi	rement for Notice of Bed Ho	ld Pofers / Land	1
ī	his REQUIREMENT is	not met as evidenced	Transfer f	rom the facility.	id before/upon	
	y:	ms. as oridonoed			1	
	Based on staff interview	, clinical record review	Interdisci	olinary Team members will r	ovious se	
а	nd facility document rev	riew, it was determined	of Mornin	g Clinical residents who tra-	eview as part	
th	ne facility staff failed to	evidence a bed hold	of Morning Clinical residents who transfer to the hospital that the Notice of Bed Hold Policy			
n	otice was provided upor	n transfer for three of 62		ist the Notice of Bed Hold P	olicy	
re	esidents in the survey sa	ample, Resident #13,				
	esident #15 and Reside	ent #1//	1		į.	- 1

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 01/23/2022 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING COMPLETED C 495272 B. WING 01/13/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE CANTERBURY REHABILITATION & HEALTH CARE CENTER RICHMOND, VA 23238 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (X5)PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 625 Continued From page 26 F 625 The facility staff failed to provide a bed hold Before/Upon Transfer was accomplished. An audit notice to Resident #13 upon transfer and will be completed by the Administrator/Designee admission to the hospital on 10/27/21, and failed to provide a bed hold notice to the resident or weekly x 4 weeks and then monthly x 2 months on resident responsible party (RP), at the time of the Bed Hold policy being provided upon resident Resident #15's transfer to the hospital on transfer. 11/27/21, and at the time of Resident #177's transfer to the hospital on 10/19/21. Findings from the audit will be presented to the DON/Designee and submitted to QAPI monthly for The findings include: review and recommendation. 1. Resident #13 was admitted to the facility on 4/2/21 with diagnoses that included but were not limited to: chronic obstructive pulmonary disease [COPD] (chronic non-reversible lung disease) (1), diabetes mellitus (inability of insulin to function normally in the body) (2) and chronic kidney disease (decreased function of the kidneys frequently as a complication of diabetes) (3). Resident #13's most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 12/17/21, coded the resident as scoring 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. MDS Section G- Functional Status, coded the resident as requiring extensive assistance in bed mobility, transfers, dressing, bathing, toileting and personal hygiene; supervision in eating.

foot ulcer."

A review of the nursing progress note dated 10/27/21 at 8:00, documented in part, "Resident has been admitted to the hospital for treatment of

On 1/11/22 at 5:00 PM, a request was made for

the bed hold notice for Resident #13.

TMENT OF HEALTH AN	ND HUMAN SERVICES	9	.4		ED: 01/23/2022
RS FOR MEDICARE &	MEDICAID SERVICES	y-1	. 1		RM APPROVED
OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DA	NO. 0938-0391 TE SURVEY MPLETED
***	495272	B. WING			C
PROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE ZIP CODE		1/13/2022
CANTERBURY REHABILITATION & HEALTH CARE CENTER			6 CAMBRIDGE DRIVE		
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PM with OSM (other signal admissions director. Vithe bed hold notice, Osprovides the bed hold in bed hold for this reside. An interview was condicted. An interview was condicted. An interview was condicted. An interview was condicted. We do not do a stated, "We do not do a stated, "He admindirector of nursing were concerns. According to the facility which documents in parapolicy at time of transfer resident to a hospital, a provide a written notice applicable, the residents specifies the duration of No further information was references: 1) Barron's Dictionary of Non-Medical Reader, 5th Chapman, page 120. 2) Barron's Dictionary of Non-Medical Reader, 5th Chapman, page 160.	taff member) #7, the When asked who provides SM #7 stated, "Admissions notice. We do not have a ent." ucted on 1/13/22 at 8:15 irector of nursing, who anything with written RP fication or bed hold." ASM (administrative staff distrator and ASM #2, the emade aware of the above entered ente				
	RS FOR MEDICARE & TOP DEFICIENCIES OF CORRECTION PROVIDER OR SUPPLIER BURY REHABILITATION & SUMMARY STA (EACH DEFICIENCY REGULATORY OR LETTER CONTINUED FROM MARY STA (EACH DEFICIENCY REGULATORY OR LETTER CONTINUED FROM MARY STA (EACH DEFICIENCY REGULATORY OR LETTER CONTINUED FROM MARY STA (EACH DEFICIENCY REGULATORY OR LETTER CONTINUED FROM MARY STA (EACH DEFICIENCY WAS CONTINUED FROM MARY STA (EACH DEFICIENCY OF TOP MARY STAN MARY STA (EACH DEFICIENCY OF TOP MARY STAN	PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 27 An interview was conducted on 1/12/22 at 3:48 PM with OSM (other staff member) #7, the admissions director. When asked who provides the bed hold notice, OSM #7 stated, "Admissions provides the bed hold notice. We do not have a bed hold for this resident." An interview was conducted on 1/13/22 at 8:15 AM with ASM #2, the director of nursing, who stated, "We do not do anything with written RP (responsible party) notification or bed hold." On 1/12/22 at 5:15 PM, ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the above concerns. According to the facility's policy on bed hold, which documents in part, "Notice of Bed-Hold policy at time of transfer. At the time of transfer a resident to a hospital, a nursing facility shall provide a written notice to the resident, or when applicable, the residents representative, which specifies the duration of the bed hold policy." No further information was provided prior to exit. References: 1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 120. 2) Barron's Dictionary of Medical Terms for the Ion-Medical Reader, 5th edition, Rothenberg and Chapman, page 160. 3) Barron's Dictionary of Medical Terms for the Ion-Medical Reader, 5th edition, Rothenberg and Chapman, page 160. 3) Barron's Dictionary of Medical Terms for the Ion-Medical Reader, 5th edition, Rothenberg and Chapman, page 160. 3) Barron's Dictionary of Medical Terms for the Ion-Medical Reader, 5th edition, Rothenberg and Chapman, page 160. 3) Barron's Dictionary of Medical Terms for the Ion-Medical Reader, 5th edition, Rothenberg and Ion-Me	RS FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES F CORRECTION (X1) PROVIDERSUPPLIERCULA IDENTIFICATION NUMBER: 495272 B. WING STI SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 27 An interview was conducted on 1/12/22 at 3:48 PM with OSM (other staff member) #7, the admissions director. When asked who provides the bed hold notice, OSM #7 stated, "Admissions provides the bed hold notice. We do not have a bed hold for this resident." An interview was conducted on 1/13/22 at 8:15 AM with ASM #2, the director of nursing, who stated, "We do not do anything with written RP (responsible party) notification or bed hold." On 1/12/22 at 5:15 PM, ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the above concerns. According to the facility's policy on bed hold, which documents in part, "Notice of Bed-Hold policy at time of transfer. 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When asked who provides the bed hold notice, OSM #7 stated, "Administors provides the bed hold notice, OSM #7 stated," Administors provides the bed hold notice on to anything with written RP (responsible party) notification or bed hold." On 1/12/22 at 5:15 PM, ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the above concerns. According to the facility's policy on bed hold, which documents in part, "Notice of Bed-Hold policy at time of transfer. At the time of transfer a esident to a hospital, a nursing facility shall provide a written notice to the resident, or when applicable, the residents representative, which appeciates the duration of the bed hold policy." No further information was provided prior to exit. References: 1) PROVIDER OR STRUCTION PREFIX PROVIDERS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE 1776 CAMBRIDGE

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CANTERBURY REHABILITATION & HEALTH CARE CENTER (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 625 Continued From page 28 2. Resident #15 was admitted to the facility on 8/5/20 with diagnoses that included but were not limited to: chronic obstructive pulmonary disease [COPD] (chronic non-reversible lung disease) (1), asthma (recurrent episodes of difficulty in breathing) (2) and osteoarthritis (degenerative changes in the joints) (3). Resident #15's most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment, a quarterly assessment, with an assessment reference date of 10/12/21, coded the resident was cognitively intact. MDS Section G- Functional Status, coded the resident as requiring extensive assistance in bed mobility, transfers, dressing, toileting and personal hygiene; supervision in eating/total dependence in bathing. A review of the (interventions to reduce acute care transfers) Transfer Form V5 dated 11/27/21, documented in part, "Transfer to hospital." A review of the nursing progress note dated 11/27/21, documented in part, "Transfer to hospital." A review of the open date of the part, "Patient noted incoherent, checked visits, several attempts to get off bed, combative, called 911, sent patient to the hospital. Called family member and notified of patient's status and	A. '.AN C	A	A. '.AN OF CORRECTION	IDENTIFICATION NUMBER:					
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SUMMARY STATEMENT OF DEFICIENCY SIZE OF PREFIX TAGE PROVIDER'S PLAN OF CORRECTION PREFIX TAGE PROVIDER'S PLAN OF CORRECTION PREFIX TAGE PROVIDER'S PLAN OF CORRECTION AND OLD THE APPROPRIATION F 625 Continued From page 28 2. Resident #15 was admitted to the facility on 8/5/20 with diagnoses that included but were not limited to: chronic obstructive pulmonary disease [COPD] (chronic non-reversible lung disease) (1), asthma (recurrent episodes of difficulty in breathing) (2) and osteoarthritis (degenerative changes in the joints) (3). Resident #15's most recent MDS (minimum data set) assessment reference date of 10/1/2/1, coded the resident as scoring 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. MDS Section G- Functional Status, coded the resident as requiring extensive assistance in bed mobility, transfers, dressing, tolleting and personal hygiene; supervision in eating/total dependence in bathing. A review of the (interventions to reduce acute care transfers) Transfer Form V5 dated 11/27/21, documented in part, "Transfer to hospital." A review of the nursing progress note dated 11/27/21 at 4:43 PM, documented in part, "Patient noted incoherent, checked vitals, several attempts to get off bed, combative, called 911, sent patient to the hospital. Called family member and notified of patient's status and				N & HEALTH CARE CENTER		1776 CAMBRIDGE DRIVE		01/13/2022	_
2. Resident #15 was admitted to the facility on 8/5/20 with diagnoses that included but were not limited to: chronic obstructive pulmonary disease [COPD] (chronic non-reversible lung disease) (1), asthma (recurrent episodes of difficulty in breathing) (2) and osteoarthritis (degenerative changes in the joints) (3). Resident #15's most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 10/12/21, coded the resident as scoring 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. MDS Section G- Functional Status, coded the resident as requiring extensive assistance in bed mobility, transfers, dressing, toileting and personal hygiene; supervision in eating/total dependence in bathing. A review of the (interventions to reduce acute care transfers) Transfer Form V5 dated 11/27/21, documented in part, "Transfer to hospital." A review of the nursing progress note dated 11/27/21 at 4:43 PM, documented in part, "Patient noted incoherent, checked vitals, several attempts to get off bed, combative, called 911, sent patient to the hospital. Called family member and notified of patient's status and	PREFIX		PREFIX (EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	OULD BE	(X5) COMPLETION DATE	N
On 1/11/22 at 5:00 PM, a request was made for the bed hold notice for Resident #15. An interview was conducted on 1/12/22 at 3:48 PM with OSM (other staff member) #7, the admissions director. When asked who provides	A A PI		2. Resident #15 was 8/5/20 with diagnoss limited to: chronic of [COPD] (chronic not asthma (recurrent expressions) (2) and of changes in the joint of the resident #15's most set) assessment, as assessment referent he resident was copy (brief interview for most the resident was copy G- Functional Status requiring extensive attransfers, dressing, thygiene; supervision in bathing. A review of the (intercare transfers) Transt documented in part, of the dimensional status of the nursing 11/27/21 at 4:43 PM, noted incoherent, che attempts to get off be sent patient to the host member and notified or reason for sending the On 1/11/22 at 5:00 PM, the bed hold notice for PM with OSM (other services).	s admitted to the facility on es that included but were not obstructive pulmonary disease in-reversible lung disease) (1), pisodes of difficulty in steoarthritis (degenerative e) (3). Trecent MDS (minimum data guarterly assessment, with an existed of 10/12/21, coded ing 15 out of 15 on the BIMS ental status) score, indicating nitively intact. MDS Section coded the resident as esistance in bed mobility, bileting and personal in eating/total dependence for Form V5 dated 11/27/21, Transfer to hospital." If g progress note dated documented in part, "Patient coked vitals, several discombative, called 911, ipital. Called family of patient's status and a resident out." If a request was made for Resident #15. Sucted on 1/12/22 at 3:48 aff member) #7, the	F 628				

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A' AN C	TATEMENT OF DEFICIENCIES AN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) E	(X3) DATE SURVEY COMPLETED	
		495272	B. WING		С		
	PROVIDER OR SUPPLIER BURY REHABILITATION &	HEALTH CARE CENTER	1	STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238		01/13/2022	
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r () ti	the bed hold notice, Osprovides the bed hold in bed hold for this reside. An interview was condicted. An with ASM #2, the distance of the stated, "We do not do a notification or bed hold. On 1/13/22 at 2:15 PM, member) #1, the admindirector of nursing were concerns. No further information was resident with the stated, stated, in the stated of the	SM #7 stated, "Admissions notice. We do not have a nt." Jucted on 1/13/22 at 8:15 irector of nursing, who anything with written RP ASM (administrative staff istrator and ASM #2, the made aware of the above was provided prior to exit. If Medical Terms for the hedition, Rothenberg and of Medical Terms for the hedition, Rothenberg and for medition, Rothenberg and for medition, Rothenberg and for the blood vessels of the bl	F 625				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILE		CONSTRUCTION	1	(X3) DA	TE SURVEY	_!
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NAME OF D		495272	B. WING				0	1/13/2022	
		HEALTH CARE CENTER		17	TREET ADDRESS, CITY, STATE, ZIP 776 CAMBRIDGE DRIVE IICHMOND, VA 23238	CODE			
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t A F a a till pp b	coded the resident as BIMS (brief interview findicating the resident impaired. MDS Section coded the resident as assistance in bed mob toileting and personal eating/total dependence. A review of the nursing 10/19/21 at 11:17 AM, "Resident noted to havincreased edema in low shortness of breath or noted. up in wheelchain in facility and insisting in hospital, does not want our physicians. Resident our physicians at 12:06 PM, of Resident transferred to hon-emergent." On 1/12/22 at 5:00 PM, the bed hold notice for finding the physicians director. When the physicians director in the physicians director. When the physicians director is the physicians of the physicians director. When the physicians director is the physicians of the physicians director. When the physicians director is the physicians of the physicians of the physicians director. When the physicians director is the physicians of the physicians director. When the physicians director is the physicians of the physicians director. When the physicians director is the physicians director is the physicians director. When the physicians director is the phys	eference date of 9/26/21, scoring 10 out of 15 on the for mental status) score, was moderately cognitively in G- Functional Status, requiring extensive sility, transfers, dressing, hygiene; supervision in the in bathing. In progress note dated documented in part, were extremities. no [Sic.] other respiratory distress or per normal self. daughter resident be sent to thim seen here by one of the internal self. dated documented in part, or hospital via stretcher. In progress noted dated documented in part, or hospital via stretcher. In a request was made for Resident #177. In the seen here by one of the self o	F	625					
S	tated, "We do not do ar	ovthing with written RP					1	1	

ST^	AN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
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		PROVIDER OR SUPPLIER BURY REHABILITATION &	HEALTH CARE CENTER		17	TREET ADDRESS, CITY, STATE, ZIP CODE 776 CAMBRIDGE DRIVE ICHMOND, VA 23238	<u> C</u>	01/13/2022	
P	X4) ID REFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	1000	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F	641 SS=D	notification or bed hold On 1/13/22 at 2:15 PM member) #1, the admir director of nursing were concerns. No further information of the survey sample, Residued Non-Medical Reader, 5 Chapman, page 111. (2) Barron's Dictionary Non-Medical Reader, 5 Chapman, page 160. (3) Barron's Dictionary Non-Medical Reader, 5 Chapman, page 160. (3) Barron's Dictionary Non-Medical Reader, 5 Chapman, page 133. Accuracy of Assessment CFR(s): 483.20(g) §483.20(g) Accuracy of The assessment must a resident's status. This REQUIREMENT is by: Based on staff interview review it was determined failed to correctly code in resident assessments for the survey sample, Residued MDS (minimum data set) the ARD (assessment rei	I." I. ASM (administrative staff nistrator and ASM #2, the e made aware of the above was provided prior to exit. Of Medical Terms for the th edition, Rothenberg and of Medical Terms for the th edition, Rothenberg and of Medical Terms for the th edition, Rothenberg and of Medical Terms for the th edition, Rothenberg and of Medical Terms for the th edition, Rothenberg and of Medical Terms for the the dition, Rothenberg and of Medical Terms for the the dition, Rothenberg and of Medical Terms for the the dition, Rothenberg and of Medical Terms for the the dition, Rothenberg and of Medical Terms for the the dition, Rothenberg and of the dition, Rothenberg and of Medical Terms for the the dition, Rothenberg and of Medical Terms for the the dition, Rothenberg and of Medical Terms for the the dition, Rothenberg and of Medical Terms for the the dition, Rothenberg and of Medical Terms for the the dition, Rothenberg and of Medical Terms for the dition, Rothenberg and of Medical Terms for the the dition, Rothenberg and of Medical Terms for the dition, Rothenberg and diti	F 64	625				
	1	12/3/2021 for falls sustain quarterly assessment on	ned since the previous						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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CANTERE	BURY REHABILITATION 8	HEALTH CARE CENTER		F	RICHMOND, VA 23238		
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F 625	Continued From page notification or bed hold On 1/13/22 at 2:15 PM member) #1, the adm director of nursing we concerns. No further information References: (1) Barron's Dictionary Non-Medical Reader, Chapman, page 111. (2) Barron's Dictionary Non-Medical Reader, Chapman, page 160. (3) Barron's Dictionary Non-Medical Reader, Chapman, page 160. (3) Barron's Dictionary Non-Medical Reader, Chapman, page 133. Accuracy of Assessmed CFR(s): 483.20(g)	31 d." A, ASM (administrative staff inistrator and ASM #2, the re made aware of the above was provided prior to exit. of Medical Terms for the 5th edition, Rothenberg and of Medical Terms for the 5th edition, Rothenberg and of Medical Terms for the 5th edition, Rothenberg and of Medical Terms for the 5th edition, Rothenberg and ents	F 6	641 F64	DEFICIENCY)	TE	2/8/2022
	by: Based on staff interview it was determined to correctly code resident assessments the survey sample, Ref. The facility staff fair MDS (minimum data sthe ARD (assessment)	ted that the facility staff or MDS (minimum data set) for two of 62 residents in resident #94 and #89. Ided to code the quarterly ret) for Resident #94 with reference date) of tained since the previous		wa: A N	Modification Minimum Data Set for Reside s completed on 1/13/2022. Modification Minimum Data Set for Reside s completed on 1/12/2022.		

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 60 100	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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CANTER	BURY REHABILITATION 8	L HEALTH CARE CENTER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238			
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F 641	Continued From page	32	F	641		1		
	MDS (minimum data sthe ARD (assessment 11/27/2021 for restrain The findings include: 1. Resident #94 was diagnoses that include dementia (1) and schi Resident #94's most rassessment with an A Resident #94 as scori interview for mental stansion. Section Journal of the prior assessment. The progress notes for in part the following: - "10/29/2021 15:43 (3 witnessed fall. RP (reresponsible party] noti (medical doctor) award (vital signs) 98.0 (temporations), 111/61 (oxygen saturation) (round in wheelchair with neceed fall with no responsible party) noti	admitted to the facility with ed but were not limited to zoaffective disorder (2). ecent MDS, a quarterly RD of 12/3/2021, coded ng a three (3) on the brief atus (BIMS) of a score of 0 y impaired for making daily documented no falls since r Resident #94 documented as sponsible party) [Name of fied via voicemail and MD e. No injuries noted v/s perature), 63 (pulse), 18 (blood pressure), 95% RA foom air). Resident resting k collar intact." 18 p.m.) Resident had a injuries. RP [Name of fied, via cellphone. call. 97.8 (temperature),		Hea the affe revie upo Coo accu resid Com revis Regi Dep accu Dire resid mon prac	idents who reside at Canterbury Rehab a lthcare who have had an MDS completed lookback period have the potential to be cted by this practice. MDS coordinator/dewed the last 30 days of MDS's for accurn completion of upcoming assessments trdinator/Designee will audit the prior MI aracy of coding. Modifications completed dents identified with discrepancies. In prehensive Assessment Policy reviewed sions necessary. It is a marked to a modification of the prior MDS Not artment on Accuracy of Assessments, an aracy of coding assessments. MDS ctor/Designee will audit coding/accuracy dents weekly x 4 weeks and then monthly on the total ending the presented to the presented to a light of the presented	d during lesignee acy and the MDS DS for I for no ursing d the of 10 y x 2 his		
		are plan for Resident #94						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	NAME OF PROVIDER OR SUPPLIER CANTERBURY REHABILITATION & HEALTH CARE CENTER			1	STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	1 01/	113/2022
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F 641	judgment due to the sincontinence, use of pand recent mobility de 7/11/21, Witnessed fa fall on 11/10/2021, Un Date Initiated: 05/17/2 On 01/13/2022 at 8:5-conducted OSM (other regional director of castated that they review the risk portal system during the assessment completing the MDS. falls that occurred bet 12/3/2021 would be did MDS with the ARD of that they would review see if any falls should On 1/13/2022 at 9:07 they had reviewed the notes and risk portal since 10/29/2021 and 11/10 and should have been ARD of 12/3/2021. Omissed documenting this. At that time, OSI have a policy specific and followed the RAL Moctober 2018, Chapte of the RAI documenter has multiple regulatory regulations at 42 CFR	Dementia, poor safety ame, poor neck control, sychoactive medications coline. Observed on floor II on 10/29/2021, Witnessed witnessed fall on 12/9/2021. 2021." 1 a.m., an interview was a staff member) #4, the se management. OSM #4 ved the progress notes and to search for any falls at time frame when OSM #4 stated that any ween 9/14/2021 and ocumented on the quarterly 12/3/2021. OSM #4 stated at Resident #94's MDS to have been coded. a.m., OSM #4 stated that colinical record, progress ystem and the falls on 1/2021 were documented on the MDS with the SM #4 stated that they had hem and they would correct of the MDS with the SM #4 stated that they did not to completion of the MDS manual. Manual, Version 1.16, dated at 1, Section 1.3 Completion of in part, "The RAI process of requirements. Federal 483.20 (b)(1)(xviii), (g), the assessment accurately	F	641			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER CANTERBURY REHABILITATION & HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	017	10,2022	
(X4) ID PREFIX TAG			ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 641	documented in part, "I accurate RAI complete have a genuine and conthe resident and can a needs with realistic go. On 1/12/2022 at approximation administrative staff madministrator and ASN were made aware of the No further information. References: 1. Dementia: A loss of with certain diseases. Ianguage, judgment, a information was obtain https://medlineplus.go. 2. Schizoaffective discidisorder is a mental coloss of contact with real problems (depression information is taken from https://medlineplus.go. 2. Resident #89 was a diagnoses that included dementia (1) and Alzhar Resident #89's most resi	dentification Using the RAI In essence, with an ed periodically, caregivers onsistent recorded "look" at attend to that resident's bals in hand" Distinctly 5:00 p.m., ASM nember) #1, the M #2, the director of nursing he findings. Was provided prior to exit. If brain function that occurs It affects memory, thinking, and behavior. This ned from the website: v/ency/article/000739.htm. Distinctly 5:00 p.m., ASM nember) #1, the M #2, the director of nursing he findings. Was provided prior to exit.	F	641			
	Resident #89 as scorir interview for mental stars - 15, 12 - being moder.						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
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The state of the s	ROVIDER OR SUPPLIER	HEALTH CARE CENTER		STR	REET ADDRESS, CITY, STATE, ZIP CODE 6 CAMBRIDGE DRIVE CHMOND, VA 23238	01	/13/2022	
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	Resident #89. The clinical record for evidence documentation restraints. On 1/12/2022 at approinterview was conduct practical nurse) #6. Linot aware of Resident of restraints when wor On 1/12/2022 at 1:00 conducted with RN (restraints when wor MDS director and OSI the regional director or #1 stated that they revised observations and staff when completing #1 stated that they we were not familiar with IN OSM #4 stated that the with the ARD of 11/27/restraints were used diperiod. On 1/12/2022 at 2:26 put they had reviewed the the ARD of 11/27/2021 it was a human error be mistake. OSM #4 state restraints used for Restra	Resident #89 failed to ion of or for the use of eximately 2:00 p.m., an ited with LPN (licensed PN #6 stated that they were is #89 ever requiring the use reking with them. p.m., an interview was registered nurse) #1, the work (other staff member) #4, if case management. RN relewed the clinical record, id spoke with the nursing the MDS assessment. RN re new to the facility and Resident #89. RN #1 and relevant review the MDS resident #89. RN #1 and relevant review the MDS resident #89. RN #1 and review the modern if the work of the clinical record and record and record in the clinical record and record in the clinical record and record rec	F	641				
	(administrative staff me administrator and ASM	ember) #1, the						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	200000000000000000000000000000000000000	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER BURY REHABILITATION 8	HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	1 017	113/2022
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F 645 SS=E	References: 1. Dementia: A loss o with certain diseases. language, judgment, a information was obtain https://medlineplus.go. 2. Alzheimer's disease an irreversible, progresslowly destroys memo eventually, the ability trasks. It is the most coin older adults." This in website https://www.nia.nih.go. PASARR Screening fo CFR(s): 483.20(k)(1)-(\$483.20(k) Preadmissi individuals with a ment with intellectual disability.	he findings. was provided prior to exit. If brain function that occurs It affects memory, thinking, and behavior. This ned from the website: v/ency/article/000739.htm. It affects memory, thinking, and behavior. This ned from the website: v/ency/article/000739.htm. It affects memory disease is serive brain disorder that ry and thinking skills and, o carry out the simplest mmon cause of dementia formation is taken from the v/health/alzheimers/basics. If MD & ID It affects on Screening for al disorder and individuals	F 6	F645 SS=E PASARR Screening for MD a CFR(s): 483.20(k)(1)-(3) PASARR for resident #103 was comp 1/12/2022.	eted on	2/8/2022
	or after January 1, 198 (i) Mental disorder as of (i) of this section, unless authority has determine independent physical aperformed by a person State mental health aut (A) That, because of the condition of the individual	9, any new residents with: lefined in paragraph (k)(3) so the State mental health ed, based on an and mental evaluation or entity other than the thority, prior to admission,		PASARR for resident #32 was comple 1/12/2022. PASARR for resident #94 was comple 1/12/2022. PASARR for resident #146 was comple 1/12/2022.	ed on	

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		(X3) DATE COMP	SURVEY		
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NAME OF F	NOVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
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				R	RICHMOND, VA 23238			
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F 645	Continued From page and (B) If the individual receivices, whether the specialized services; (ii) Intellectual disability of authority has determing (A) That, because of the condition of the individual receivices, whether the specialized services pand (B) If the individual receivices, whether the specialized services for \$483.20(k)(2) Exceptions (i) The preadmission services and to a nursing facility of the services of the individual receivices, whether the specialized services for \$483.20(k)(2) Exceptions (ii) The preadmission services in the individual receiving admitted to the interpretation of the individual receiving admitted to the interpretation of the individual receiving admitted to the individual receiving admitted to the individual receiving the indiv	quires such level of individual requires or ty, as defined in paragraph of unless the State of developmental disability of prior to admission-the physical and mental dual, the individual requires rovided by a nursing facility; quires such level of individual requires or intellectual disability. The proposes of this creening program under a section need not provide the case of the readmission an individual who, after nursing facility, was a hospital. The program under a section to the admission an individual-the facility directly from a gracute inpatient care at the ing facility services for the individual received care in		645 Final Range R		ening for viduals Canterbuto be current ening of llectual I and II. for R Level I sions	iry	
	before admission to the	se attending physician has certified, Imission to the facility that the individual o require less than 30 days of nursing		Findings from the audit will be presented to the DON/Designee and submitted to QAPI monthly for review and recommendation.				

TO THE RESERVENCE OF THE PARTY OF THE	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER BURY REHABILITATION 8	HEALTH CARE CENTER		17	TREET ADDRESS, CITY, STATE, ZIP CODE 776 CAMBRIDGE DRIVE ICHMOND, VA 23238		10/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 645	section- (i) An individual is condisorder if the individual is condisorder defined in 48 (ii) An individual is conintellectual disability if intellectual disability are is a person with a redescribed in 435.1010. This REQUIREMENT by: Based on staff interviereview it was determined to evidence compreadmission screening is of 62 residents in the Residents #103, #32, which is the findings include: 1. The facility staff fail a timely manner for Readmitted to the facility readmission on 6/18/2 PASRR was not compreadmission	sidered to have a mental al has a serious mental 3.102(b)(1). Insidered to have an the individual has an serious defined in §483.102(b)(3) elated condition as of this chapter. Is not met as evidenced ew and clinical record led that the facility staff apletion of a level 1 PASRR and and resident review) for the survey sample, #94, #146, #22 and #56. Bed to complete a PASRR in esident #103 who was on 5/26/2021 with a local. Resident #103's letted until 1/12/2022. In the dother in the facility with do but were not limited to land post-traumatic stress #103's most recent MDS quarterly assessment with reference date) of dent #103 as scoring a 7 or mental status (BIMS) of leting severely impaired for	F	645			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495272	B. WING		С	
NAME OF D	ROVIDER OR SUPPLIER	430272	1 5. 11.110	OTDEST LODDESS OF CTUE IN CO.	01/13/2022	
		L HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 645	evidence a level 1 PA On 1/11/2022 at approrequest was made to a member) #1, the admit PASRR for Resident # On 1/12/2022 at approrequest was resident # On 1/12/2022 at approrequest was resident # of 1/12/2022 at 1:15 conducted with OSM (director of social servitadministrator. OSM # to the facility and were PASRR for Resident # they had completed a for Resident #103 that that prior to the COVID PASRR was complete however there were withem to admit resident OSM #3 stated that the complete the PASRR amanner but was not so allowed. OSM #3 stated that the completed it then. AS all attempts to get the and if the resident were completed it within 24-that the waivers had caregarding completion of stated that they had a and performance improved.	103's clinical record failed to SRR. Eximately 4:30 p.m., a ASM (administrative staff inistrator for the Level 1 #103. Eximately 9:30 a.m., ASM sing provided a Level 1 #103 with a completion date p.m., an interview was (other staff member) #3, the ces and ASM #1, the 3 stated that they were new a unable to find the Level 1 #103. OSM #3 stated that new PASRR on 1/12/2022 a morning. OSM #3 stated D-19 (3) pandemic the d prior to admission, aivers in place that allowed as without the assessment. The ey were supposed to after admission in a timely ure of the exact timeframe ed that when they realized have one [PASRR] they M #1 stated that they made PASRR prior to admission e admitted without it they 48 hours. ASM #1 stated aused confusion for staff of them [PASRR]. ASM #1 QAPI (quality assurance)	F6	545		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		495272	B. WING				С	
NAME OF P	ROVIDER OR SUPPLIER	430212	D. 111110	S	STREET ADDRESS, CITY, STATE, ZIP CODE	01	/13/2022	
CANTERE	BURY REHABILITATION 8	& HEALTH CARE CENTER		1	776 CAMBRIDGE DRIVE RICHMOND, VA 23238			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 645	Continued From page	40	F	645				
	was made for the imp into place.	rovement plan that was put						
	#1 and OSM #3 provious assurance and perform meeting dated 12/22/2 part, "QAPI Action Plat [sic]/Preadmission Sci Review. Goals/Object Complete all PASSR's residents admission that all PASSR's [sic] a including level 2 PASS Completed Date: 1/10 date of compliance for stated that it was 1/10. On 1/13/2022 at approving the facility policy repasses.	mance improvement) 2021 which documented in an. Issue/Concern: PASSR reening and Resident tive/Expected Outcome: a [sic] upon admission of Audit the charts to ensure are completed if needed BR's [sic]Projected /2022" When asked the the QAPI plan, ASM #1 /2022. eximately 9:30 a.m., a ASM #1, the administrator agarding completion of the						
	On 1/13/2022 at 1:10 the facility did not have completion of the PAS							
	Emergency Declaratio 11/29/2021, document "Waive Pre-Admission Resident Review (PAS Medicare and Medicare 42CFR 483.20(k), allow admit new residents w 1 or Level 2 Preadmiss assessments may be pon or before the 30th of the state of the sta	sed in part on page 16, Screening and Annual GARR). CMS (Centers for d Services) is waiving wing nursing homes to ho have not received Level sion Screening. Level 1 performed post-admission.						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	or indovenional	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495272	B. WING				C /13/2022
NAME OF PI	ROVIDER OR SUPPLIER	Section 200	\$100 to 100 months		STREET ADDRESS, CITY, STATE, ZIP CODE	01,	13/2022
CANTERB	3URY REHABILITATION &	& HEALTH CARE CENTER		1	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 PREFII TAG	PREFIX (EACH CORRECTIVE ACTION S			(X5) COMPLETION DATE
F 645		e 41 tual disability (ID) should be	F	645	5		
	referred promptly by the PASARR program for	the nursing home to State Level 2 Resident Review" obtained from the website:					
		files/document/covid-19-em					
	On 1/13/2022 at 12:15 administrator and ASN were made aware of t	M #2, the director of nursing					
	No further information	was provided prior to exit.					
	References:						
	the brain stops. A stro "brain attack." If blood than a few seconds, th nutrients and oxygen. lasting damage. This if from the website:	hen blood flow to a part of oke is sometimes called a d flow is cut off for longer					
	disorder that develops experienced a shockir event. This informatio website:	ess disorder (PTSD): A s in some people who have ng, scary, or dangerous on was obtained from the ov/health/topics/post-traum isd/index.shtml.					
	are a large family of vi people and may differe including camels, cattl	P-19 is caused by a RS-CoV-2. Coronaviruses iruses that are common in ent species of animals, le, cats, and bats. Rarely, can infect people and then					

	OF DEFICIENCIES F CORRECTION	IDENTIFICATION NUMBER:		TPLE CONST	(X3) DATE SURVEY COMPLETED		
		495272	B. WING	30000		C 01/13/2022	
	ROVIDER OR SUPPLIER BURY REHABILITATION 8	L HEALTH CARE CENTER		1776 CA	ADDRESS, CITY, STATE, ZIP CODE MBRIDGE DRIVE DND, VA 23238	1 01/	13/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	C	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 645	MERS-CoV and SAR. virus that causes COV virus is a betacoronal SARS-CoV. All three origins in bats. The seare similar to the one suggesting a likely sint this virus from an aninexact source of this viinformation was obtain https://www.cdc.gov/cml#How-COVID-19-S2. The facility staff faif for Resident #32 who on 7/7/2021. Resident #32 was addiagnoses that include Parkinson's disease (**Resident #32's most reset), a quarterly assess (assessment reference coded Resident #32 a interview for mental staff, 14 - being cognitidecisions. Review of Resident #32 at appropries was made to Assert was made t	le. This occurred with S-CoV, and now with the A/ID-19. The SARS-CoV-2 virus, like MERS-CoV and of these viruses have their equences from U.S. patients that China initially posted, gle, recent emergence of nal reservoir. However, the rus is unknown. This ned from the website: oronavirus/2019-ncov/faq.ht preads. Iled to complete a PASRR was admitted to the facility with ed but were not limited to 1) and schizophrenia (2). Becent MDS (minimum data isment with an ARD edate) of 10/30/2021, is scoring a 14 on the brief atus (BIMS) of a score of 0 lively intact for making daily size clinical record failed to SRR. Eximately 4:30 p.m., a ASM (administrative staff inistrator for the Level 1 32.	F	645			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONS	(X3) DATE SURVEY COMPLETED		
		495272	B. WING		0		C
	ROVIDER OR SUPPLIER BURY REHABILITATION 8	HEALTH CARE CENTER		1776 C	AMBRIDGE DRIVE	1 01	/13/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 645	conducted with OSM director of social servi administrator. OSM # COVID-19 (3) pandent completed prior to administrator in place residents without the astated that they were stated that they were stated that they were stated that they were of the extended	(other staff member) #3, the ces and ASM #1, the f3 stated that prior to the nic the PASRR was mission, however there that allowed them to admit assessment. OSM #3 supposed to complete the on in a timely manner but fact timeframe allowed. Then they realize they did not be completed it then. ASM and all attempts to get the sion and if the resident it they completed it within stated that the waivers had staff regarding completion M #1 stated that they had a ce and performance completing the PASRR. At is made for the it was put into place. Eximately 10:30 a.m., ASM and the QAPI (quality mance improvement) mance improvement) mance improvement in the completed in the completed if needed and the charts to ensure are completed if needed and the QAPI plan, ASM #1	F	645			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495272	B. WING				C
	NAME OF PROVIDER OR SUPPLIER CANTERBURY REHABILITATION & HEALTH CARE CENTER			17	TREET ADDRESS, CITY, STATE, ZIP CODE 776 CAMBRIDGE DRIVE ICHMOND, VA 23238	01/	/13/2022
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)				(X5) COMPLETION DATE
F 645	PASRR for Resident # On 1/13/2022 at 12:15 administrator and ASM were made aware of the second of th	the facility did not have a f32. 5 p.m., ASM #1, the #2, the director of nursing he findings. was provided prior to exit. se: A type of movement ation was obtained from the hov/medlineplus/parkinsonsdi hizophrenia is a serious who have it may hear voices may think other people are metimes they don't make The disorder makes it hard or take care of remation is taken from the hy/schizophrenia.html 19 is caused by a RS-CoV-2. This information website: pronavirus/2019-ncov/faq.ht preads. ed to complete a PASRR in esident #94 who was on 5/17/2021 with a formation the model.	F	545			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495272	B. WING	<u> </u>		C 01/13/2022	
	ROVIDER OR SUPPLIER BURY REHABILITATION 8	LA HEALTH CARE CENTER	'	STREET ADDRESS, CITY, STATE, Z 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	IP CODE	01710/2022	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		ACTION SHOULD BE TO THE APPROPRIAT		
F 645	diagnoses that include schizophrenia (1) and #94's most recent MD quarterly assessment reference date) of 12/as scoring a 3 on the status (BIMS) of a scoseverely impaired for Review of Resident #8 evidence a level 1 PA On 1/11/2022 at approrequest was made to member) #1, the admit PASRR for Resident #8 On 1/12/2022 at approrequest was made to member) #1, the admit PASRR for Resident #8 of 1/12/2022. On 1/12/2022 at 1:15 conducted with OSM (director of social service administrator. OSM #8 to the facility and were PASRR for Resident #94 that in that prior to the COVID PASRR was completed a for Resident #94 that in that prior to the COVID PASRR was completed to SM #3 stated that the complete the PASRR 8	mitted to the facility with ed but were not limited to dementia (2). Resident (2) (2) (2) (3) (3) (2) (2) (4) (4) (4) (4) (4) (4) (4) (4) (4) (4	F	645			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		495272	B. WING		MARK DESCRIPTION OF THE PROPERTY OF THE PROPER	01/	13/2022
	ROVIDER OR SUPPLIER BURY REHABILITATION 8	& HEALTH CARE CENTER	,	177	REET ADDRESS, CITY, STATE, ZIP CODE 76 CAMBRIDGE DRIVE CHMOND, VA 23238		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 645	Resident #94 did not completed it then. As all attempts to get the and if the resident we completed it within 24 that the waivers had oregarding completion stated that they had a and performance imprompleting the PASRI was made for the imprinto place. On 1/13/2022 at apprometing dated 12/22/2 part, "QAPI Action Plate [sic]/Preadmission Screview. Goals/Object Complete all PASSR's residents admission that all PASSR's [sic] a including level 2 PASS Completed Date: 1/10 date of compliance for plan, ASM #1 stated the On 1/13/2022 at 12:15 administrator and ASN were made aware of the No further information References: 1. Schizophrenia: "Screwick in the said i	ted that when they realize have one [PASRR] they is M #1 stated that they made PASRR prior to admission re admitted without it they -48 hours. ASM #1 stated raused confusion for staff of them [PASRR]. ASM #1 QAPI (quality assurance rovement) plan on R. At this time a request rovement plan that was put death of the QAPI (quality mance improvement) which documented in Insue/Concern: PASSR reening and Resident tive/Expected Outcome: Is [sic] upon admission of Audit the charts to ensure are completed if needed PAPI (and it was 1/10/2022.	F	645			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		495272	B. WING			01/	/13/2022	
NAME OF PI	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE			
CANTERE	3URY REHABILITATION {	& HEALTH CARE CENTER			MBRIDGE DRIVE			
Million and the Control of the Contr	CONTROL CONTRO			RICHMO	OND, VA 23238			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 645	Continued From page	3 47	F	645				
	that aren't there. They trying to hurt them. So sense when they talk. for them to keep a job themselves." This info website https://medlineplus.go 2. Dementia: A loss o with certain diseases. language, judgment, a information was obtain	y may think other people are ometimes they don't make. The disorder makes it hard or take care of ormation is taken from the ov/schizophrenia.html of brain function that occurs It affects memory, thinking, and behavior. This		340				
	was obtained from the https://www.cdc.gov/c ml#How-COVID-19-Sp	ARS-CoV-2. This information website: coronavirus/2019-ncov/faq.ht preads.						
	(preadmission screeni timely manner for Res	on 9/17/2020. Resident						
	9/17/20 with diagnose: limited to: non-traumath hemorrhage (bleeding diabetes mellitus (inabnormally in the body) (disease (decreased fufrequently as a complication of the complete series of the complete se	within the brain) (1), pility of insulin to function (2) and chronic kidney						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
		495272	B. WING				C /13/2022
	PROVIDER OR SUPPLIER BURY REHABILITATION 8	& HEALTH CARE CENTER		1776	EET ADDRESS, CITY, STATE, ZIP CODE 6 CAMBRIDGE DRIVE HMOND, VA 23238		10/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 645	coded the resident as BIMS (brief interview indicating the resident MDS Section G- Funct resident as requiring a mobility, transfers, drepersonal hygiene; sup A review of Resident at to reveal evidence of either prior to or on accase. A PASRR for Resident provided on 1/12/22 at An interview was concently, with OSM (other services director. Where the services director. Where the services director. Where the services director is the services director is the services director is the services director. Where the services director is the services director is the services director is the services director is the services director. Where the services director is the s	s scoring 15 out of 15 on the for mental status) score, at was cognitively intact. Ctional Status, coded the extensive assistance in bed essing, bathing, toileting and pervision in eating. #146's clinical record failed completion of a PASRR dmission on 9/17/20. Int #146 dated 1/12/22 was at 11:00 AM. ducted on 1/12/22 at 1:15 staff member) #3, the social men asked about the PASRR ing completed on 1/12/22, a could not find the PASRR's, Prior to COVID ere done before admission, by could be done after the wilding. We will go ahead and if needed refer to a level and if needed refer t	F	645			

	OF DEFICIENCIES F CORRECTION	IDENTIFICATION NUMBER:		TIPLE CONS		(X3) DATE SURVEY COMPLETED	
		495272	B. WING			C 01/13/2022	
	ROVIDER OR SUPPLIER	L HEALTH CARE CENTER		1776 C	T ADDRESS, CITY, STATE, ZIP CODE AMBRIDGE DRIVE MOND, VA 23238	1 01	713/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 645	patients admitted to n illness (MI) or intellect referred promptly by the PASARR program for On 1/12/22 at 5:15 PM member) #1, the admidirector of nursing we concerns. On 1/13/22 at 1:10 PM not have a policy for PM not h	day of admission, new ursing homes with a mental tual disability (ID) should be the nursing home to State Level 2 Resident Review." M, ASM (administrative staff inistrator and ASM #2, the re made aware of the above M, ASM #1 stated, "We do	F	545			
	#22's PASRR was not Resident #22 was adn 11/14/20 with diagnose not limited to: cerebro (hemorrhage of blocks	on 11/14/2020. Resident completed until 1/12/2022. nitted to the facility on es that included but were					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1321 20		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
11		495272	B. WING				C /13/2022
STOWNSHIP TO STOWN STORY OF STORY	ROVIDER OR SUPPLIER SURY REHABILITATION 8	L HEALTH CARE CENTER	•	17	TREET ADDRESS, CITY, STATE, ZIP CODE 776 CAMBRIDGE DRIVE RICHMOND, VA 23238		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	V. (4)	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 645	mellitus (inability of inathe body) (2) and positive (mood disorder occurring). Resident #22's most reset) assessment, a quassessment reference the resident as scoring (brief interview for methe resident was seven A review of Resident Freveal evidence of corprior to or on admission A PASRR for Resident provided on 1/12/22 at An interview was concept, with OSM (other services director. Who for Resident #22 being OSM #3 stated, "No I so I did them today. F	sulin to function normally in t-traumatic stress disorder ring after a traumatic event) secent MDS (minimum data parterly assessment, with an edate of 10/20/21, coded grown of 15 on the BIMS intal status) score, indicating rely cognitively impaired. #22's clinical record failed to impletion of a PASRR either on on 11/14/20. It #22 dated 1/12/22 was to 11:00 AM. Succeed on 1/12/22 at 1:15 staff member) #3, the social en asked about the PASRR grownletted on 1/12/22, could not find the PASRR's, Prior to COVID	F	645			
	after COVID, they couresident was in the burand complete them and II. Normally they would hours of admission." An interview was conditioned the properties of the properties	ilding. We will go ahead and if needed refer to a level do be completed within 24-48 ducted on 1/12/22 at 1:20 strative staff member) #1, stated, "There are CMS here is a waiver for ar period of time."					

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	65 1550	2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		495272	B. WING				C /13/2022	
	ROVIDER OR SUPPLIER BURY REHABILITATION 8	L HEALTH CARE CENTER		17	TREET ADDRESS, CITY, STATE, ZIP CODE 776 CAMBRIDGE DRIVE SICHMOND, VA 23238	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 645	admit new residents v 1 or Level 2 Preadmis assessments may be On or before the 30th patients admitted to n illness (MI) or intellect referred promptly by t PASARR program for On 1/12/22 at 5:15 PM member) #1, the adm director of nursing we concerns. On 1/13/22 at 1:10 PM not have a policy for F No further information References: (1) Barron's Dictionary Non-Medical Reader, Chapman, page 111. (2) Barron's Dictionary Non-Medical Reader, Chapman, page 160. (3) Barron's Dictionary Non-Medical Reader, Chapman, page 467 6. The facility staff faile PASRR (preadmission review) for Resident #56 were not limited to dia	wing nursing homes to who have not received Level sion Screening. Level 1 performed post-admission. day of admission, new ursing homes with a mental sual disability (ID) should be the nursing home to State Level 2 Resident Review." M. ASM (administrative staff inistrator and ASM #2, the re made aware of the above of ASRR". was provided prior to exit. of Medical Terms for the 5th edition, Rothenberg and Medical Terms for the 5th edition for the 5th edition for the 5th edition for the 5th edition for the 5th editio	F	645				

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495272	B. WING		C	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	01/13/2022	
CANTERE	BURY REHABILITATION 8	HEALTH CARE CENTER		1776 CAMBRIDGE DRIVE RICHMOND, VA 23238		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 645	resident's cognition as Review of Resident #1 reveal a level I PASRI after admission to the On 1/12/22 at 1:16 p.I conducted with OSM social services directors staff member) #1 (the stated she completed this day (1/12/2022) be that one had been contrat prior to COVID, P be done prior to admis Medicaid and the Dep PASRRs could be donstated PASRRs should hours of admission. Obeen a waiver in place that had changed. On 1/12/22 at 5:15 p.r (the director of nursing above concern. No further information Baseline Care Plan CFR(s): 483.21(a)(1)-1 §483.21 Comprehensi Planning §483.21(a) Baseline Care	e date of 11/11/21 coded the smoderately impaired. 56's clinical record failed to R was completed prior to or facility. m., an interview was (other staff member) #3 (the or) and ASM (administrative administrator). OSM #3 Resident #56's PASRR on ecause she could not find impleted. OSM #3 stated ASRRs were supposed to sision but after COVID, eartment of Health said the after admission. ASM #1 did be done within 24 to 48 DSM #3 stated there had but she was not sure if m., ASM #1 and ASM #2 g) were made aware of the was presented prior to exit. (3) Eve Person-Centered Care	F 64	F655 SS=D Baseline Care Plan	2/8/2022	
	that includes the instru	care plan for each resident actions needed to provide entered care of the resident				

FORM APPROVED OMB NO. 0938-0391

PRINTED: 01/23/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495272	B. WING				С	
NAME OF D	ROVIDER OR SUPPLIER	430212	D. WING_	0.7	DEST ADDRESS SITU STATE TO SOLE	01/	/13/2022	
NAME OF F	NOVIDEN ON SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE			
CANTERE	SURY REHABILITATION &	L HEALTH CARE CENTER		1776 CAMBRIDGE DRIVE				
				KI	CHMOND, VA 23238		,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 655	Continued From page	Continued From page 53						
		I standards of quality care.	F6	33				
	The baseline care pla		Т	he C	are Plan was updated to include Colosto	omy		
		n 48 hours of a resident's	С	are f	or resident #326.			
	admission.	in to floate of a fooldering						
	(ii) Include the minimu	ım healthcare information	Т	he C	are Plan was updated to include Oxyger	usage		
	necessary to properly	care for a resident	1		sident #328.	•		
	including, but not limit							
	(A) Initial goals based	on admission orders.	R	esid	ents who were admitted to Canterbury	Rehab		
	(B) Physician orders.				lealthcare requiring baseline care plans			
	(C) Dietary orders.(D) Therapy services.		completion have the potential to be affected by this					
	(E) Social services.			practice.				
		endation, if applicable.	F					
	(1) 11 (0) (1) (1) (1)	энаалын аррнаава.	В	aseli	ne Care Plans were audited for all reside	ents		
	§483.21(a)(2) The fac	ility may develop a	11					
	comprehensive care p	lan in place of the baseline			vere admitted to the facility in the last 3 sure baseline care plans were initiated.			
	care plan if the compr				y audit included development and			
		1 48 hours of the resident's	1111		mentation of a Baseline Care Plan for ea	ch		
	admission.		1		ent that includes the instructions needed			
		nents set forth in paragraph epting paragraph (b)(2)(i) of			le effective and person-centered care of			
	this section).	epting paragraph (b)(2)(i) or	1,000					
	una accuorij.				ent that met professional standards of qu	lanty	1	
	§483.21(a)(3) The fac	cility must provide the	01	car	e.			
1	- 10 Teles (1981년 - 1981년 -	esentative with a summary		- a a li	no Coro Dian Deliau reviewed no revision	.		
	of the baseline care pl	an that includes but is not			ne Care Plan Policy reviewed no revisior	.5		
	limited to:		ne	ecess	sary.			
	(i) The initial goals of		-	J	tion and ideal back a Chaff Davidson			
		resident's medications and			tion provided by the Staff Development	100		
	dietary instructions.	troatments to be			inator/Designee for the Interdisciplinary			
	(iii) Any services and	cility and personnel acting			censed Nursing staff on the developmer			
	on behalf of the facility		1 250		mentation of a Baseline Care Plan for ea			
		nation based on the details			nt that includes the instructions needed			
		care plan, as necessary.			le effective and person-centered care of			
		is not met as evidenced			nt that met professional standards of qu			
	by:		of	care	e, and the timeliness of 48 hours of resid	lent		
	Based on observation	, staff interview, facility	ac	lmiss	sion.			
L.	document review and	clinical record review it				l.		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	2 2		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495272	B. WING				С
NAME OF P	ROVIDER OR SUPPLIER	453212	D. WING_	S	TREET ADDRESS, CITY, STATE, ZIP CODE	01/	13/2022
CANTERE	BURY REHABILITATION 8	HEALTH CARE CENTER		17	776 CAMBRIDGE DRIVE RICHMOND, VA 23238		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ζ .	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 655	develop a complete be 62 residents in the sur #326 and #328. The facility staff failed baseline care plan to a Resident #326 and fair care plan to address a oxygen use. The findings include: 1. Resident #326 was 1/4/22. Resident #326 were not limited to chrof breast cancer and a Resident #326's admis assessment was not conursing evaluation data Resident #326 was aleplace and time. Review of Resident #37 revealed physician's or 1/11/22 for the resident Resident #326's baseli only included a section plan did not include an regarding the resident's that was needed. On 1/12/22 at 12:56 p. conducted with RN (reminimum data set coor (administrative staff me administrator) and OSN	to develop a complete address colostomy care for led to develop a baseline and include Resident #328's admitted to the facility on bis diagnoses included but conic kidney disease, history in underactive thyroid. Sision minimum data set completed. An admission ed 1/4/22 documented ent and oriented to person, 26's clinical record reders dated 1/10/22 and tis colostomy care. ne care plan dated 1/5/22 and tis colostomy or other care y other information is colostomy or other care m., an interview was gistered nurse) #1 (the dinator), ASM		of M mpl mew wee the C Care nstr cent stan noun	rdisciplinary Team members will review a Morning Clinical the development and lementation of a Baseline Care Plan for early admitted resident. An audit will be omplished by the Director of MDS/Design lekly x 4 weeks and then monthly x 2 mont development and implementation of a Base Plan for each resident that includes the ructions needed to provide effective and thered care of the resident that met profest adards of quality of care, and the timeline rs of resident admission. Itings from the audit will be presented to the N/Designee and submitted to QAPI monther and recommendation.	ee hs on aseline person- ssional ss of 48	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495272	B. WING			C 01/13/2022	
	ROVIDER OR SUPPLIER BURY REHABILITATION 8	L HEALTH CARE CENTER	1	STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		_D BE	(X5) COMPLETION DATE	
F 655	approach in caring for the facility staff try to a plan within 48 hours of baseline care plan she items including activiti nutritional status and care areas. On 1/12/22 at 2:09 p.r. conducted with RN #3 of the care plan is that the needs of the patie resident's baseline care admission and should such as pain, falls and baseline care plan she because the resident and electrolyte dysfun. On 1/12/22 at 2:28 p.r. member) #4 stated it is practice that they wou on a resident's baseline. On 1/12/22 at 5:15 p.r. (the director of nursing above concern. The facility policy titled documented, "1. To as immediate care needs baseline care plan will forty-eight (48) hours of 2. The interdisciplinary healthcare practitioner	cach in caring for the disciplines and identifying an the patient. RN #1 stated establish a baseline care of admission and the could include basic need less of daily living, skin, pain, significant medication or m., an interview was an end of the purpose the it is individualized to meet an end of the resident of the facility staff's best and include colostomy care are startisk for skin breakdown ction. In OSM (other staff is the facility staff's best and include colostomy care are care plan. In ASM #1 and ASM #2 and ware of the startisk for skin breakdown ction. In ASM #1 and ASM #2 and the resident's are met and maintained, a be developed within of the resident's admission. In the resident's admission. In the resident's admission. In the resident's end will review the starting the resident the resident's end will review the starting the resident the res	F	655			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495272	B. WING			20-0-0	C /13/2022
	NAME OF PROVIDER OR SUPPLIER CANTERBURY REHABILITATION & HEALTH CARE CENTER			1776	EET ADDRESS, CITY, STATE, ZIP CODE 6 CAMBRIDGE DRIVE HMOND, VA 23238	01/	113/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 655	not limited to the followa. Initial goals based b. Physician orders; c. Dietary orders; d. Therapy services e. Social services; a f. PASARR recommend of the large in opening (stoma) made Stools moving through the stoma into a bag at This information was continued by the stoma into a bag at This information was of the	care needs including, but wing: d on admission orders; d on admission orders; d and nendation, if applicable." was presented prior to exit. rgical procedure that brings needs the abdominal wall. In the intestine drain through and the intestine drain through attached to the abdomen." Obtained from the website: v/ency/article/002942.htm admitted to the facility on B's diagnoses included but betes, acute kidney failure dary COVID-19. Resident mum data set assessment in admission nursing 2 documented Resident ented to person and place. In. Resident #328 was receiving oxygen at two and via nasal cannula.	F	655			

001110	CT ON WEDIONINE &	VILDIOAID SERVICES				CIMP IN	J. 0936-039 I
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495272	B. WING				C /13/2022
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	1 01	TOTECLE
CANTER	BURY REHABILITATION 8	HEALTH CARE CENTER		1	11776 CAMBRIDGE DRIVE RICHMOND, VA 23238		
(VA) ID	CUMMADV CT	ATEMENT OF DEFICIENCIES	T		T		T
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 655	Continued From page	57	F	655			
	conducted with RN (reminimum data set cool (administrative staff madministrator) and OS of case management) plan is a holistic approresident, taking in all capproach in caring for the facility staff try to eplan within 48 hours obaseline care plan should items including activitinutritional status and scare areas. On 1/12/22 at 2:09 p.r. conducted with RN #3 of the care plan is that the needs of the patieresident's baseline care admission and should such as pain, falls and oxygen use should ab baseline care plan becafety and breathing. On 1/12/22 at 2:28 p.m. facility staff's best pracoxygen use on a resid On 1/12/22 at 5:15 p.m. (the director of nursing above concern.	nember) #1 (the sM #4 (the regional director . RN #1 stated the care bach in caring for the disciplines and identifying an the patient. RN #1 stated establish a baseline care of admission and the build include basic need es of daily living, skin, pain, significant medication or, an interview was . RN #3 stated the purpose at it is individualized to meet on the replant is created on include all basic care plans					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 PR 020000000000000000000000000000000000	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495272	B. WING_				C /13/2022	
	ROVIDER OR SUPPLIER BURY REHABILITATION 8	HEALTH CARE CENTER		17	TREET ADDRESS, CITY, STATE, ZIP CODE 776 CAMBRIDGE DRIVE IICHMOND, VA 23238	011	10,2022	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 656 F 656 SS=D	CFR(s): 483.21(b)(1) §483.21(b) Comprehe §483.21(b)(1) The fact implement a compreh care plan for each res resident rights set fort §483.10(c)(3), that inco objectives and timefra medical, nursing, and needs that are identific assessment. The come describe the following (i) The services that a or maintain the reside physical, mental, and required under §483.2 (ii) Any services that we under §483.24, §483.2 provided due to the re under §483.10, includit treatment under §483.3 (iii) Any specialized sere in the resident services provide as a result of force in the resident services provide as a result of force in the resident services provide as a result of force in the resident services provide as a result of force in the resident services provide as a result of force in the resident services provide as a result of force in the resident services provide as a result of force in the resident services provide as a result of force in the resident services provide as a result of force in the resident services provide as a result of force in the resident services provide as a result of force in the resident services provide as a result of force in the resident services provide as a result of force in the resident services provide as a result of force in the resident services provide as a result of force in the resident services provided the resident services provided due to the re under §483.24, §483.2 provided due to the re under §483.24, §483.2 provided due to the re under §483.24 provided due to the re under §483.24 provided due to the re under §483.25 provided due to the re under §483.26 provided due to the re unde	ensive Care Plans ility must develop and ensive person-centered ident, consistent with the h at §483.10(c)(2) and cludes measurable mes to meet a resident's mental and psychosocial ed in the comprehensive prehensive care plan must - re to be furnished to attain nt's highest practicable psychosocial well-being as 14, §483.25 or §483.40; and rould otherwise be required 25 or §483.40 but are not sident's exercise of rights ng the right to refuse 10(c)(6). rvices or specialized the nursing facility will PASARR facility disagrees with the R, it must indicate its nt's medical record. the resident and the ve(s)- ls for admission and erence and potential for ities must document	F	Carrent Resident Resi	Sident #131's Orthotic/Splint was assessed by sident #426's Television was assessed by sintenance department to be functioning if was turned on per resident channel preshe time of survey. Ident #117's oxygen was applied per physical that reside at Canterbury Rehab and the time of survey. Idents that reside at Canterbury Rehab and the time of survey.	d by 2022. the properly ference sician and e the audit n	2/8/2022	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	177 - 247	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495272	B. WING		С	
NAME OF P	ROVIDER OR SUPPLIER	433212	B. WING _	STREET ADDRESS, CITY, STATE, ZIP CODE	01/13/2022	
		HEALTH CARE CENTER		1776 CAMBRIDGE DRIVE RICHMOND, VA 23238		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOULD B. CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
	plan, as appropriate, i requirements set forth section. This REQUIREMENT by: Based on staff intervir and clinical record rev facility staff failed to do comprehensive care p in the survey sample, #426 and Resident #1 The facility staff failed #131's comprehensive splint, failed to implement comprehensive care p and failed to implement comprehensive care p oxygen. The findings include: 1. Resident #131 was 9/12/20 with diagnoses limited to: cerebral infa or blockage of blood veto a lack of oxygen) (1) affecting one side of the atherosclerotic cardiov consisting of lipids and arterial walls) (3). Resident #131's most industrial walls) (3).	in the comprehensive care in accordance with the in paragraph (c) of this is not met as evidenced aw, facility document review iew, it was determined the evelop/implement the lan for three of 62 residents Resident #131, Resident 17. It is implement Resident acrae plan for a left hand ent Resident #426's lan for preferred activities at Resident #117's lan for the administration of admitted to the facility on a that included but were not rection [CVA] (hemorrhage lessels of the brain leading hemiplegia (paralysis e body) (2) and ascular disease (plaque cholesterol building up in		Education was provided to the IDT Team an licensed nursing staff by the Director of Nursing/Designee on the Comprehensive P Centered Care plan policy. Interdisciplinary members will review as part of Quarterly C Conferences the development and implement of a Comprehensive person-centered Care. A random audit of 5 resident will be complete part of the Care Planning process weekly x and then monthly x 2 months to ensure one compliance with the development and implementation of a Comprehensive person centered Care Plan process. Findings from the audit will be presented to DON/Designee and submitted to QAPI montreview and recommendation.	Person- y Team are entation Plan. eted as 4 weeks going	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					(X3) DATE SURVEY COMPLETED		
		495272	B. WING	1		C 01/13/2022			
	ROVIDER OR SUPPLIER BURY REHABILITATION 8	& HEALTH CARE CENTER		177	REET ADDRESS, CITY, STATE, ZIP CODE 76 CAMBRIDGE DRIVE CHMOND, VA 23238	,	710/22		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	0002	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE		
	MDS Section G- Fundaresident as requiring a mobility, transfers, drepersonal hygiene; independence in bathin During the initial facility PM, Resident #131 waside of the bed with his hand curled up. At this Resident #131 stated, the top drawer." Whe the splint on, Resident myself, and the staff used to be in therapy on 1/12/22 at 9:30 AM without splint on hand side of the bed. A review of Resident #plan dated 9/21/20, do "FOCUS-I have limited left hemiplegia status/INTERVENTIONS-Grain positioning and with toileting. I require Neutral left hand splint.	t was cognitively intact. It was a sitting and total and an	F	656					
	An interview was cond PM, with OSM (other s physical therapist. Wh								

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495272	B. WING			1	C /13/2022
	ROVIDER OR SUPPLIER BURY REHABILITATION 8	L HEALTH CARE CENTER		17	TREET ADDRESS, CITY, STATE, ZIP CODE 776 CAMBRIDGE DRIVE ICHMOND, VA 23238	01/	13/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	therapy, and we would nurses put it on now." An interview was cond AM with CNA (certified When asked who was Resident #131 with plastated, "He usually do mornings. So I do not noon. Sometimes the An interview was cond PM with RN (registere director and OSM (oth regional director of carasked her start date, F1/10/22." When asked plan, RN #1 stated, "T is to provide a holistic resident and to inform head to toe and psych aspects." When asked intervention on the corshould be applied, OS splints should be applied, OS splints should be applied. On 1/12/22 at 5:15 PM member) #1, the admidirector of nursing wer findings. A review of the facility' person-centered care in documented in part, "A person-centered care in measurable objectives resident's physical, psysical, ps	ducted on 1/12/22 at 9:10 d nursing assistant) #1. responsible to assist acing his splint, CNA #1 esn't wake up in the put the splint on till about rapy puts the splint on." ducted on 1/12/22 at 12:56 d nurse) #1, the MDS er staff member) #4, the re management. When RN #1 stated, "I started d the purpose of the care plan approach in caring for the all disciplines. It includes osocial care for them in all d if splints included as an imprehensive care plan M #4 stated yes, of course, ed. 1, ASM (administrative staff inistrator and ASM #2, the e made aware of the above s "Comprehensive, plan" policy, version 1.3, a comprehensive,	F	656			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL' A. BUILDI	TIPLE CONSTRUCTION ING			SURVEY PLETED
		495272	B. WING				C /13/2022
Service And Automatical Service Servic	ROVIDER OR SUPPLIER BURY REHABILITATION 8	L HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, Z 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	IP CODE	1 011	113/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
F 656	resident. The comprecare plan will: include timeframes; describe furnished to attain or in highest practicable physychosocial well-bein reducing decline in the and/or functional level. No further information. References: (1) Barron's Dictionary Non-Medical Reader, Chapman, page 111. (2) Barron's Dictionary Non-Medical Reader, Chapman, page 264. (3) Barron's Dictionary Non-Medical Reader, Chapman, page 52. 2. Resident #426 was diagnoses that include anoxic brain damage (failure (2). Resident # (minimum data set), a an ARD (assessment 10/21/2021, coded the impaired for making dacoded Resident #426 assistance of two or mand total assistance of personal hygiene, toiled receiving a tube feedir	chensive, person-centered a measurable objectives and the services that are to be maintain the resident's sysical, mental, and ng. Aid in preventing or a resident's functional status is: was provided prior to exit. of Medical Terms for the 5th edition, Rothenberg and of Medical Terms for the 5th edition, Rothenberg and of Medical Terms for the 5th edition, Rothenberg and of Medical Terms for the 5th edition, Rothenberg and of Medical Terms for the 5th edition, Rothenberg and of Medical Terms for the 5th edition, Rothenberg and of Medical Terms for the 5th edition, Rothenberg and of Medical Terms for the 5th edition, Rothenberg and of Medical Terms for the 5th edition, Rothenberg and of medical Terms for the 5th edition, Rothenberg and Medical Terms for the 5th edition, Rothenberg and Medical Terms for the 5th edition, Rothenberg and Medical Terms for the 5th edition	F	656			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495272	B. WING				C
	ROVIDER OR SUPPLIER	& HEALTH CARE CENTER		17	TREET ADDRESS, CITY, STATE, ZIP CODE 776 CAMBRIDGE DRIVE ICHMOND, VA 23238		/13/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			(X5) COMPLETION DATE
F 656	top of the dresser at the bed. A note on the terminate preferred television of observed to be off. Additional observation at 2:45 p.m., 4:30 p.m. a.m. and 1:45 p.m., redescribed above. On 1/11/2022 at approinterview was conduct responsible party. Reparty voiced concerns not following their requirements of the sports channels Resident #426's responsible party voiced concerns not following their requirements of the sports channels Resident #426's responsible party voiced concerns not following their requirements of the sports channels Resident #426's responsible party voiced concerns not following their requirements of the sports channels Resident #426's responsible party voiced concerns not following their requirements of his previous the only things that he to. The comprehensive can dated 12/01/2020 door #426] requires assistate leisure time r/t (related cognitive deficits. Date Under "Interventions" "Assist resident with The 12/01/2020. I enjoy menjoy church and social and sports. Date Initiations. Date Initiations. Date Initiations. Date Initiations. Date Initiations. Date Initiations. The preference of th	A television was located on the foot of Resident #426's levision documented mannels, the television was as conducted on 1/11/2022 at 8:30 evealed the findings as evealed the findings as evealed the findings as every stated that he regarding the facility staff uests to turn the television is for Resident #426. It is career and it was one of the really showed a response every stated that he really showed a response every stated in part, "[Resident ince to structures [sic] his it documented in part, V. Date Initiated: 12/01/2020." It documented in part, V. Date Initiated: 12/01/2020" The mented "I am dependent on initive stimulation, social edeficits, physical ted: 12/14/2020." Under	F	656			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495272	B. WING	500			C /13/2022
	ROVIDER OR SUPPLIER BURY REHABILITATION 8	& HEALTH CARE CENTER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 776 CAMBRIDGE DRIVE RICHMOND, VA 23238		13/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD I TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			(X5) COMPLETION DATE
F 656	The "Activities-Quarte Review" dated 4/22/2 [Resident #426] watch broadcast, the recrea facetime calls for [Resweekly" On 1/12/2022 at 9:39 conducted with OSM activities. OSM #10 s Resident #426's unit. personalized activities their preferences and #10 stated that they rethe resident's personal activities. On 1/12/2022 at 1:45 conducted with CNA (#8. CNA #8 stated that Recare from staff for all adid not attend activitie #8 stated that Resider enjoyed listening to fotelevision. On 1/12/2022 at 2:00 conducted with LPN (ILPN #6 stated that Reparticipate in activities bed most days. LPN #426 was nonverbal and eyes. LPN #6 stated that Resider enjoyed.	erly/Annual Participation 021 documented in part, " nes sports and ESPN tion team facilitates sident #426] and his family a.m., an interview was (other staff member) #10, tated that they worked on OSM #10 stated that they for the residents based on personal choices. OSM elied on the care plan using all experiences to provide p.m., an interview was certified nursing assistant) at Resident #426 was at in the bed most days. Esident #426 required total activities of daily living and as outside of the room. CNA at #426 liked sports and orball and sports on the p.m., an interview was idensed practical nurse) #6. Sident #426 did not and stayed in their room in #6 stated that Resident mod followed objects with his hat Resident #426 used to sion prior to it breaking.	F	656			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	103 177	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495272	B. WING			C 01/13/2022		
	ROVIDER OR SUPPLIER	HEALTH CARE CENTER	•	17	REET ADDRESS, CITY, STATE, ZIP CODE 76 CAMBRIDGE DRIVE CHMOND, VA 23238	01/	10/2022	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD I TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			(X5) COMPLETION DATE	
	not sure if the family we broken or if maintenant #6 stated whoever districted broken should have remaintenance for repair. On 1/12/2022 at appropriate twas made to director for any work of Resident #426's televity. On 1/12/2022 at 2:49 conducted with OSM stated that Resident # and non-responsive. The had scheduled weekly Resident #426's responsive to the televity were not aware the television was not work provided an alternate as streaming device or ranged of the television was not work provided an alternate as the television was not work provided and the television was not work provided an alternate as the television was not work provided an alternate as the television was not work provided an alternate as the television was not work provided an alternate as the television was not work provided an alternate as the television was not work provided an alternate as the television was not work provided an alternate as the television was not work provided an alternate as the television was not work provided an alternate as the	per of 2021 and they were was aware that it was not was aware of this. LPN accovered the television was exported it to the family and rs. Describe the separate of this to the family and rs. Describe the separate of this to the family and rs. Describe the separate of	F	656				

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	2 10 TO 11 William	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			a cauca a na manaya kada na Automot				С	
		495272	B. WING	-		01/	/13/2022	
	ROVIDER OR SUPPLIER BURY REHABILITATION 8	& HEALTH CARE CENTER		17	TREET ADDRESS, CITY, STATE, ZIP CODE 776 CAMBRIDGE DRIVE RICHMOND, VA 23238			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	**************************************	ID PROVIDER'S PLAN OF CORRECTIO PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPI DEFICIENCY)			(X5) COMPLETION DATE	
F 656	checked Resident #42 was not broken but ha settings adjusting. AS television was working On 1/12/2022 at appro #1, the administrator a nursing were made av No further information References: 1. Anoxic brain dama getting to the brain. T obtained from the web https://www.nlm.nih.go 001435.htm 2. Congestive heart fa the heart can't pump e body's needs. Heart fa your heart has stoppe working. It means that pump blood the way it both sides of the heart obtained from the web https://medlineplus.go 3. Resident #117 was	26's television and that it ad to have the channel SM #1 stated that the g at that time. coximately 5:00 p.m., ASM and ASM #2, the director of ware of the above concern. In was presented prior to exit. age: Not enough oxygen This information was biste: cov/medlineplus/ency/article/ failure: A condition in which enough blood to meet the ailure does not mean that ad or is about to stop t your heart is not able to the should. It can affect one or to the triangle of the condition was besite: cov/heartfailure.html admitted to the facility on	F	656	DEFICIENCY)			
	were not limited to hea and acute kidney failu admission minimum da	ata set with an assessment 10/21, coded the resident as ct. Section O coded ing received oxygen.						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	91 (0000) 0000000000000000000000000000000	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER BURY REHABILITATION 8	& HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	01/13/2022	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAL DEFICIENCY)		
F 656	revealed a physician's oxygen at two liters penasal cannula. Resid care plan dated 12/15 altered respiratory sta Provide oxygen as ord On 1/11/22 at 1:29 p.r Resident #117 was obnot receiving oxygen. On 1/12/22 at 2:09 p.r conducted with RN (restated the purpose of individualized to meet RN #3 stated nurses in reviewing the care pland aides implement the kardex. On 1/12/22 at 2:43 p.m. conducted with RN #2 #117's tracheostomy with the resident uses oxygasked what a physicial oxygen meant, RN #2 oxygen all the time." On 1/12/22 at 5:15 p.m. staff member) #1 (the director of nursing above concern.	s order dated 12/8/21 for er minute continuously via ent #117's comprehensive /21 documented, "I have tus/Difficulty Breathing. dered." m. and 1/12/22 at 8:21 a.m., served lying in bed and was egistered nurse) #3. RN #3 the care plan is that it is the needs of the patient. Implement the care plan by in in the computer system he care plan by reviewing a m. an interview was and read and the care plan by reviewing a m. an interview was and recently removed and the sometimes. When the sometimes when it's order for continuous stated, "They should have administrator) and ASM #2 by were made aware of the	F	356		
F 657	Care Plan Timing and CFR(s): 483.21(b)(2)(i) §483.21(b) Comprehen)-(iii)	F 68	F657 SS=D Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)	on e	

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OLIVILIY	TO TON MEDICANE &	WEDICAID SERVICES			OIMP INC	<i>J.</i> 0936-039 i			
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Marian Marian Marian Control	LE CONSTRUCTION		SURVEY PLETED			
						С			
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NAME OF PI	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE					
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	TORT REINBIEMATION	THEACHT GARL GENTER		RICHMOND, VA 23238					
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F 657	Continued From page	. 68	F 65:			2/8/2022			
1 00.			F 657			529			
		orehensive care plan must	A C	omprehensive Care Plan was held for Re	sident				
	be-	days after completion of	#42	6 with Resident Representative on 1/31	/2022.				
	(i) Developed within 7 days after completion of the comprehensive assessment.			The state of the s					
	(ii) Prepared by an interdisciplinary team, that			ident 148 was assessed for continued us	e of side				
	includes but is not lim		rail	s and was found to not have need for the	eir usage				
	(A) The attending phy	⁄sician.	100000000000000000000000000000000000000	his time. Comprehensive Care Plan was					
	(B) A registered nurse with responsibility for the with requirement for bed rail update not needed.								
	resident.		0.00000	lers for side rails were not required due					
	(C) A nurse aide with	responsibility for the		continuation of side rail usage.					
	resident. (D) A member of food and nutrition services staff.			ontinuation of stage and added					
		ticable, the participation of	Residents who reside at Canterbury Rehab and						
		esident's representative(s).		Ilthcare who meet the requirement for a					
		be included in a resident's		nprehensive Care plan have the potentia					
		participation of the resident		ected by this practice. An audit was comp					
	and their resident repr	resentative is determined		MDS Coordinator/Designee for current i	1 () () () () () () () () () (
1	not practicable for the	development of the	100000000000000000000000000000000000000	ne last quarter who meet the criteria for					
	resident's care plan.			prehensive Care Plan meetings to ensur					
		staff or professionals in		umentation supports Resident/Resident					
	or as requested by the	ned by the resident's needs		resentation supports resident/resident	11	ı			
		sed by the interdisciplinary	940	eting. Those found to have not had	ale Flaii				
		ssment, including both the	The state of the s		C				
	comprehensive and qu	THE TOTAL STATE OF THE STATE OF		tation/attendance to the Comprehensive					
	assessments.	1 (200 m (200 € 1) (1 (200 m) (200 m) (1 (200 m) (200 m) (1 (200 m) (meeting in the last quarter were contact	ted for	i			
		is not met as evidenced		ortunity for meeting to discuss the					
	by:	and the desirence of the	Com	prehensive Care Plan.					
		ord review, staff interview,							
		ew and facility document	00-20-01-00-00-0	dents who reside at Canterbury Rehab a					
		ned that facility staff failed comprehensive care plan		thcare who require update/revision the					
		in the survey sample,		have the potential to be affected by this	200				
	Resident #426 and Re		documentation practice. An audit was completed for						
	Troolson III. Lo and 1.0	diddit # 140.		dents requiring update/revision to the Ca					
	The facility staff failed	to include the resident	Mod	lifications were made for residents ident	ified				
	representative in review		with	discrepancies.					
		lan for Resident #426 and							

failed to review and revise Resident #148's

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	(X3) DATE SURVEY COMPLETED						
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No. Visional and Color	ROVIDER OR SUPPLIER BURY REHABILITATION &	HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238						
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F 657	Continued From page comprehensive care page. The findings include:	69 plan for the use of bed rails.	F 657						
	representative in revier comprehensive care processions and diagnoses that include anoxic brain damage failure (2). Resident # (minimum data set), an ARD (assessment 10/21/2021, coded the impaired for making dicoded Resident #426 assistance of two or mand total assistance of personal hygiene, toiled to the impaired for making dicoded Resident #426 assistance of two or mand total assistance of personal hygiene, toiled to 1/11/2022 at appropriate to the impaired for making dicoded Resident #426 receiving a tube feeding pump. Resident #426 open and non-verbal. On 1/11/2022 at appropriate to 1/11/2022 at appropriate was conduct responsible party. Reparty voiced concerns not informing them of the Resident #426's responsible party.	Inditted to the facility with ed but were not limited to (1) and congestive heart (426's most recent MDS quarterly assessment with reference date) of e resident as being severely eally decisions. Section G as requiring total more staff with bed mobility of one staff member for eting, dressing and eating. Eximately 12:30 p.m., an eximately 12:35 p.m., an eximately 12:3	Education was completed by the Administrator/Designee on the inclusion of resident representative in the review and revision of the comprehensive care plan. An audit will be completed by the Social Service Director weekly x 4 weeks and then monthly x 2 months of resident/resident representative invitations to the Care Plan meetings. Education was completed by the Staff Development Coordinator/Designee to the Interdisciplinary team and Licensed nursing staff on the updating/revision of the Comprehensive Care plan to meet current resident needs. Interdisciplinary Team members will review in Morning Clinical the updating/revision of the Comprehensive Care plan. An random audit of 5 residents will be completed by the Director of Nursing/Designee weekly x 4 weeks and then monthly x 2 months to ensure the updating/revision of the Comprehensive Care Plan occurs timely and reflect the current resident needs. Findings from the audit will be presented to the DON/Designee and submitted to QAPI monthly for review and recommendation.						
	advocated for Resider non-verbal and could it	at #426 because they were not speak for themselves me calls scheduled with the							

STATEMENT OF DEFICIENCIES (AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER BURY REHABILITATION 8	L HEALTH CARE CENTER		STREET ADDRESS, CITY 1776 CAMBRIDGE DRI RICHMOND, VA 232	IVE	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CO	DER'S PLAN OF CORRECTION RRECTIVE ACTION SHOULD B ERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 657	attend the care plan in attend by facetime bu were to occur because Resident #426's response had voiced this concepreviously but had new Review of Resident #4 evidence documentatic care plan meeting to ror notification of the replan meeting. On 1/11/2022 at approrequest was made to member) #1, the adminiterdisciplinary care put the responsible part to the responsible part (social worker) held arresident's wife regarding SW on this day was rerelayed her availability has established a Care 25th at 2pm." ASM #2 meeting review note documented family att On 1/12/2022 at 1:00 put conducted with RN (redirector and OSM (oth regional director of castated that they were rethought that the care put to the conducted with the ca	pusly received invitations to meetings and was willing to the never knew when they are no one let them know. It is not the social worker were heard any updates. 426's clinical record failed to on of an interdisciplinary eview/revise the care plants provided party of a care obtained by the company of a care of an obtained by the company of a care obtained by the company of a care of an obtained by the company of a care of an obtained by the company of a care of an obtained by the company of a care of an obtained by the company of a care of a	F	557			

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	care for the total resid disciplines. On 1/13/2022 at 9:30 conducted with OSM is services. OSM #3 stathe facility and were wimprove care planning had started doing care team in the resident's responsible party to in stated that they began at the facility in early E stated that they had a meetings that were be working to get them be schedule. OSM #3 stawas a long term care in and staffing issues had being set up. OSM #3 clinical record and staff documentation of a care 2021. On 1/13/2022 at approximate and OSM #3 provide assurance and perform meeting dated 12/22/2 part, "Data: Care Pla Analysis (Root Cause scheduled due to staffing set of the control of the care plans to the control of the care plans to the care plans	a.m., an interview was #3, the director of social ted that they were new to rorking on a process to a. OSM #3 stated that they enavigation meetings as a room and calling the clude them. OSM #3 roster of care plan hind schedule and were tack on the quarterly tated that Resident #426 resident and the pandemic did delayed the meetings are rowned Resident #426's ted that there was no re plan meeting held in the process after starting to the process after s	F	657	DEFICIENCY)		
	will schedule, create le and their families. Sta be notified in a timely r include, the facility will	D (3). Residents not DPlan: Social Services Itters and mail to residents If and family members will Inanner. Required staff will Ifollow CDC (centers for Ines to ensure safety for					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
CANTERE	URY REHABILITATION 8	HEALTH CARE CENTER		1	1776 CAMBRIDGE DRIVE		
TOTAL CHI. NO MERICANISMON	AND THE RESIDENCE OF THE PROPERTY OF THE STANDARD STANDAR			F	RICHMOND, VA 23238		
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			ING		DEFICIENCY)		500, 6000m)
			1	-6			
F 657	Continued From page	72	F (657			
		meetings" When asked	1	551			
		e for the QAPI plan, ASM					
		/10/2022. At this time, a			1		
		nade for evidence of the					
		neeting and letter mailed to					
	Resident #426's response	onsible party as					
		API plan. OSM #3 stated					
		he process with the short					
		d not finished the long-term					
	residents at that time.						
	On 1/12/2022 at appro	eximately 5:00 n m . a	ŀ				
		ASM #1, the administrator					
		garding reviewing and/or					
	revising the care plan.						
	3 3 4						3
	The facility policy, "Ca	re Plans, Comprehensive					
		umented in part, "The					
		(IDT), in conjunction with					
	the resident and his/he						
	representatives, devel						
1		n-centered care plan for					
	facilitate resident and/	re planning process will: a.				1	
		e an assessment of the					
	resident's strengths an						
		nt's personal and cultural					
		ping the goals of care"					
	The policy further docu						
		must review and update the					
	care plan:at least qu	arterly, in conjunction with					
	the required quarterly I	MDS assessment"					
		ximately 12:15 p.m., ASM					
		nd ASM #2, the director of					
	nursing were made aw	are of the above concern.					
	No further information	was presented prior to exit.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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200000000000000000000000000000000000000	ROVIDER OR SUPPLIER BURY REHABILITATION 8	L HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP COI 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	DE		10/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	[1]	N SHOULD BE E APPROPRIA		(X5) COMPLETION DATE
F 657	getting to the brain. Tobtained from the well https://www.nlm.nih.g 001435.htm 2. Congestive heart fithe heart can't pump body's needs. Heart fayour heart has stoppe working. It means that pump blood the way it both sides of the heart obtained from the well https://medlineplus.go 3. COVID-19: COVID coronavirus called SA are a large family of vipeople and may differ including camels, cattle animal coronaviruses spread between people MERS-CoV and SARS virus that causes COV virus is a betacoronav SARS-CoV. All three corigins in bats. The seare similar to the one is suggesting a likely sin this virus from an anim exact source of this virus information was obtain https://www.cdc.gov/cml#How-COVID-19-Sp 2. The facility staff failed	ge: Not enough oxygen This information was posite: pov/medlineplus/ency/article/ ailure: A condition in which enough blood to meet the ailure does not mean that d or is about to stop t your heart is not able to should. It can affect one or t. This information was posite: v/heartfailure.html -19 is caused by a RS-CoV-2. Coronaviruses ruses that are common in ent species of animals, e, cats, and bats. Rarely, can infect people and then de. This occurred with S-CoV, and now with the PID-19. The SARS-CoV-2 irus, like MERS-CoV and of these viruses have their quences from U.S. patients that China initially posted, gle, recent emergence of nal reservoir. However, the rus is unknown. This led from the website: pronavirus/2019-ncov/faq.ht	F	657			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495272	B. WING		100000	C /13/2022
	ROVIDER OR SUPPLIER BURY REHABILITATION 8	HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238		110/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		BE	(X5) COMPLETION DATE
F 657	6/19/20. Resident #14 were not limited to dia disease and COVID-1 quarterly minimum da assessment reference the resident's cognitio On 1/11/22 at 2:16 p.r observed lying in bed rails in the upright post Resident #148's comp 9/22/20 failed to reveated bed rails. Review of Resident #7 1/11/22 failed to reveated a rails. On 1/12/22 at 12:56 p conducted with RN (reminimum data set coo (administrative staff madministrator) and OS of case management) plan is a holistic approach in caring for On 1/12/22 at 2:09 p.m conducted with RN #3 of the care plan is that	dmitted to the facility on 48's diagnoses included but betes, chronic kidney 9. Resident #148's ta set assessment with an e date of 12/20/21, coded in as severely impaired. In., Resident #148 was with bilateral grab bar bed ition. In the facility of the series of the facility of the redinator), ASM ember) #1 (the redinator), ASM ember) #1 (the redinator), ASM ember) #1 (the facility of the facility of the lisciplines and identifying an the patient. In an interview was an interview was each in caring for the lisciplines and identifying an the patient. In an interview was an interview was an interview was and identifying an the patient. In an interview was an interview was an interview was and identifying an the patient. In an interview was an interview was an interview was an interview was and identifying an the patient. In an interview was an interview was an interview was an interview was and identifying an the patient. In an interview was an interview	F	657		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	OV TOWNSTON THE PROPERTY OF		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495272	B. WING _				C /13/2022
100,100,000,000,000	ROVIDER OR SUPPLIER BURY REHABILITATION 8	HEALTH CARE CENTER		17	TREET ADDRESS, CITY, STATE, ZIP CODE 776 CAMBRIDGE DRIVE RICHMOND, VA 23238	017	13/2022
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ζ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
F 657	On 1/12/22 at 2:28 p.r of bed rails should be comprehensive care p. On 1/12/22 at 5:15 p.r (the director of nursing above concern.	m., OSM #4 stated the use included on a resident's plan. m., ASM #1 and ASM #2 g) were made aware of the was presented prior to exit.	F 6				
SS=D	CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The faci the comprehensive as and the preferences or program to support res activities, both facility- individual activities and designed to meet the i physical, mental, and p each resident, encours and interaction in the of This REQUIREMENT by: Based on observation family interview, staff in document review it was facility staff failed to pro meet the needs of one survey sample, Resides The findings include: Resident #426 was add diagnoses that includes anoxic brain damage (**	d independent activities, interests of and support the osychosocial well-being of aging both independence community. is not met as evidenced s, clinical record review, interviews and facility is determined that the ovide preferred activities to of 62 residents in the	F F M t R H p w o a	Residence of cut city in the same of cut cut cut in the same of c	9 SS=D Activities to Meet Interests/Need ident (s): 483.24©(1) dent #426 Television / preferred activity wided. The Television was assessed by the ntenance Director to be working properly survey process. dents who reside at Canterbury Rehab and theare and have activities of choice have to ntial to be affected by this practice. An aucompleted by the Activities Director/Designment residents to ensure their preferred ities meet their current needs. ities Policy reviewed no revisions necessal	vas during d the idit gnee	2/8/2022

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(v) 100/74/2009/04/75		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		405272	DI ANGRAMAN DESCRIPTION				С
NAME OF F	ROVIDER OR SUPPLIER	495272	B. WING			01	13/2022
		HEALTH CARE CENTER		1	TREET ADDRESS, CITY, STATE, ZIP CODE 776 CAMBRIDGE DRIVE RICHMOND, VA 23238		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 679	an ARD (assessment 10/21/2021, coded the impaired for making docoded Resident #426 assistance of two or mand total assistance of personal hygiene, toiled On 1/11/2022 at approaches operation was made room. Resident #426 receiving a tube feeding pump. Resident #426 open and non-verbal. top of the dresser at the bed. A note on the telepreferred television chobserved to be off. The observed to be pulled #426 and their roommate 1:45 p.m., 4:30 p.m. a.m. and 1:45 p.m., revidescribed above. On 1/11/2022 at approaches a party voiced concerns not following their required on the sports channels Resident #426's responenjoyed listening to any because of his previous and total previous to the sports channels resident #426's responential previous to the sports channels resident #426's responential previous the sports channels resident previous the sports cha	quarterly assessment with reference date) of a resident as being severely ally decisions. Section G as requiring total nore staff with bed mobility of one staff member for eting, dressing and eating. Eximately 12:30 p.m., an a coff Resident #426 in their was observed lying in bed no attached to a feeding was alert with their eyes. A television was located on the foot of Resident #426's evision documented annels, the television was ne privacy curtain was halfway between Resident ate. Seconducted on 1/11/2022 and 1/12/2022 at 8:30 evealed the findings as eximately 2:15 p.m., an end with Resident #426's responsible regarding the facility staff ests to turn the television for Resident #426. Insible party stated that he	F	Adi Dep me res the Dir pro	ucation was provided by the ministrator/Designee for the Activities partment staff on the provision of activities the resident needs. A random audit of idents will be completed weekly x 4 weelen monthly x 2 months by the Activities ector/Designee to ensure that the staff a poviding residents with the preferred activitients from the audit will be presented to DN/Designee and submitted to QAPI montriew and recommendation.	the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495272	B. WING				C
NAME OF PE	ROVIDER OR SUPPLIER	733212	D. Trine		REET ADDRESS, CITY, STATE, ZIP CODE	01/	/13/2022
		& HEALTH CARE CENTER		177	76 CAMBRIDGE DRIVE CHMOND, VA 23238		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	The comprehensive c dated 12/01/2020 doc #426] requires assistal leisure time r/t (related cognitive deficits. Dat Under "Interventions" "Assist resident with T 12/01/2020. I enjoy menjoy church and soci and sports. Date Initia care plan further docu staff for activities, cogniteraction r/t cognitive limitations. Date Initia "Interventions" it docu preferred cavities are and watching TV. Dat The "Activities-Quarte Review" dated 4/22/20 [Resident #426] watch broadcast, the recreat facetime calls for [Resweekly" On 1/12/2022 at 9:39 a conducted with OSM (activities. OSM #10 st Resident #426's unit. personalized activities their preferences and #10 stated that they re the resident's personal activities. On 1/12/2022 at 1:45 p conducted with CNA (af #8. CNA #8 stated that	care plan for Resident #426 cumented in part, "[Resident ance to structures [sic] his d to) his physical and ite Initiated: 12/01/2020." It documented in part, IV. Date Initiated: music R&B and oldies, I also itals. I enjoy watching TV fated: 12/01/2020" The fumented "I am dependent on gnitive stimulation, social fie deficits, physical fated: 12/14/2020." Under fumented in part, "My fusic, sensory stimulation, fite Initiated: 12/14/2020." forly/Annual Participation for 10/21 documented in part, " fines sports and ESPN fition team facilitates fident #426] and his family a.m., an interview was for the residents based on for OSM #10 stated that they for the residents based on for the residents and the for the residents for the residents and the for the residents for the residents and the for the residents for the resident #426 for the resi	F	679			

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
	495272	B. WING			C 01/13	3/2022
NAME OF PROVIDER OR SUPPLIER CANTERBURY REHABILITATION & HE	EALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	er or	01/13	512022
PREFIX (EACH DEFICIENCY MU	MENT OF DEFICIENCIES IST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORI X (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	St	(X5) COMPLETION DATE
Continued From page 78 CNA #8 stated that Reside care from staff for all activities on #8 stated that Resident #4 enjoyed listening to footbattelevision. On 1/12/2022 at 2:00 p.m conducted with LPN (licer LPN #6 stated that Reside participate in activities and bed most days. LPN #6 stated that watch sports on television LPN #6 stated that the telebroken since November on the sure if the family was broken or if maintenance #6 stated whoever discover broken should have report maintenance for repairs. On 1/12/2022 at approximate request was made to OSM director for any work order Resident #426's television. On 1/12/2022 at 2:49 p.m. conducted with OSM #10, stated that Resident #426 and non-responsive. OSM had scheduled weekly virtal Resident #426's responsite stated that Resident #426 football coach and enjoyed channels on the television they were not aware that Felevision was not working	dent #426 required total vities of daily living and utside of the room. CNA 426 liked sports and all and sports on the a., an interview was used practical nurse) #6. ent #426 did not destayed in their room in stated that Resident followed objects with his resident #426 used to use to use to use the room in stated that it was use aware of this. LPN rered the television was sted it to the family and the family bed ridden for the family bed ridden fo	F	679			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		405070	1				С
		495272	B. WING			01	/13/2022
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
CANTERE	URY REHABILITATION 8	& HEALTH CARE CENTER		1	1776 CAMBRIDGE DRIVE		
OMMITTERE	OKT KENADIENATION O	THEALTH OAKE CENTER		F	RICHMOND, VA 23238		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD B		COMPLETION DATE
TAG	REGULATORT OR L	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	AIE.	
			-				
F 679	Continued From page	79	F	679			
	16 (5)	activity for him, possibly a		Table 57			
		adio to listen to sports.					
		the activities department					
		and ipads available for					
		10 stated that if they had					
		sion was not working they					
	would have had maint	tenance check it.					
	On 1/12/2022 at appre	oximately 3:30 p.m., OSM					
	- 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	or of plant operations stated	i i				
		any work order requests for					
	Resident #426's televi						
	0 4/40/0000						
		oximately 5:00 p.m., ASM					
	(administrative staff madministrator stated the	보이면 사용하다 보다 10mg 전에 대한 보이다면 보이면 보이면 보이다.					
		26's television and that it					
		ad to have the channel					
	settings adjusted. AS						
	television was working	g at that time.					
	On 1/12/2022 at appro	oximately 5:00 p.m., a					
		ASM #1, the administrator					
		egarding providing activities					
	to residents.						
	The facility policy, "Ac						
	documented in part, "/						
		interests of and support the					
		osychosocial well-being of les are not necessarily					
		ties being provided only by					
		acility staff, volunteers,					
		family members may also					
		Individualized and group					
	• Date to the contract of the	that: reflect the schedules,					
	choices and rights of t	he residents"					
	On 1/12/2022 at appro	oximately 5:00 p.m., ASM					
	On It izizozz at appro	DAITHALEIY J.UU P.III., MOIVI					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	125 15	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495272	B. WING _		C 01/13/2022	
	ROVIDER OR SUPPLIER	& HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	01/13/2022	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 679	nursing were made av	e 80 and ASM #2, the director of ware of the above concern. was presented prior to exit.	F 6	79		
	getting to the brain. Tobtained from the web https://www.nlm.nih.go001435.htm 2. Congestive heart fathe heart can't pump ebody's needs. Heart fayour heart has stoppe working. It means that pump blood the way it	posite: pov/medlineplus/ency/article/ aillure: A condition in which enough blood to meet the aillure does not mean that d or is about to stop t your heart is not able to e should. It can affect one or t. This information was posite:	F 6	F684 SS=E Quality of Care	2/8/2022	
	applies to all treatmen facility residents. Base assessment of a resident that residents receive accordance with profe practice, the comprehe care plan, and the resi This REQUIREMENT by: Based on observation	damental principle that t and care provided to d on the comprehensive ent, the facility must ensure treatment and care in ssional standards of ensive person-centered		CFR(s): 483.25 Lidocaine patch was removed at time of Physician and family were notified of Lid 5% being applied instead of Lidocaine cretopically. Education was provided by the Nursing/Designee to LPN #3 on following orders and Comprehensive Care plan. Residents who reside at Canterbury Rehalthcare who receive medications have potential to be affected by this practice.	locaine patch eam 4% Director of g physician ab and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	10.500 PM (0.000 DC)		E CONSTRUCTION		SURVEY PLETED		
		495272	B. WING			1	C /13/2022		
NAME OF P	ROVIDER OR SUPPLIER	CONTRACTOR AND		9	TREET ADDRESS, CITY, STATE, ZIP CODE	1 017	13/2022		
	TOUR MEANS				776 CAMBRIDGE DRIVE				
CANTERE	SURY REHABILITATION 8	HEALTH CARE CENTER			RICHMOND, VA 23238				
=77/2/1/2012			,	15					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE _	(X5) COMPLETION DATE		
					Medication Administration Policy revie	wed no			
F 684	Continued From page	81	F	684	revisions necessary.				
	was determined that t	he facility staff failed to			Education provided by the Staff Develop	oment	I.		
		per physician's order and					taff		
		of care for one of 6 residents			Coordinator/Designee for the licensed r				
	in the Medication Adm	ninistration task, Resident			on the administration of medication pe				
	#14.				order and following of the Comprehens				
	FOLIANI JUNE DANIERO (PHT) SHIP THE STATE OF	W 1999 At 82 420 50 Str. Nr. 30			An audit will be completed by the Staff				
		nistered a Lidocaine patch			Coordinator/Designee weekly x 4 week		en		
		stead of Lidocaine cream			monthly x 2 months of residents who receive				
		topically four times a day for			medications to ensure medication are g	iven per			
		e physician, the incorrect and dose 5% vs 4% and			physician order and following of the Co	mpreher	nsive		
		shoulder of this medication.			Care Plan.				
	location kines vs neck	anodider of this medication.							
	The findings include:				Findings from the audit will be presented	d to the			
	J				DON/Designee and submitted to QAPI				
	Resident #14 was adn	nitted on 6/28/2 and had the			review and recommendation.	1			
	diagnoses of but not li	mited to dementia,		1	Tevicin directions				
	traumatic brain injury,					4			
	migraine, overactive b								
		gia. The most recent MDS							
	Age of the control of	as a quarterly assessment							
		nent Reference Date) of							
	10/12/21. The resider	npaired in ability to make							
		ne resident was coded as				1			
	requiring total care for								
		; limited assistance for				1			
		, dressing, and toileting;							
		; and was occasionally to							
	frequently incontinent	of bowel and bladder.							
	On 1/12/22 at 8:25 AV								
		bserved to preparing and							
	administering the follow	wing medications for							
	Resident #14:								
	(1) Tramadal E0 m= /=	ailliarama) 1 tah							
	 Tramadol 50 mg (n Oxybutynin 5 mg 1 								
	(3) Topiramate 50 mg								

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	TIPL	E CONSTRUCTION	(X3) DATE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	1000 - 200000000000000000000000000000000		E CONSTRUCTION		PLETED
			1.005,5156	Wildist II			С
		495272	B. WING		×		/13/2022
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
CANTERE	BURY REHABILITATION &	HEALTH CARE CENTER		1	1776 CAMBRIDGE DRIVE		
				F	RICHMOND, VA 23238		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREF	17	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	_	(X5) COMPLETION
TAG		SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA		DATE
					DEFICIENCY)		
E 604	0 "						
F 684	Continued From page		F	684			
	(4) Ezetimibe 10 mg						
	(5) Zoloft 50 mg 1 tat						
	(6) Omeprazole 20 m						
	(7) Lidocaine 5% pate	on applied to knee.					
	The pharmacy label o	n the box for the Lidocaine					
	patch was observed to	have another resident's					
	name on it. LPN #3 v	erbally gave Resident #14					
		it the patch, asking her if					
		on her knee or on her back				1	
	and the resident chos	e to have it put on her knee.					
	A review of the clinica	record revealed a nurse's					
		2:14 PM written by LPN #3					0
	that documented, "res						
	remove lidocaine pato	h on her knee."					
		1, during reconciliation of					
	the above medication)
		ian's orders, it was noted					
		er for a Lidocaine patch 5%					
		ck for Resident #14. The					
	review of Resident #14						
		28/21 for "Lidocaine Cream					
		oulder topically four times a s not what was observed					
	그 없어 가능하는 어느 아느 수 있는 아이었는데 있는데 그렇게 그러워 생겼다면 하다 그리다.	PN #3 administered the					
		s cream) and dose (5% vs					
		e vs neck/shoulder) of this				1	
	medication.	or to the diagnostic and					
	On 1/13/22 at 7:45 AM	Lan intonvious was					
		i, an interview was 4, the unit manager. He					
		s not on the schedule for					
	this date and that LPN		1				
		egular facility nurse. When					1
		t #14 was administered a					
		2/22, LPN #4 immediately					
	10.00	patch." When informed of					1

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING		SURVEY
		495272	B. WING			C /13/2022
No. Account to the last of the	ROVIDER OR SUPPLIER BURY REHABILITATION 8	HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	Œ	 10/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	and the state of t	N SHOULD BE E APPROPRIAT	(X5) COMPLETION DATE
	rights of medication are followed and that the eadministered as order comprehensive care pure "Administer analgesia followed, LPN #4 states." A review of the facility Medications document administered in accord orders, including any run The individual administered in according to the individual administered to another individual administered for a particular administered to another permitted by state law approved by the direct of 1/12/22 at approximation of day meeting, ASM #4 (Administrative Staff Mand Director of Nursing aware of the findings. provided by the end of References: (1) Tramadol is used to severe pain. Information obtained from thtps://medlineplus.gov.ml	the commentation was not seed. When asked if the colan documenting, as per orders" was seed it was not. policy "Administering need, "4. Medications are colance with prescriber required time frame10. Itering the medication set (3) times to verify the redication, right dosage, right (route) of administration cation25. Medications or resident may not be ser resident, unless and facility policy, and or of nursing services." mately 5:30 PM at the end set and ASM #2 sembers) the Administrator of the process of the survey. The relieve moderate to the process of the survey. The relieve moderate to the treat overactive bladder.	F	684		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A1 (000000000000000000000000000000000000	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED		
		495272	B. WING	*			C
12 (CONT.) (CONT.) (CONT.)	ROVIDER OR SUPPLIER BURY REHABILITATION 8	HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	DE	01.	/13/2022
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI) TAG		ON SHOULD BE IE APPROPRIA		(X5) COMPLETION DATE
F 688 SS=D	https://medlineplus.go tml (3) Topiramate is use Information obtained f https://medlineplus.go tml (4) Ezetimibe is used Information obtained f https://medlineplus.go tml (5) Zoloft is used to tr Information obtained f https://medlineplus.go tml (6) Omeprazole is use gastroesophageal refluinformation obtained finttps://medlineplus.go tml (7) Lidocaine 5% pato types of pain. Information obtained finttps://medlineplus.go tml (7) Lidocaine 5% pato types of pain. Information obtained finttps://medlineplus.go tml Increase/Prevent Decr CFR(s): 483.25(c)(1)-(§483.25(c) Mobility. §483.25(c)(1) The faciliresident who enters the	d to treat seizures. from by/druginfo/meds/a697012.h to treat high cholesterol. from by/druginfo/meds/a603015.h reat depression from by/druginfo/meds/a697048.h ed to treat by/druginfo/meds/a693050.h ch is used to treat certain from by/druginfo/meds/a603026.h rease in ROM/Mobility 3) lity must ensure that a be facility without limited	F 6	684			
	range of motion unless	not experience reduction in the resident's clinical s that a reduction in range					

	to FORTMEDIONINE &	WEDIONID OF WIOLD				CIMP IAC	J. 0930-039 I
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	25 (25/25/07/07/07		E CONSTRUCTION		SURVEY PLETED
							С
		495272	B. WING			I	/13/2022
NAME OF P	ROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE		
CANTER	RIIDV DEHARII ITATION S	HEALTH CARE CENTER		1	776 CAMBRIDGE DRIVE		
OANTENE	OUT REHABILITATION 6	A HEALIH CARE CENTER		F	RICHMOND, VA 23238		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	[1]	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		COMPLETION DATE
500,000			1		DEFICIENCY)	acceptors	
	865						
F 688	Continued From page		F	688			2/8/2022
	of motion is unavoidal	ble; and		F	688 SS=E Increase/Prevent Decrease		
				F	ROM/Mobility		
		ent with limited range of					
	motion receives appro			C	CFR(s): 483.25©(1)-(3)		
		ange of motion and/or to			• • • •		
	prevent further decrea	ase in range of motion.		C	On 1/12/2022 the resident was assessed t	for a new	,
	\$492 25/a)/2) A ranida	and with limited as a little.			plint and splint was obtained on 1/12/20		
		ent with limited mobility services, equipment, and		_	part data spart was obtained on 1/12/20	22.	
		or improve mobility with		R	esidents who resident at Canterbury Reh	ah and	
		ble independence unless a			lealthcare and utilize orthotic/splints hav		
		demonstrably unavoidable.					
		is not met as evidenced			otential to be affected by this practice. A	n audit	
	by:				as completed by the Director of		
		n, staff interview and facility			ehabilitation/Designee of current resider		
		is determined that the		0	rders for splits to ensure appropriate app	olication	of
	facility staff failed to pr	rovide treatment and		sp	olint.		
	services to maintain o	r improve mobility for one of					Ξ.,
		vey sample, Resident		E	ducation was completed by the Director	of	
	#131,				ehabilitation/Designee for the Licensed n		
	5				aff on the utilization of orthotic/splints for		
	Resident #131 was ob				rovision of treatment and services to mai		
		and 1/12/21 without the			nprove mobility. An audit will be comple		
	resident's left hand an	tral resting splint for the			irector of Rehabilitation/Designee weekly		
	resident's left fland an	d Wrist in place.			eeks and then monthly x 2 months on cu	A Libert At	
	The findings include:						
	The infamge molade.				esidents who utilize orthotics/splints, to e	nsure	
	The facility staff failed	to implement the splint for		aþ	ppropriate application of splint.		
	Resident #131.	The state of the s				00000	
					ndings from the audit will be presented to		
		mitted to the facility on			ON/Designee and submitted to QAPI mor	ithly for	
		s that included but were not		re	view and recommendation.	T.	
		arction [CVA] (hemorrhage					
		essels of the brain leading					
) hemiplegia (paralysis					
	affecting one side of th						
		ascular disease (plaque					
	consisting of lipids and	I cholesterol building up in				į.	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	AV. 100028113114404	TIPLE CONSTRUCTION		ATE SURVEY DMPLETED
		495272	B. WING			C 01/13/2022
	ROVIDER OR SUPPLIER BURY REHABILITATION 8	HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238		01/13/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		LD BE	(X5) COMPLETION DATE
	data set) assessment, with an assessment recoded the resident as BIMS (brief interview of indicating the resident MDS Section G- Fundamental for the section of the section	recent MDS (minimum, a quarterly assessment, eference date of 12/18/21, scoring 15 out of 15 on the for mental status) score, was cognitively intact. Itional Status, coded the extensive assistance in bed essing, toileting and ependent in eating and total graph of the service of the extensive assistance in bed essing, toileting and ependent in eating and total graph of the service of the extensive assistance in bed essing, toileting and ependent in eating and total graph of the service of the extensive assistance in bed essing, toileting and is a she was sitting on the service of the extensive o	F	688		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	653		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		495272	B. WING				С
NAME OF P	ROVIDER OR SUPPLIER	450212		_	STREET ADDRESS, CITY, STATE, ZIP CODE	01/	13/2022
CANTERE	BURY REHABILITATION 8	HEALTH CARE CENTER			1776 CAMBRIDGE DRIVE RICHMOND, VA 23238		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 688	Continued From page	87	F	688	3		
	A review of the physic	ian orders, dated 8/31/21, Neutral resting splint for left					
	PM, with OSM (other physical therapist. Wiresponsible to assist F	Resident #131 with placing ated, "He used to be in					v
	AM with CNA (certified When asked who was Resident #131 with pla stated, "He usually do mornings. So I do not	acing his splint, CNA #1					
	AM with OSM #1, the When asked about the OSM #1 stated, "I just will qualify for more the back on the caseload.	directed on 1/12/22 at 9:40 director of rehab services. e splint for Resident #131, re-evaluated him and he erapy, so I have put him I also looked at his splint er another type of splint for					
	On 1/12/222/1/21 at 5: administrator and ASM informed of the finding	1 #2, the director of nursing					
		or policy regarding splints 22 at 1:10 PM, ASM #1, the We do not have that					
	No further information	was provided prior to exit.					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		495272	B. WING				C /13/2022
A Section of Proceedings of the analysis of th	ROVIDER OR SUPPLIER SURY REHABILITATION &	L HEALTH CARE CENTER		17	TREET ADDRESS, CITY, STATE, ZIP CODE 776 CAMBRIDGE DRIVE ICHMOND, VA 23238	<u> </u>	10/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	2000	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 688	Non-Medical Reader, Chapman, page 111. (2) Barron's Dictionar Non-Medical Reader, Chapman, page 264. (3) Barron's Dictionary	y of Medical Terms for the 5th edition, Rothenberg and y of Medical Terms for the 5th edition, Rothenberg and y of Medical Terms for the 5th edition, Rothenberg and	F	688			
	S 483.25(i) Respirator tracheostomy care and tracheostomy care and The facility must ensured needs respiratory care care and tracheal such care, consistent with practice, the comprehe care plan, the resident and 483.65 of this sub This REQUIREMENT by: Based on observation document review it was facility staff failed to pronsistent with the corperson-centered plan residents in the survey Resident #73, Resider The facility staff failed Resident #15 at the flo	d tracheal suctioning. re that a resident who e, including tracheostomy clioning, is provided such professional standards of ensive person-centered ts' goals and preferences, part. is not met as evidenced a, staff interview and facility as determined that the covide respiratory services enprehensive of care for four of 62 a sample, Resident #15, and #117 and Resident #328. to administer oxygen to eaver a succession of the sample of		CFR Ress phy find Ressi new Ressi phys findi Obta	nined physician order for the usage of oxordered flow rate on resident #328. Undit was conducted by the DON/Designe	e rvey d with a he vey ygen e on	2/8/2022
		Resident # 73's nebulizer	(curre	ent residents with ordered oxygen therap racy of physician ordered flow rate.	y for	

CLIVILI	O TON WEDICARE &	VIEDICAID SERVICES				OMR MC	7. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	18		CONSTRUCTION	(X3) DATE COMP	SURVEY
		495272	B. WING _				C /13/2022
	ROVIDER OR SUPPLIER BURY REHABILITATION 8	HEALTH CARE CENTER		17	REET ADDRESS, CITY, STATE, ZIP CODE	0.1,	10,2022
				RI	ICHMOND, VA 23238		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 695	use, failed to administ per physician's orders	89 Inner when it was not in er oxygen to Resident #117 , and failed to obtain a ne administration of oxygen	r	An a Thei nebu	audit was conducted by the Respiratory rapist/Designee on current residents wit ulizer treatments to ensure proper stora ulizer mask and tubing.	ge of	
	8/5/20 with diagnoses limited to: chronic obs [COPD] (chronic non-asthma (recurrent epis breathing) (2) and ostic changes in the joints) Resident #15's most reset; assessment, a quassessment reference the resident as scoring (brief interview for mentite resident was cogn G- Functional Status, or requiring extensive astransfers, dressing, toi hygiene; supervision in bathing. A review of Resident #	ecoarthritis (degenerative (3). ecent MDS (minimum data arterly assessment, with an date of 10/12/21, coded of 15 out of 15 on the BIMS intal status) score, indicating litively intact. MDS Section coded the resident as sistance in bed mobility,	Pr no St Lic man record ne usa	duca porce diminysic age poce orev aff I cens ask wee espin d the quir der buli	edure for Administration of Nebulizer revisions necessary. Education provided by Development Coordinator/Designee for sed Nursing staff on proper storage of nearly and tubing when not in use. Ekly audit will be accomplished by the ratory Therapist/Designee weekly x 4 we nen monthly x 2 months on residents that is expensed and nebulizer treatments to errobtained, oxygen administered per order izer mask and tubing properly stored beto.	t taff on d by the oxygen viewed, v the ebulizer eeks at nsure er and tween	
	via the nasal cannula.' A review of the physici documented in part, "0	sleep apnea. minister oxygen as ordered an orders dated 12/3/21,	DC)/N	gs from the audit will be presented to th Designee and submitted to QAPI monthly and recommendation.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	N 1253 - 16		ECONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495272	B. WING	D. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1.		1	C /13/2022
10 PARTIES NEW PROPERTY 1 PARTIES NAMED 10 PART	ROVIDER OR SUPPLIER BURY REHABILITATION 8	HEALTH CARE CENTER		1	TREET ADDRESS, CITY, STATE, ZIP CODE 776 CAMBRIDGE DRIVE RICHMOND, VA 23238	01/	13/2022
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 695	maintain 02 saturation During initial resident 12:15 PM, observation the residents O2 (oxyger minute.) On 1/12/22 at 2:12 PM setting on the oxygen at 5.0 liters per minute. An interview was conc PM with LPN (licensed asked what flow rate F set at, LPN #2 stated, reading 5." LPN #2 st the middle of the ball a asked who checks the stated, "We are to che shift." On 1/12/22 at 5:00 PM member) #1, the admi director of nursing wer concerns. On 1/13/22 at 1:10 PM administrator stated, "' oxygen therapy and st The "NIDEK-NUVO" of manual, documents in adjustment know to the know may have alread medically prescribed p in the horizontal plan for	observation on 1/11/22 at a for of Resident #15 revealed gen) setting was at 5.0 liters If, Resident #15's oxygen concentrator was observed etc. Sucted on 1/12/22 at 2:20 depractical nurse) #2. When Resident #15's oxygen was ""The oxygen level is tated, "The line should be in and it is set on 5." When exoxygen setting, LPN #2 eck the oxygen setting every etc. If, ASM (administrative staff nistrator and ASM #2, the er made aware of the above etc. If, ASM #1, the expected was applied to the staff of the staff expected	F	695			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	10.7 **********	TIPLE CONSTRUCTION			SURVEY
		495272	B. WING				С
NAME OF P	ROVIDER OR SUPPLIER	490212	B. WING	STREET ADDRESS, CITY, STATE, ZI	IP CODE	01/	/13/2022
		& HEALTH CARE CENTER		1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	II CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ACTION SHOULD B O THE APPROPRIA		(X5) COMPLETION DATE
F 695	References: (1) Barron's Dictionary Non-Medical Reader, Chapman, page 120. (2) Barron's Dictionary Non-Medical Reader, Chapman, page 50. (3) Barron's Dictionary Non-Medical Reader, Chapman, page 420. 2. Resident # 73 was diagnosis that include respiratory failure [1]. MDS (minimum data is assessment with an A date) of 11/14/2021, cosoring a 0 [zero] on it status (BIMS) of a sco severely impaired of codecisions. On 01/11/2022 at approxi 01/12/2022 at approxi 01/12/2022 at approxi 01/12/2022 at approxi 01/12/2022 at approxi 05servations of Residenebulizer mask lying code table uncovered. The POS [physician's 73 documented in part 2.5 (3) MG/3ML [millig every 6 [six] hours as of breath] or wheezing Date: 10/25/2021. Sta The comprehensive ca dated 10/26/2021 documented in part code in the comprehensive ca dated 10/26/2021 documented in part code in the comprehensive ca dated 10/26/2021 documented in part code in the comprehensive ca dated 10/26/2021 documented in part code in the comprehensive ca dated 10/26/2021 documented in part code in the comprehensive ca dated 10/26/2021 documented in part code in the comprehensive ca dated 10/26/2021 documented in part code in the comprehensive ca dated 10/26/2021 documented in part code in the comprehensive ca dated 10/26/2021 documented in part code in the comprehensive ca dated 10/26/2021 documented in part code in the comprehensive ca dated 10/26/2021 documented in part code in the code in the code in part code in the code in	y of Medical Terms for the 5th edition, Rothenberg and y of Medical Terms for the 5th edition, Rothenberg and y of Medical Terms for the 5th edition, Rothenberg and admitted to the facility with d but was not limited to: Resident #73's most recent set), a significant change RD (assessment reference oded Resident # 73 as he brief interview for mental ore of 0 - 15, 0 [zero] - being ognition for making daily roximately 1:45 p.m., mately 9:45 a.m., and mately 12:45 p.m., ent # 73's room revealed a on Resident # 73's bedside order sheet] for Resident # t, "Albuterol Solution 0.5 - ram/milliliter] inhale orally needed for SOB [shortness via [by] nebulizer. Order	F	695			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL' A. BUILDI		CONSTRUCTION		SURVEY PLETED
		495272	B. WING				C /13/2022
200000000000000000000000000000000000000	ROVIDER OR SUPPLIER BURY REHABILITATION 8	HEALTH CARE CENTER		17	TREET ADDRESS, CITY, STATE, ZIP CODE 776 CAMBRIDGE DRIVE ICHMOND, VA 23238	1 01	113/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	к	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	documented in part, "/ medication/puffers as effectiveness and side 10/26/2021." On 01/12/2022 at app interview was conduct practical nurse] # 7 re follows for storing a ne not in use. LPN # 7 st in a plastic bag to kee germs." When LPN # Resident # 73's nebuli "I believe you." On 01/12/2022 at app [administrative staff medirector, ASM # 2, dire ASM # 3, regional vice ASM # 4, regional dire were made aware of th No further information References: [1] When not enough of lungs into your blood. obtained from the web https://www.nlm.nih.go ilure.html. 3. Resident #117 was a 12/6/21. Resident #11 were not limited to hea and acute kidney failur admission minimum da	Under "Interventions" it Administer ordered. Monitor for effects. Date Initiated: roximately 1:15 p.m. an ed with LPN [licensed garding the procedure staff ebulizer mask when it was tated, "It should be placed p it clean and free of 7 was asked to observe zer mask, LPN # 7 stated, roximately 4:10 p.m., ASM ember] # 1, executive ector of clinical services, e president of operations, ctor of clinical services, he above findings. was provided prior to exit. Doxygen passes from your This information was site: Doymedlineplus/respiratoryfa admitted to the facility on 7's diagnoses included but refailure, respiratory failure e. Resident #117's has set with an assessment D/21, coded the resident as	F	695			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		E CONSTRUCTION		E SURVEY PLETED
		495272	B. WING			C 01/13/2022	
	ROVIDER OR SUPPLIER	L HEALTH CARE CENTER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	01.	11312022
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	oxygen at two liters per nasal cannula. Resident #117's comp 12/15/21 documented status/Difficulty Breath ordered." On 1/11/22 at 1:29 p.r. Resident #117 was obnot receiving oxygen. On 1/12/22 at 2:43 p.r. conducted with RN (restated Resident #117's recently removed and sometimes. When asl order for continuous ostated, "They should homoly and the continuous of the director of nursing above concern. No further information 4. Resident #328 was 1/5/22. Resident #328 was 1/5/22. Resident #328 were not limited to dial	ing received oxygen. 117's clinical record s order dated 12/8/21 for er minute continuously via orehensive care plan dated , "I have altered respiratory ning. Provide oxygen as m. and 1/12/22 at 8:21 a.m., oserved lying in bed and was egistered nurse) #2. RN #2 s tracheostomy was the resident uses oxygen ked what a physician's	F	695	,		
	was not completed. A evaluation dated 1/5/2	mum data set assessment n admission nursing 2 documented Resident ented to person and place.					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	TIPLE CONSTRUCTION NG		E SURVEY PLETED
		495272	B. WING_			C /13/2022
	ROVIDER OR SUPPLIER BURY REHABILITATION 8	L HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	1 011	110/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION X (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 700 SS=D	observed lying in bed a half liters per minute a half liters per minute Review of Resident #3 physician's orders faile order for oxygen. Resplan dated 1/6/22 failer regarding oxygen. On 1/12/22 at 2:40 p.r. conducted with RN (restated there should be resident's oxygen use. #328 transferred from days prior and was transferred from days prior and was transfer member) #1 (the (the director of nursing above concern. No further information Bedrails CFR(s): 483.25(n)(1)-(\$483.25(n) Bed Rails. The facility must atternal alternatives prior to insia bed or side rail is use correct installation, use rails, including but not elements.	m. Resident #328 was receiving oxygen at two and e via nasal cannula. 328's January 2022 ed to reveal a physician sident #328's baseline care ed to reveal documentation m., an interview was egistered nurse) #2. RN #2 e a physician's order for a for a resident the facility COVID unit two consferred with oxygen. m., ASM (administrative administrator) and ASM #2 g) were made aware of the was presented prior to exit. 4) pt to use appropriate stalling a side or bed rail. If ed, the facility must ensure ed, and maintenance of bed limited to the following the resident for risk of	F 7	595	pected sion is	2/8/2022
		the resident for risk of ails prior to installation.	а	ppropriate for the resident's size and weigh	it.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	0.00	LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495272	B. WING			3/2022
	ROVIDER OR SUPPLIER BURY REHABILITATION 8	HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	1	TOTAL
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 700	bed rails with the residerepresentative and obto installation. §483.25(n)(3) Ensure are appropriate for the §483.25(n)(4) Follow to recommendations and and maintaining bed in This REQUIREMENT by: Based on observation interview and clinical indetermined that the fairn interview and clinical indetermined that the fairn plement bed rail recidents in the survey and #148. The facility staff implement and failed to obtain use of bed rails and the bed rails for Resident clinical need. The findings include: 1. Resident #326 was 1/4/22. Resident #326 was 1/4/22. Resident #326 was 1/4/24 were not limited to chrof breast cancer and a Resident #326's admissassessment was not conursing evaluation data	the risks and benefits of dent or resident tain informed consent prior that the bed's dimensions resident's size and weight. The manufacturers' specifications for installing ails. is not met as evidenced in, resident interview, staff ecord review, it was cility staff failed to quirements for two of 62 ye sample, Residents #326 mented bed rails for a documented clinical ain informed consent for the e facility staff implemented #148 without a documented but admitted to the facility on by diagnoses included but onic kidney disease, history in underactive thyroid. It is diagnosed in mented bed admitted to the facility on the sidney disease, history in underactive thyroid. It is diagnosed included but onic kidney disease, history in underactive thyroid. It is diagnosed included but onic kidney disease, history in underactive thyroid. It is diagnosed included but onic kidney disease, history in underactive thyroid.	Results and for point results the	sident #148 Side rails removed at the time rvey. The maintenance director reviewed inufacturer's recommendation and re-inspit the residents' bed to ensure that the bed mension are appropriate for the resident's light. Sidents residing in the facility with bed rail potential to be affected by this practice. Intenance director/designee will perform lit on all beds in the building to ensure the mensions are appropriate for the resident sight, and ensure facility is following the mufacturer's recommendation and specific installing and monitoring beds/bed rails. The ector of Nursing/designee will evaluate all dents with bed rails to ensure the dent/resident representative has been ad risks and benefits of bed rails and that infisent obtained, and physician order obtain	size and s have Facility 100% bed's size and cations The	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMR M	<i>).</i> 0938-0391	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495272	B. WING _				C / 13/2022	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
				17	776 CAMBRIDGE DRIVE			
CANTERE	BURY REHABILITATION 8	& HEALTH CARE CENTER		R	ICHMOND, VA 23238			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	×	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	_	COMPLETION DATE	
F 700	Continued From page	96		700				
1 700	0.00		F /	700				
	On 1/11/22 at 1:55 p.i	m., Resident #326 was		Care	e plans will be updated to reflect residen	its plan		
		with bilateral grab bar bed	1		are.			
	rails in the upright pos	suori.						
	A safety/assistive dev	rice evaluation dated 1/4/22		Red	Safety Policy reviewed no revisions nece	essarv.		
	and the second contract of the	3. Does the resident use the			Director of Education/designee will edu			
		to achieve independent bed	1		managers on base line care planning, up	and the second		
		s the resident use a side rail			plans and incorporating that the			
		of bed independently?	II.		dent/resident representative our obtaini	ing		
	No9. Does the resid	lent request that the side			rmed consent prior to the installation of			
	rails be raised? No. 1				and that risk/benefits have been review			
	request a grab bar for				ninistrator/Regional Director of Mainten			
		Safety/Assistive Device	TV		cate the maintenance director/staff on			
	Needs (a check besid	e) None."			ducting inspections on bed frames, bed			
	Davious of Davidant #	2201- 1 2002			ensions, mattresses, bed rails to ensure	safety		
	Review of Resident #3	ed to reveal an order for			eliminate risk of entrapment for residen			
		326's baseline care plan						
	dated 1/5/22 failed to	하는 100 kg (100 kg (10		The	Director of Nursing/designee will perfor	m		
		urther review of Resident	11111		kly audit x 4 weeks and then monthly x 2			
	#326's clinical record		910		new admissions to ensure base line care			
	documentation that in	formed consent for the use	110		been completed appropriately with sid	2000		
	of bed rails was obtain	ned.			ensuring informed consent was establish			
			81		ew in risk/benefits. The Maintenance			
	On 1/12/22 at 2:09 p.r		11		ctor/designee will perform house audits	everv		
	Electrical designation of the second	egistered nurse) #3. RN #3			oth for 4 months to ensure regulatory and			
		what should be done in	11		ufacturer compliance on all beds. Any pa			
		with bed rails on their bed.	11		ends will be reported to the Quality Assu			
		nt device evaluation should			Performance Committee at least quarter			
	be completed and the					•		
		hat determine if the bed restraint. RN #3 stated that		Find	ings from the audit will be presented to	the		
		ments bed rails are not	1		I/Designee and submitted to QAPI month			
		ent is not using the bed rails			ew and recommendation.	ily IUI		
		d rails should not be used.	'	evie	ew and recommendation.			
		n., Resident #326 was lying						
		ar bed rails were removed.						
	An interview was cond	lucted with Resident #326.						

	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:			LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495272	B. WING			1	C /13/2022	
	ROVIDER OR SUPPLIER SURY REHABILITATION 8	L HEALTH CARE CENTER	1	1	STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238		110/2022	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE	
F 700	her about the bed rails consent for the use of On 1/12/22 at 5:15 p.r staff member) #1 (the (the director of nursing above concern. On 1/13/22 at 1:10 p.r facility did not have a No further information 2. Resident #148 was 6/19/20. Resident #14 were not limited to dia disease and COVID-1 quarterly minimum datassessment reference the resident's cognition On 1/11/22 at 2:16 p.m observed lying in bed rails in the upright pos	o facility staff had talked to s and did not request the bed rails. m., ASM (administrative administrator) and ASM #2 g) were made aware of the m., ASM #1 stated the policy regarding bed rails. was presented prior to exit. admitted to the facility on 48's diagnoses included but betes, chronic kidney 9. Resident #148's ta set assessment with an date of 12/20/21, coded in as severely impaired. n., Resident #148 was with bilateral grab bar bed	F	700				
	9/22/20 failed to reveal bed rails. A safety/assistive devidocumented in part, "3 side rail or grab bars to mobility? No5. Does or grab bar to get out of No9. Does the reside rails be raised? No. 10 request a grab bar for	documentation regarding ce evaluation dated 11/3/21 d. Does the resident use the pachieve independent bed the resident use a side rail of bed independently? ent request that the side D. Does the resident						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					
			73.07 (A. 170.00 (A. 1			19	С
		495272	B. WING_			01/	13/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
CANTERE	BURY REHABILITATION 8	HEALTH CARE CENTER		1776 CAMBRIDGE DRIVE			
				RICHMOND, VA 23238			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF X (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	SHOULD BE	E	(X5) COMPLETION DATE
F 700	Continued From page	98	F 7	700			
	Needs (a check besid	e) None."					
	1/11/22 failed to revearails.	148's clinical record on al a physician's order for bed					
	was asked to describe regards to a resident v	egistered nurse) #3. RN #3 what should be done in with bed rails on their bed.					
	be completed and the numerous questions the rails are considered a if an assessment docu	nt device evaluation should evaluation contains hat determine if the bed restraint. RN #3 stated that uments bed rails are not ent is not using the bed rails					
	On 1/12/22 at 5:15 p.r staff member) #1 (the	d rails should not be used. n., ASM (administrative administrator) and ASM #2 g) were made aware of the					
	Sufficient Nursing Staf		F 7	25			2/8/2022
	the appropriate competer provide nursing and resident safety and attempracticable physical, mwell-being of each resident assessments and considering the nudiagnoses of the facility	sufficient nursing staff with etencies and skills sets to elated services to assure ain or maintain the highest nental, and psychosocial dent, as determined by and individual plans of care					

			-	II. s		CIVID INC	J, 0330-033 I
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION		SURVEY PLETED
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		495272	B. WING	-		01/	/13/2022
	ROVIDER OR SUPPLIER BURY REHABILITATION 8	& HEALTH CARE CENTER		1	TREET ADDRESS, CITY, STATE, ZIP CODE 776 CAMBRIDGE DRIVE RICHMOND, VA 23238		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 725	by sufficient numbers types of personnel on nursing care to all res resident care plans: (i) Except when waive this section, licensed (ii) Other nursing pers limited to nurse aides. §483.35(a)(2) Except paragraph (e) of this s designate a licensed r nurse on each tour of This REQUIREMENT by: Based on resident inticlinical record review, facility staff failed to primeet the needs for on survey sample, Resided Who is coded as dependent of bathing, with a show Wednesdays and Satu CNA (certified nursing) The findings include: Resident #162 was addiagnoses that include hemiplegia [1], muscle pressure Resident #162's most	cility must provide services of each of the following a 24-hour basis to provide idents in accordance with dunder paragraph (e) of nurses; and onnel, including but not when waived under section, the facility must nurse to serve as a charge duty. is not met as evidenced serview, staff interview and it was determined that the rovide sufficient staffing to be of 62 residents in the ent # 162. to provide Resident # 162 and and on one staff member wer two times a week, urdays, due to insufficient	F	I I I I I I I I I I I I I I I I I I I	F725 SS=E Sufficient Nursing Staffing CFR(s): 483.35(a)(1)(2) Resident # 162 was provided a shower af was post Covid status and moved from the Unit. Residents who reside in Canterbury Rehatlealth Care have the potential to be affer practice. Shower Schedules will be reviewensure scheduled per resident preference at Staffing Policy reviewed no revisions need through Friday for the next three months and it in the composition of the next three months and it is continued need. Weekly call ecruitment with the corporate recruitment will continue for the next three months and it is continued need. Daily Labor Meeting exiew staffing needs for the week in advance to the facility is able to meet the need sidents. Showers will be reviewed by the anager to ensure residents are showered efference weekly x 4 weeks and then Months to ensure ongoing compliance with occas. dings from the audit will be presented to N/Designee and submitted to QAPI montinew and recommendation.	b and cted by to ved to e. essary. Monday and son of team of team of team of the Unit per of this	his

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	55.000 (50.000 (50.000)		CONSTRUCTION		SURVEY PLETED
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	ROVIDER OR SUPPLIER BURY REHABILITATION 8	3 HEALTH CARE CENTER	•	17	TREET ADDRESS, CITY, STATE, ZIP CODE 776 CAMBRIDGE DRIVE ICHMOND, VA 23238	01.	113/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	N 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	(assessment reference coded Resident # 162 interview for mental st - 15, 15 - being cognit decisions. Resident # requiring extensive as members for activities totally dependent of o On 01/112022 at apprinterview was conduct When asked if staff as # 162 stated that they on Wednesdays and Stated, "I am suppose but I'm not getting the preference to take short Resident #162 stated done. She stated staff When asked how not scheduled made her for that she didn't feel clear that she didn't feel clear the comprehensive cadated 07/08/2021 doc have an ADL [activities Performance Deficit. Under "Interventions" "BATHING: total of one 07/08/2021." The facility's "Kardex" 01/22/2022 documented Hygiene. I require total hygiene care." Under "BATHING: total care."	the date) of 12/29/2021, as scoring a 15 on the brief tatus (BIMS) of a score of 0 tively intact for making daily at 162 was coded as a sistance of two staffs of daily living and being the staff member for bathing. Toximately 1:56 p.m., an atted with Resident # 162. Toximately 1:56 p.m., an atted with Resident # 162 are scheduled for showers are scheduled for showers attendays. Resident #162 do get them twice a week m." She stated it was her owers twice a week. That staff were not getting it at a did give her sponge baths. Toying showers as the last seel Resident # 162 stated an. The plan for Resident # 162 umented in part, "Focus. It is of daily living] Self Care Date Initiated: 07/08/2021." It documented in part, the Date Initiated: Toximately 11:01 a.m. an are plantely 11:01 a.m. an are	F	725			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPLE CONSTRUCTION	A CONTRACTOR OF THE PARTY OF TH	SURVEY PLETED
	495272	B. WING			C /13/2022
NAME OF PROVIDER OR SUPPLIER CANTERBURY REHABILITATION &	HEALTH CARE CENTER	-1	STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	1 011	113/2022
PREFIX (EACH DEFICIENCY	FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		BE	(X5) COMPLETION DATE
to describe the procedu LPN # 5 stated, "Resid day and we use a dry s When asked about Res schedule and receiving "[Resident # 162] was s every Wednesday and to 11:00 p.m. shift." Review of the facility st 09/15/2021 and the faci CNAs were scheduled on 09/22/2021 the facili CNAs were scheduled on 09/27/2021 the facili CNAs were scheduled and on 10/10/2021 the three CNAs onducte member] # 9, staffing or to describe the minimal requirements CNAs [ce in order to provide adec resident care OSM # 9 four CNAs on the 7:00 a four CNAs on the 3:00 three CNAs on the 11:0	ait manager. When asked the president showers tents get a bed bath every shampoo for their hair." Is sident # 162's shower to showers LPN # 5 stated, scheduled for showers Saturday on the 3:00 p.m. It affing schedule for sility census revealed three for Resident # 162's unit; ity census revealed three for Resident # 162's unit, ity census revealed two for Resident # 162's unit facility census revealed duled for Resident # 162's unit facility census revealed duled for Resident # 162's unit facility census revealed duled for Resident # 162's unit facility census revealed duled for Resident # 162's unit facility census revealed duled for Resident # 162's unit facility census revealed duled for Resident # 162's unit facility census revealed duled for Resident # 162's unit facility census revealed two for Resident # 162's unit f	F	725		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		NSTRUCTION		SURVEY PLETED
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		495272	B. WING			01	/13/2022
	ROVIDER OR SUPPLIER BURY REHABILITATION 8	& HEALTH CARE CENTER		1776	ET ADDRESS, CITY, STATE, ZIP CODE CAMBRIDGE DRIVE IMOND, VA 23238	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 725	[licensed practical nurreviewing Resident # September 2021 throid 5 was asked why Residents on the dates stated, "I can't answer On 01/13/2022 at apprinterview was conduct nursing assistant] # 3. the procedure for residented, "Residents get When asked why a reshower on their sched stated, "We can't alway we don't have enough On 01/13/2022 at apprinterview was conducted."	rse] # 5, unit manager. After 162's shower sheets dated ugh December 2021, LPN # ident # 162 did not receive listed above. LPN # 5 r why." roximately 11:22 a.m. an ted with CNA [certified . When asked to describe dent showers CNA # 3 ta bed bath every day." sident would not receive a luled shower day CNA # 3 ays give showers because	F	725			
	review of the bathing s dated September 202 ASM # 2 was inform the receive a shower or the above. When asked in to receive showers or ASM # 2 stated yes. A staff was a reason for receive showers or tube scheduled ASM # 2 stated (administrative staff me and ASM # 2, director aware of the findings.	o baths twice a week as ated no. roximately 2:15 p.m., ASM ember) #1, administrator					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	20 0		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495272	B. WING				C /13/2022
	ROVIDER OR SUPPLIER BURY REHABILITATION 8	HEALTH CARE CENTER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	01.	713/2022
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
F 725	Continued From page	103	F	725			
SS=D	Quadriplegia. Paralys function in part of your something goes wrong pass between your bracan be complete or paboth sides of your bod one area, or it can be information was obtain https://medlineplus.go/Label/Store Drugs and CFR(s): 483.45(g)(h)(f) §483.45(g) Labeling of Drugs and biologicals labeled in accordance professional principles appropriate accessory instructions, and the exapplicable. §483.45(h) Storage of §483.45(h)(1) In according the facility biologicals in locked contemperature controls, appersonnel to have acces §483.45(h)(2) The facility biologicals in locked contemperature controls, appersonnel to have acces §483.45(h)(2) The facility biologicals in locked contemperature controls, appersonnel to have acces §483.45(h)(2) The facility biologicals in locked contemperature controls, appersonnel to have acces §483.45(h)(2) The facility biologicals in locked contemperature controls, appersonnel to have acces §483.45(h)(2) The facility biologicals in locked contemperature controls, appersonnel to have acces §483.45(h)(2) The facility biologicals in locked, permanently af storage of controlled do the Comprehensive Dr Control Act of 1976 and abuse, except when the	need from the website: v/paralysis.html. I Biologicals 1)(2) I Drugs and Biologicals used in the facility must be with currently accepted , and include the and cautionary expiration date when Drugs and Biologicals dance with State and ty must store all drugs and compartments under proper and permit only authorized	I I I I R H P D m se w or	Med med locki med desid lealit ract eeve medid ecur	It SS=D Label/Storage Drugs and Biological (s): 483.45(g)(h)(1)(2) dications were returned to the cart and the dication cart was secured at time of the sum at the medication cart, and not leaving it in the medication cart while the care of line of sight. Idents who reside at Canterbury Rehab and the care have the potential to be affected by it. Idents who reside at Canterbury Rehab and the care have the potential to be affected by it. Idents who reside at Canterbury Rehab and the care have the potential to be affected by it. Idents who reside at Canterbury Rehab and the care have the potential to be affected by it. Idents who reside at Canterbury Rehab and the care have the potential to be affected by it.	e rvey. ations, rt was y this	2/8/2022

OLIVILI	CT ON MEDICANE &	WEDICAID SERVICES				OMB M). 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	8 6		CONSTRUCTION	(X3) DATE COMP	SURVEY
		495272	B. WING _				C /13/2022
NAME OF P	ROVIDER OR SUPPLIER			-	TREET ADDRESS, CITY, STATE, ZIP CODE	017	13/2022
520-740-750-750 N	TO THE ENGLISH OF THE ENGLISH						
CANTER	BURY REHABILITATION A	L HEALTH CARE CENTER	1	17	776 CAMBRIDGE DRIVE		
	r	- THE THE STATE OF		R	ICHMOND, VA 23238		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	E	(X5) COMPLETION
TAG		SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA		DATE
					DEFICIENCY)		
E 764							
F 761	Continued From page		F 7	61		1	
	be readily detected.	imal and a missing dose can		ا Adr	ministration of Medications policy review	•	
		is not met as evidenced		revi	isions necessary. Educations policy review	red no	
	by:	is not met as evidenced		Ctaf	isions necessary. Education was provided	l by the	
		n, staff interview, clinical		ola:	f Development Coordinator/Designee fo	r the	
		cility document review, it	1 .	ice.	nsed Nursing staff on securing medication	ons,	
		he facility staff failed to	1	ock	ing of the medication cart, not leaving		
		safe and secure manner	r	nec	dications unsecured on the top of the car	t while	
		g units, the Grove unit.	τ	ne	cart is not in line of sight, and the proper	storage	
			0	of d	rugs and biologicals.		
	The facility staff failed	to secure medications and		- 1			
	lock the medication ca	(1)		Δr	a audit will be conducted on each unit on	random	
		the cart while the cart was			ifts weekly x 4 weeks and then monthly :		
	out of the line of sight					. 2	
	medications to resider	nts on the Grove unit.			onths by the Staff Development		
	The findings include:				ordinator/Designee on securing medicat	ions,	
1	The findings include:				cking of the medication cart, not leaving		
	Resident #164 was an	lmitted on 6/27/14 and had			edications unsecured on the top of the ca		
	the diagnoses of but n				e cart is not in line of sight, and the prop	er storag	e
		ementia, diabetes, viral		of	drugs and biologicals		
		ressure and gastrostomy.					
	The most recent MDS	(Minimum Data Set) was			dings from the audit will be presented to		
		t with an ARD (Assessment			N/Designee and submitted to QAPI mon	thly for	
		/24/21. The resident was		rev	iew and recommendation.	//	
1		nitively impaired in ability to					
	make daily life decision					1	
1	coded as requiring ext					1	
		tal care for all other areas					
	bowel and bladder.	ng; and was incontinent of				1	
	bower and bladder.						
	Resident #23 was adm	nitted on 5/14/21 and had					
	the diagnosis of but no						
		nic obstructive pulmonary					
	disease, bilateral abov	A CONTRACTOR OF THE PROPERTY O					
		nd high blood pressure.					
		(Minimum Data Set) was a					
		with an ARD (Assessment					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495272	B. WING			1	C /13/2022
NATIONAL PROPERTY OF	ROVIDER OR SUPPLIER BURY REHABILITATION 8	HEALTH CARE CENTER		17	STREET ADDRESS, CITY, STATE, ZIP CODE 776 CAMBRIDGE DRIVE RICHMOND, VA 23238	<u> </u>	113/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	3183	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 761	Reference Date) of 10 coded as being severability to make daily lift was coded as requiring dressing; total care foof daily living; and was bladder. On 1/12/22 at 8:25 AM Practical Nurse) was of Medication Administrator Resident #164. LP administered the follow (1) Aspirin 81 mg (mil (2) Metoprolol 12.5 m (3) Senna syrup 176 m (3) Senna syrup 176 m (3) Senna syrup 176 m (4) Metoprolom (5) Metoprolom (7) Metoprolom (7) Metoprolom (8) Senna syrup 176 m (9) Metoprolom (9) Metoprolom (1) Metoprolom	al/21/21. The resident was elly cognitively impaired in fe decisions. The resident g extensive assistance for r all other areas of activities incontinent of bowel and for the feature of	F	761			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	P526 - 9124 (1961) - 913		E CONSTRUCTION		E SURVEY PLETED
		405272	B. WING				С
		495272	B. WING	_		01	/13/2022
NAME OF P	ROVIDER OR SUPPLIER			,	STREET ADDRESS, CITY, STATE, ZIP CODE		
CANTERE	RURY REHABILITATION A	& HEALTH CARE CENTER		1	1776 CAMBRIDGE DRIVE		
O/MITERE	OKT KENADILITATION C	TICALITI GARE GENTER		F	RICHMOND, VA 23238		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 761	Continued From page	106	F	761	ı		
	room. He was noted medication cart.	to glance at the top of the					
	On 1/12/22 at 8:57 AM medication cart. The	M, LPN #3 returned to the					
		of LPN #3's line of sight for					
	LPN #3 then proceede administer the followin #23:	ed to prepare and ng medications to Resident					
	(4) Norvasc 10 mg (m (1) Aspirin 81 mg 1 tal (5) Baclofen 5 mg 1 tal	b.					
	(6) Hydralazine 25 mg (7) Ondansetron 4 mg	1 tab.					
	(8) Pantoprazole 40 m	ng powder.					
	(9) Prednisone 2.5 mg					j	
	per 15 ml (milliliters), p	de 20 meq (milliequivalents)				ļ	
		nl, give 5 ml for 500 mg.				}	
	(11) Reppia 100 mg/m	ii, give 5 mi for 500 mg.					
	On 1/12/22 at 9:06 AM	/I, after pulling Resident					
	#23's medications, the	en putting away the					
	All the state of t	ent #164, at 9:13 AM, LPN					
		room for Resident #23 to					
		medications. Resident #23					
		v) bed. LPN #3 pulled the					
		d of Resident #23 to provide					
	privacy when administ						
		tube. LPN #3 had left the					
		ted and the pill cards or					
		The medication cards and Hydralazine, Prednisone,					
		n, and Baclofen were on top					
	of the medication cart						
		of line of sight of LPN #3					
		the curtain at the window					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495272	B. WING				С
NAME OF B	ROVIDER OR SUPPLIER	433272	B. WING	_		01	/13/2022
		A HEALTH CARE CENTER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	side) bed resident pasout of the room to get bed resident. A house hallway also passed bed resident out of the roomoved the medication cart was still unlocked bottles still on top, unsline of sight of LPN #3 On 1/12/22 at 9:27 AN cart. The medications out of the line of sight approximately 14 minus away except for the beemptied the trash can cart with the Aspirin st moved the cart to the emptied the trash can cart with the Aspirin st moved the cart to the nurse's station, which area where several rewheelchairs and at tab other end of the nurse in her personal bag. L cart which still had the on top. On 1/12/22 at 9:31 AN medication cart, pluggeon top of the cart, and	attending to the "A" (door seed by the cart going in and supplies to tend to the "A" ekeeper that was in the by the medication cart. If, the CNA took the "A" bed in in her wheelchair, and in cart out of the way. The with the pill cards and supervised and out of the ware unsupervised and of LPN #3 for attes. She put all of the pills of the cart, then locked the ill on top. LPN #3 then end of the hall to the was in an open community sidents were seated in oles. She then went to the station to put away items LPN #3 had her back to the bottle of unsecured aspirin I LPN #3 returned to the ed in the computer that was then put the aspirin away is left on top of the cart for a after the other	F	761			
		, an interview was 3. When asked how the be maintained when the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495272	B. WING			C 01/13/2022	
	NAME OF PROVIDER OR SUPPLIER CANTERBURY REHABILITATION & HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	E	1 01/	13/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	2000 U	SHOULD BE		(X5) COMPLETION DATE
F 761	that it should be locked computer screen. Whanything else, LPN #3 anything else." When medications unsupervithely should not be left. On 1/12/22 at 9:45 AM conducted with LPN # when it was in front of the Metoprolol on top. notice the medication his view was blocked that if he had, he would medication in the cart. cart not in line of sight medications should now while unsupervised. A review of the facility Medications" documer administration of medication nurse or aid doorway of the resider drawers facing inward No medications are ke cart must be clearly via administering medication must be inaccessible to passing by." On 1/12/22 at approximof day meeting, ASM # (Administrative Staff M and Director of Nursing anything medication of supering in the staff M and Director of Nursing anything and staff M and Director of Nursing anything anything anything screen.	the cart, LPN #3 stated d and minimize the den asked if there was stated, "I can't think of asked about leaving the rised, LPN #3 stated that ton top of the cart. If an interview was 4, who had been by the cart Resident #164's room with He stated that he did not on top of the cart because by the computer. He stated d have secured the LPN #4 stated that the of LPN #3 and that the of LPN #3 and that the of have been left on top policy, "Administering actions, the medication cart ked when out of sight of the de. It may be kept in the not's room, with open and all other sides closed. Bet on top of the cart. The sible to the personnel ions, and all outward sides o residents or others mately 5:30 PM at the end and ASM #2 lembers) the Administrator of the respectively, were made No further information was	F	761			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULT		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495272	B. WING_			C 01/13/2022	
	ROVIDER OR SUPPLIER BURY REHABILITATION 8	HEALTH CARE CENTER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	017	13/2022
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 761	Continued From page	109	F	761			
	References:						
	and prevent heart atta Information obtained f						
	(2) Metoprolol is used pressure. Information obtained finttps://medlineplus.go tml						
	(3) Senna is used to t Information obtained fi https://medlineplus.go	hard are a control of the control of					
	Information obtained for	treat high blood pressure. rom v/druginfo/meds/a692044.h					
	(5) Baclofen is a musc Information obtained fr https://medlineplus.gov tml						
	(6) Hydralazine is used pressure. Information obtained fr https://medlineplus.gov tml	10-707					
	vomiting. Information obtained fr	ed to prevent nausea and rom u/druginfo/meds/a606022.h					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER	100272	1	_	FREET ADDRESS, CITY, STATE, ZIP CODE	01	/13/2022
		L HEALTH CARE CENTER		17	776 CAMBRIDGE DRIVE ICHMOND, VA 23238		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 761	tml (9) Prednisone reduce inflammation caused I Information obtained f https://medlineplus.go ml (10) Potassium chloric levels which can affect Information obtained f https://medlineplus.go ml (11) Keppra is used to	sed to treat ux from ov/druginfo/meds/a601246.h es swelling and oy many conditions. from ov/druginfo/meds/a601102.ht de treats low potassium t how the heart works. from ov/druginfo/meds/a601102.ht prevent seizures.	F7	761			
F 804 SS=E	Information obtained f https://medlineplus.go tml Nutritive Value/Appear CFR(s): 483.60(d)(1)(3) §483.60(d) Food and c Each resident receives §483.60(d)(1) Food pr conserve nutritive value §483.60(d)(2) Food an attractive, and at a saftemperature.	rom v/druginfo/meds/a699059.h r, Palatable/Prefer Temp 2) drink s and the facility provides- epared by methods that he, flavor, and appearance; and drink that is palatable,	F 8	F P C C	F804 SS=E Nutritive Value/Appearance, Palatable/Preference Temperature FR(s): 483.60(d)(10(2) Fresident Food Council meeting was held 19/2022 to discuss resident concerns resood temperatures and quality of food being the second secon	garding	2/8/2022 ed.

OLIVILI	O TON MEDIONINE &	MEDICAID SERVICES				OIMP INC	0. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	70 000000000000000000000000000000000000		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER			-	TREET ADDRESS, CITY, STATE, ZIP CODE	1 01/	13/2022
THE OF T	NO VIDEN ON OUT FIELD						
CANTERE	SURY REHABILITATION &	HEALTH CARE CENTER		1	776 CAMBRIDGE DRIVE		
				R	RICHMOND, VA 23238		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
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IAG	NEGOLATORT ON L	SCIDENTIFTING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(IE	DAIL
					BETTOLINGTY		
F 804	Continued From page	. 111		004			
1 001			F	804			
		n, resident interview and	N.				
		determined that the facility	1	Re	sidents who reside at Canterbury Rehab	and	
	staff failed to provide			He	ealthcare and eat meals prepared in hous	anu	
		e lunch meal service on the	1	the	notential to be effect to the	e have	
	Tuckahoe unit.		1		potential to be affected by this process	. An audi	t
				wa	s completed by the Dietary Director/Dec	ianoo on	
	The facility staff failed	to provide food at a		all	units, for each meal service time to encu	iro	
	palatable temperature	during lunch service on		pal	atable temperatures were being maintai	nod	
		sampled on the Tuckahoe				ileu.	Í
		as not warm or palatable.		B	Resident Hot plate and		
		•		n	Resident Hot plate system will be utilized	for	
	The findings include:				naintaining temperature of food at a pala	table	
					emperature. Education was provided but	-l	
	During the dates of the	e survey, group gatherings		Α	dministrator/Designee for dietary staff o		
	were limited due to an			te	emperatures of meal service, Nutritive	n paiatai	ble
		erview was not conducted,		V	alue/Appearance Del		
	however private interv			To	alue/Appearance, Palatable/Preference		
	The state of the s	t council meeting minutes		10	emperature.		
		021 and 12/16/2021 was		2			P)
	conducted. The minut			Ar	audit will be completed by the Director	of Diota	-
				se	rvices weekly x 4 weeks and then month	or pietai	У
	documented complain			mo	onths to monitoring palatable temperatu	y x 2	
		d being cold when served		me	Pals on all three and table temperatu	res of	
	at the facility.			Car	eals on all three meals on all three units a	it	
	Decident #405			Cai	nterbury Rehab and Healthcare.		
		mitted to the facility with					
		d diabetes (2) and liver		Fin	dings from the audit will be presented to	the	
	disease. Resident #10			DO	N/Designee and submitted to QAPI mont	ine.	
		quarterly assessment with		revi	iew and recommendation.	hly for	
i	an ARD (assessment r			1	and recommendation.		
	12/9/2021, coded Resi						
		1/11/2022 at 12:51 p.m.,					
		erviewed. When asked					
	about the quality of the		1				
	stated: "It's terrible. So	me days, I wouldn't even					
	give it to my dog."					1	
	Day Democrate	AND COMPANY OF THE PARTY OF THE		-			
		nitted to the facility with					ı
		d but were not limited to					- 1
	major depressive disor	der (3) and chronic	1				- 1

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		405070	D MINIO				С
		495272	B. WING			01	/13/2022
	ROVIDER OR SUPPLIER BURY REHABILITATION 8	& HEALTH CARE CENTER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	#15's most recent MD quarterly assessment reference date) of 10/#15 as being cognitive approximately 2:15 p. conducted with Reside complained about the the food being served Resident #13 was adr diagnoses that include chronic obstructive pudiabetes. Resident #1 quarterly assessment coded Resident #13 a On 1/12/2022 at approinterview was conduct Resident #13 complain and quality of the food On 1/12/2022 at 12:20 plated and sent to the 1/12/2022 at 12:40 p.r was served on the Tuctemperatures of the foobtained by OSM (othersistant dietary manawere: Chicken and dumpling	disease (4). Resident (S) (minimum data set), a with an ARD (assessment (12/2021, coded Resident (ely intact. On 1/11/2022 at m., an interview was ent #15. Resident #15 temperature and quality of . mitted to the facility with (a) but were not limited to Imonary disease and (3's most recent MDS, a with an ARD of 10/10/2021, (a) being cognitively intact. (b) being cognitively intact. (c) coximately 10:45 a.m., an (c) ed with Resident #13. (c) p.m., a test tray was (c) p.m., a test tray was (c) Tuckahoe unit. On (c) (m), (when the final meal (c) c) change of the product (c) and degrees (c) and dumplings- 108 degrees (c) and dumplings- 112 (c) degrees Fahrenheit (c) any was sampled by a	F	804			
	dumplings were not wa						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	99	TIPLE CONSTRUCTION		E SURVEY IPLETED
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, it can be a state of the stat	ROVIDER OR SUPPLIER BURY REHABILITATION 8	& HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	E 120	BE	(X5) COMPLETION DATE
F 804	stated these food itembe palatable. On 1/12/2022 at 2:35 conducted with OSM imanager, OSM #11, ti OSM #13, the district that to provide warm put they checked temperastarting the tray line, a chargers to hold the testated that they had durays on the carts and times to help staff in pOSM #11 stated that the complaints from reside the past and had reso complaints. OSM #13 tray audits twice a westemperature of the foodegrees Fahrenheit with #13 stated that any test degrees Fahrenheit with investigate why it was On 1/12/2022 at approximately policy on serving palated on 1/13/2022 at 1:10 put facility did not have on 1/12/2022 at approximately with the facility did not have on 1/12/2022 at approximately with the administrator and the administr	p.m., an interview was #12, the assistant dietary he dietary manager and manager. OSM #11 stated palatable food to residents atures of all foods prior to and used plate warmers and emperature. OSM #13 ecreased the amount of staggered the delivery assing them out efficiently, hey had received ents regarding the food in lived some of the stated that they performed ek and the goal was for the dot to be at least 135 hen it was served. OSM mperature below 135 ould trigger them to low.	F	804		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
_		495272	B. WING			1	C /13/2022	
	ROVIDER OR SUPPLIER BURY REHABILITATION 8	& HEALTH CARE CENTER	·	STREET ADDRESS, CITY, STATE, ZIF 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	CODE			
(X4) ID PREFIX TAG				PROVIDER'S PLAN C X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIE!	CTION SHOULD B		(X5) COMPLETION DATE	
F 804	References: 1. COVID-19 COVID-19 is caused I SARS-CoV-2. Corona viruses that are communities and bats. coronaviruses can infective en people. This and SARS-CoV, and incauses COVID-19. The betacoronavirus, like I SARS-CoV. All three corigins in bats. The seare similar to the one suggesting a likely sin this virus from an animexact source of this virus information was obtain https://www.cdc.gov/cml#How-COVID-19-Sp. 2. Diabetes mellitus A chronic disease in we regulate the amount of information was obtain that the context is a context in the conte	by a coronavirus called aviruses are a large family of non in people and may nimals, including camels, Rarely, animal ect people and then spread occurred with MERS-CoV now with the virus that he SARS-CoV-2 virus is a MERS-CoV and of these viruses have their equences from U.S. patients that China initially posted, gle, recent emergence of nal reservoir. However, the rus is unknown. This ned from the website: oronavirus/2019-ncov/faq.ht oreads	F 8					
	when feelings of sadne frustration get in the w period of time. It also o works. This informatio website:	mood disorder. It occurs						

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN		(X3) DATE SURVEY COMPLETED		
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		495272	B. WING_			01	/13/2022
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
CANTERE	BURY REHABILITATION 8	HEALTH CARE CENTER			776 CAMBRIDGE DRIVE		
				R	ICHMOND, VA 23238		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 804	Continued From page	115	F8	304			
SS=D	lead to shortness of bobtained from the web https://www.nlm.nih.go Food Procurement, Ste CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety. The facility must - §483.60(i)(1) - Procure approved or considere state or local authoritie (i) This may include for from local producers, and local laws or regu (ii) This provision does facilities from using progardens, subject to cosafe growing and food (iii) This provision does from consuming foods §483.60(i)(2) - Store, paserve food in accordant standards for food sent This REQUIREMENT by: Based on observation document review it was	difficult to breath that can reath. This information was osite: by/medlineplus/copd.html. bre/Prepare/Serve-Sanitary y requirements. e food from sources of satisfactory by federal, es. od items obtained directly subject to applicable State lations. Is not prohibit or prevent oduce grown in facility mpliance with applicable -handling practices. Is not preclude residents not procured by the facility. brepare, distribute and face with professional vice safety. is not met as evidenced y staff interview, and facility as determined facility staff en equipment in a sanitary ance with professional	CF Th in foo Re Ca be Ed cle sa sta alt Di th de	12 Sore/ IR(s) Rede accord od sore side accord on the acc	SS=D Food Procurement, //Prepare/Serve-Sanitary 2: 483.60(i)(1) (2) eli slicer was cleaned in a sanitary manne ordance with the professional standards service safety on 1/12/2022. ents who eat meals prepared by the kitch rbury Rehab and Healthcare have potent ected by this practice. etion was provided to kitchen staff on the ing of the deli slicer to ensure it is cleaned by manner in accordance with the professional for food service safety. A random aution shifts will be accomplished by the cor of Dietary/ Designee weekly x 4 weeks monthly x 2 months on proper cleaning or icer in a sanitary manner in accordance we refessional standards for food service safety. The sanitary manner in accordance were formally standards for food service safety.	r and for en at ial to d in a sional dit s and f the with ety.	2/8/2022
	The findings include:		re	viev	w and recommendation.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1000	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		495272	B. WING			C	
NAME OF P	ROVIDER OR SUPPLIER	433212] B. WING _	STREET ADDRESS, CITY, STATE, ZIP CODE	L	01/13/2022	
		3 HEALTH CARE CENTER		1776 CAMBRIDGE DRIVE RICHMOND, VA 23238			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG		LD BE	(X5) COMPLETION DATE	
F 812	Continued From page	116	F 8	812			
	The facility failed to fu was available for use	illy clean the deli slicer that in the facility kitchen.					
	observation of the fac with OSM (other staff manager. Observation deli slicer located on a kitchen. The deli slicer covered with a clear p about the deli slicer, C used the day before a available for use. Uposlicer, visible food debt the surface of the deli was observed on the COSM #11 observed the and stated that it was would have to be take OSM #11 stated that t slicer apart after each surface and the blade	on inspection of the delication of the delicatio					
	member) #1, the admi policy on maintaining to The facility policy, "Sa part, "All equipment, utensils shall be wash- loosen soils by using to means necessary and and/or chemical sanitize	ASM (administrative staff inistrator for the facility the deli slicer. nitation" documented in food contact surfaces and ed to remove or completely he manual or mechanical sanitized using hot water zing solutions" The policy					
	further documented, ". utensils that do not fit i	For fixed equipment or in the dishwashing					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495272	B. WING _		C 01/13/2022		
	ROVIDER OR SUPPLIER BURY REHABILITATION 8	HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		(X5) COMPLETION DATE	
F 812	steps: a. Equipment we necessary to allow accessary to allow acceptant will be so particle accumulation manual or dishwashin. According to the FDA administration) Food (in part, "4-601.11 Equipment, Nonfood-Contact Surf (A) Equipment for utensils shall be clean (B) The food-conequipment and pans sencrusted grease depraccumulations. (C) Nonfood-conshall be kept free of an food residue, and other This information was considered.	all consist of the following will be disassembled as cess of the all parts; b. Removable craped to remove food and washed according to g procedures" (food and drug Code 2017, it documented Food-Contact Surfaces, aces, and Utensils. od-contact surfaces and to sight and touch. Pf tact surfaces of cooking shall be kept free of cosits and other soil	F8	12			
	(administrative staff m	1 #2, the director of nursing					
F 880 SS=D	No further information Infection Prevention & CFR(s): 483.80(a)(1)(2	The state of the s	F 88	F880 SS=D Infection Prevention & Contro	1	2/8/2022	
	§483.80 Infection Con The facility must estab infection prevention ar	lish and maintain an		CFR(s): 483.80(a)(1)(2)(4)€(f)		-	

PRINTED: 01/23/2022 FORM APPROVED

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	100 100		E CONSTRUCTION	(X3) DATE	SURVEY PLETED
	l	495272	B. WING				C /13/2022
	PROVIDER OR SUPPLIER BURY REHABILITATION 8	& HEALTH CARE CENTER		s 1	STREET ADDRESS, CITY, STATE, ZIP CODE 776 CAMBRIDGE DRIVE RICHMOND, VA 23238	°U 17	13/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	designed to provide a comfortable environm development and tran diseases and infection \$483.80(a) Infection program. The facility must estable and control program (I a minimum, the following services und arrangement based up conducted according the accepted national stan \$483.80(a)(2) Written providing services und arrangement based up conducted according the accepted national stan \$483.80(a)(2) Written procedures for the probut are not limited to: (i) A system of surveillating possible communicable disease reported; (ii) When and to whom communicable disease reported; (iii) Standard and transit to be followed to prevered; (iv) When and how isolated including but (A) The type and durated depending upon the intinvolved, and	a safe, sanitary and tent and to help prevent the ismission of communicable ins. brevention and control blish an infection prevention IPCP) that must include, at ving elements: In for preventing, identifying, g, and controlling infections seases for all residents, ors, and other individuals der a contractual pon the facility assessment to §483.70(e) and following indards; standards, policies, and ogram, which must include, ance designed to identify le diseases or can spread to other in possible incidents of e or infections should be is mission-based precautions ent spread of infections; ation should be used for a not limited to:	F	FF VV CC pp W pp M rec Ccc thh	LPN #3 was provided with education on Prevention & Control the use of gloves a administration of medication following is prevention guidelines. Resident # 23 physician was notified on improper administration of medication as of survey and no new orders were receivatime. Residents who reside at Canterbury Rehathealthcare and receive medication have to be affected by this practice. A was completed by the Staff Development Coordinator/Designee during various medications of the staff of medications of medications. Medication Administration Policy reviewed evisions necessary. ducation was completed by the Staff Development of medication policy and in the Medication Administration policy and in the medication of medications.	the at the tin yed at the he hand ithe he hand ithe hication of were not hot	er ne at not

OLIVILI	OT ON WEDICANE &	WEDICAID SERVICES				OWR NO	D. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1000 PK		CONSTRUCTION	COM	SURVEY PLETED
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NAME OF P	ROVIDER OR SUPPLIER		_'	STF	REET ADDRESS, CITY, STATE, ZIP CODE	1 017	113/2022
9					6 CAMBRIDGE DRIVE		
CANTERE	BURY REHABILITATION 8	LA HEALTH CARE CENTER			CHMOND, VA 23238		
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 880	Continued From page	119	F 88	80			
	least restrictive possib	ole for the resident under the					
	circumstances.				ekly audit x 4 weeks and then monthly	x 2	1
		s under which the facility	1	mon	ths will be accomplished by the Staff		
	must prohibit employe	es with a communicable	[Deve	elopment Coordinator/Designee on the	proper	
	disease or infected sk		i	nfec	tion control practices for the administr	ation of	
	contact with residents		r	medi	ication. These audits will be accomplish	ned at	
	contact will transmit th		١ ،	varyi	ng medication times and shifts to ensur	re	
	by staff involved in dir	procedures to be followed			ing compliance with this process.		
	by stall involved in ull	ect resident contact.		- 17			
	§483.80(a)(4) A system	m for recording incidents	F	indi	ngs from the audit will be presented to	the	
	identified under the fa-				Designee and submitted to QAPI mont		
	corrective actions take	en by the facility.	N. C.		w and recommendation.		
				1			
	§483.80(e) Linens.						
	Personnel must handle						
	transport linens so as infection.	to prevent the spread of					
	\$492 90/6\ A====	ž					
	§483.80(f) Annual revi	ew. It an annual review of its					
	IPCP and undate their	program, as necessary.					
	This REQUIREMENT	is not met as evidenced				İ	
	by:	atoff interview alleles					
		, staff interview, clinical					
		lity document review, it was cility staff failed to follow					
		ces for the administration of					
	medication for one of 6						
		ion task; Resident #23.					
	The findings include:						
		itted on 5/14/21 and had					
	the diagnosis of but no						
		nic obstructive pulmonary					
	disease, bilateral above						
	depression, aphasia, a The most recent MDS	nd high blood pressure. (Minimum Data Set) was a					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495272	B. WING				C /13/2022
	ROVIDER OR SUPPLIER BURY REHABILITATION 8	HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP (1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	CODE	1 01/	13/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	TO THE PROPERTY OF THE PROPERT	TION SHOULD BI THE APPROPRIA		(X5) COMPLETION DATE
	Reference Date) of 10 coded as being severability to make daily lift on 1/12/22 at 8:59 AM Practical Nurse) was of Medication Administrations She was observed sail putting clean gloves of touch the medication cart, the computer that with the medication cart, the cart after she unlocked packages and bottles listed below, that she is medication below with (1) Norvasc 10 mg (mid (2) Aspirin 81 mg 1 tate (3) Baclofen 5 mg 1 tate (3) Baclofen 5 mg 1 tate (4) Hydralazine 25 mg (5) Ondansetron 4 mg (6) Pantoprazole 40 mm (7) Prednisone 2.5 mg (8) Potassium chloride per 15 ml (milliliters), pg (9) Keppra 100 mg/ml, LPN #3 was observed that were in pill form (#gloved hand and then individual cups. On 1/12/22 at 9:34 AM #3, when asked about (gloved) hand from the stated that she had glo	with an ARD (Assessment b/21/21. The resident was ely cognitively impaired in fe decisions. M, LPN #3 (Licensed observed during the observed during the observed during the observed during the observed during the observed during her hands and on. Then she proceeded to cart on the top and sides of observed during the medication of observed during the medication of observed during the medication of observed during the medication of observed during the medication of observed during the medication of observed during the medications observed during the medications observed during the medications observed during the medications of the during the medications of the medications of the medications of observed during the medications of	F	880			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	The second second		E CONSTRUCTION		SURVEY PLETED
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The second of th	ROVIDER OR SUPPLIER BURY REHABILITATION 8	HEALTH CARE CENTER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	01	/13/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	more y	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	Medications" documer established facility inferences (e.g., handwashing, and isolation precautions, of medications, as approposed for a programment of medications, as approposed for a programment of medications, as approposed for medications, as approposed for medication, as approposed for medication, the nurwhen handling and given "Skill 1: Administering Prepare the required in containers: When rempour the necessary nuruly and then place the tab medication cup Docapsules with hands. For tablets into your hart Transport medications carefully 14. Perform PPE [personal protecti Rationale: Hand hygien spread of microorganis on transmission based Administer the medication Administer	PN #3 stated that she ach resident. policy, "Administering need, "24. Staff follows ection control procedures ntiseptic technique, gloves, etc.) for the administration plicable." Ind Perry's, Fundamentals of age 847, "For safe rese uses aseptic technique ring medications." Oral Medications: 6. medications: b. Multidose oving tablets or capsules mber into the bottle cap lets or capsules in a not touch tablets or Rationale: Pouring capsules and is unsanitary. 12. to patient bedside a hand hygiene and put on the equipment] if indicated. The end PPE prevent the research precautions. 20. The end of the end precautions. 20. The end of the en	F	0888			

		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULI IDENTIFICATION NUMBER: A. BUILDI			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495272	B. WING				C /13/2022
	PROVIDER OR SUPPLIER BURY REHABILITATION 8	HEALTH CARE CENTER		177	REET ADDRESS, CITY, STATE, ZIP CODE 76 CAMBRIDGE DRIVE CHMOND, VA 23238		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	2322	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 880	Settings recommendal Infection Control Prace (HICPAC) include the recommendations for settings. Healthcare per alcohol-based hand ruwater for the following Immediately before to Before performing an "Gloves are not a substitution of the setting o	tions of the Healthcare tices Advisory Committee following strong hand hygiene in healthcare ersonnel should use an ab or wash with soap and clinical indications: uching a patient aseptic task" stitute for hand hygiene." obtained from the website: andhygiene/providers/guide mately 5:30 PM at the end #1 and ASM #2 Itembers) the Administrator g, respectively, were made No further information was if the survey. treat high blood pressure. from //druginfo/meds/a692044.h elieve some types of pain cks and strokes. om //druginfo/meds/a682878.h te relaxant.	F	880			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/C

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		ECONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CANTERE	BURY REHABILITATION 8	HEALTH CARE CENTER		1	776 CAMBRIDGE DRIVE		
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	110		1				
F 880	Continued From page	123	F8	200			
		· · · · · · ·	'	000			
	(4) Hydralazine is use	d to treat high blood					
	pressure.	<u> </u>					
	Information obtained f						
	https://medlineplus.go	v/druginfo/meds/a682246.h					
	tml						
	(F) O-11						
	vomiting.	ed to prevent nausea and					
	Information obtained f	rom					
		v/druginfo/meds/a606022.h					
	tml	v/dragiiiio/iiiods/a500022.ii					
	(6) Pantoprazole is us	ed to treat					i i
	gastroesophageal refli						
	Information obtained f						
		v/druginfo/meds/a601246.h					
	tml						
	(7) Prednisone reduce	bre pulling and		- 1			
	inflammation caused b						
	Information obtained fi						
	https://medlineplus.go	v/druginfo/meds/a601102.ht					
	ml						
	1000						
	(8) Potassium chloride			- 1		1	
	levels which can affect	The state of the s					
	Information obtained fr	2.600(15)(20)					
	ml	//druginfo/meds/a601102.ht					
	110						
	(9) Keppra is used to p	revent seizures.					
	Information obtained fr						
		//druginfo/meds/a699059.h					
	tml						
THE PERSON NAMED IN	Resident Bed		F 90	9	F909 SS=F Resident Bed		2/8/2-
SS=F	CFR(s): 483.90(d)(3)				1909 33-F Resident Dea	Î	2/8/2022
					CFR(s): 483.90(d)(3)		
					5(5): 405:50(d)(5)		

				_		CIVIDIA	0.0000-0001
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	**************************************	E SURVEY PLETED
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	BURY REHABILITATION 8	L HEALTH CARE CENTER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238		
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	bed frames, mattresse part of a regular maining areas of possible entrand mattresses are us separately from the bed ensure that the bed raframe are compatible. This REQUIREMENT by: Based on observation interview, facility docurecord review, it was ostaff failed to perform the manufacturers" instresidents in the survey #138, #326, #148, #14 and #168. The facility staff failed inspections per the mafor 2021 for Residents #146, #131, #22, #13, failure to conduct reguing possible entrapment has routine maintenance praffect all 177 residents. The findings include: 1. Resident #105 was a 8/31/20, and most received in the most reset, a quarterly assess (assessment reference coded as having no cogmaking daily decisions,	et Regular inspection of all es, and bed rails, if any, as tenance program to identify apment. When bed rails sed and purchased ed frame, the facility must ils, mattress, and bed is not met as evidenced is not met as evidenced is resident interview, staff ment review, and clinical letermined that the facility regular bed inspections per structions for 10 of 62 asample, Residents #105, 6, #131, #22, #13, #15, to perform regular bed insufficients instructions #105, #138, #326, #148, #15, and #168 beds. The far inspections to identify azards as part of the rogram had the potential to using beds in the facility. admitted to the facility on ently readmitted on 7/13/21, and diabetes and liver excent MDS (minimum data sment with an ARD date) of 12/9/21, he was	T he could be seen to	on r 413, fundaddientr Facil 1009 ensuman ped residentra finda ime inda ime inda ime inda ime inda ime inda ime inda ime inda inda inda inda inda inda inda inda	Maintenance Director performed bed in resident #105, #138,#326, #148, #146, #1, #15, and #168 beds. Any items related to ction and manufactures instructions was ressed and no concerns noted regarding rapment hazards as part of the inspection lity maintenance director/designee will performed beds our functioning and maintained furfacturer's instructions, as well as inspectionate frames, mattresses and bed rails to ensure suffers our free from any areas of possible apment. Administrator/Regional Director of Main reducate the maintenance director/staff of fucting inspections on bed frames, bed rensions, mattresses, bed rails to ensure seliminate risk of entrapment. Maintenance Director/designee will performe audits every month for 4 months to entatory and manufacturer compliance on a patterns or trends will be reported to the latory and manufacturer compliance compliance on the latory and manufacturer compliance on a patterns or trends will be reported to the latory and manufacturer compliance committed quarterly. Ings from the audit will be presented to the latory and recommendation.	to bed possible n. perform ding to per ction of ure tenance on afety orm sure all beds. eee at	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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NAME OF PROVIDER OR SUPPLIER CANTERBURY REHABILITATION & HEALTH CARE CENTER			1	STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238		13/2022		
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	a.m., Resident #105 w bed. Bilateral side rails #105 stated he regular turning and positioning. A review of Resident # plan dated 9/14/20 rev to use bed assist rails extremities) during AD to assist w/ (with) rolling. On 1/12/22 at 12:40 p. member) #5, the regio operations, and OSM awere interviewed. Whe information regarding inspection of beds utilis. OSM #5 stated that no He stated the majority bed rails. He stated his staff does an initial insprails are initially applied does not retain evidence inspection. He stated of certain a load to grounderformed once a year employs an outside verbed inspections. He staff and mattresses test was not performed during 2021. He did no lack of inspections. Wh	uiring the extensive bed mobility. .m. and 1/12/22 at 9:32 //as observed sitting up in sewere engaged. Resident rely uses the side rails for 3. 2105's comprehensive care realed, in part: "Instruct pt. and pull with UEs (upper Ls (activities of daily living) and." m., OSM (other staff and director of plant regular maintenance director, an asked to provide regular maintenance zing any type of side rails, at all facility beds have rails. For residents do not utilize restorically, the maintenance poetion of the bed when defined. However, he stated he coe of these initial ordinarily the facility makes ditest on each bed is a test on each bed in the facility andor to perform the annual ated this test includes bed a test on any bed in the facility the provide a reason for the len asked to provide a spections, he stated the	F	909				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL [*] A. BUILDI		E CONSTRUCTION		X3) DATE SURVEY COMPLETED	
		495272	B. WING	12	STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		C	
NAME OF P	PROVIDER OR SUPPLIER				STREET ADDRESS CITY STATE ZIP CODE	01/	/13/2022	
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CANTERE	3URY REHABILITATION 8	& HEALTH CARE CENTER		1000 Vincine				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA	BE	(X5) COMPLETION DATE	
	inspections, but the far maintenance policy to manufacturers' instruct residents identified with manufactured by [name on 1/12/22 at 5:00 p.r. staff member) #1, the the director of nursing concerns. On 1/13/22 confirmed understand residents included in the Areview of the facility Service," revealed, in shall be provided to all grounds, and equipmes shall follow the manufamaintenance scheduled Areview of the bed marevealed, in part: "Visuaccessories for broker check for loose hardwork." No further information 2. Resident #138 was 6/1/18, and most recent with diagnoses including stroke, and peripheral most recent MDS (min	acility follows the general or maintain equipment per the octions. He stated all beds for rith this concern are me of bed manufacturer]. Im., ASM (administrative endaministrator, and ASM #2, gr, were informed of these of at 1:24 p.m., ASM #1 ding of the number of this concern. If policy, "Maintenance personnel facturer's recommended endaministrator and ware on a monthly basis." In was provided prior to exit. In admitted to the facility on ently admitted on 7/31/20, ing diabetes, a history of a livascular disease. On the	F	909	Deliver Consideration Contract V			
	scored 15 out of 15 on							

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	***************************************		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER		The state of the s		STREET ADDRESS, CITY, STATE, ZIP CODE	01/	/13/2022
CANTERE	BURY REHABILITATION 8	HEALTH CARE CENTER		1	1776 CAMBRIDGE DRIVE RICHMOND, VA 23238		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 909	Continued From page	127	F	909			
	extensive assistance of bed mobility.	of two staff members for					
	On 1/11/22 at 12:45 p observed lying in his b interviewable at the tir						
		#138's comprehensive care realed, in part: "Grab bars /positioning."					
	were interviewed. Whe information regarding inspection of beds utili OSM #5 stated that no He stated the majority bed rails. He stated his	nal director of plant #6, maintenance director, en asked to provide					
	rails are initially appliedoes not retain evidentinspection. He stated of certain a load to ground performed once a year	d. However, he stated he ce of these initial ordinarily the facility makes d test on each bed is					
	bed inspections. He st frames and mattresses test was not performed during 2021. He did not lack of inspections. Wh policy regarding bed in facility does not have a inspections, but the fac	ated this test includes bed s. However, he knows this d on any bed in the facility of provide a reason for the nen asked to provide a aspections, he stated the a policy specific to bed cility follows the general					
	manufacturers' instruct residents identified with	maintain equipment per the ions. He stated all beds for notice this concern are e of bed manufacturer].					

	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. 60 - 80		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 776 CAMBRIDGE DRIVE			
O) III III	OK! KENADIENAHON C	TEACHT CARE CENTER		R	RICHMOND, VA 23238			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 909	Continued From page On 1/12/22 at 5:00 p.r staff member) #1, the the director of nursing concerns. On 1/13/22 confirmed understand residents included in the No further information 3. Resident #326 was 1/4/22. Resident #326 were not limited to chrof breast cancer and a Resident #326's admis assessment was not conursing evaluation dat Resident #326 was also place and time. On 1/11/22 at 1:55 p.m observed lying in bed. On 1/12/22 at 12:40 p.member) #5, the regio operations, and OSM is were interviewed. Whe information regarding inspection of beds utility OSM #5 stated that not the stated the majority bed rails. He stated his staff does an initial install are initially applied does not retain evidence.	m., ASM (administrative administrator, and ASM #2, were informed of these at 1:24 p.m., ASM #1 ing of the number of his concern. was provided prior to exit. admitted to the facility on 5's diagnoses included but onic kidney disease, history an underactive thyroid. Sision minimum data set completed. An admission ed 1/4/22 documented ent and oriented to person, and, Resident #326 was m., OSM (other staff and director of plant #6, maintenance director, en asked to provide regular maintenance zing any type of side rails, at all facility beds have rails. of residents do not utilize storically, the maintenance pection of the bed when d. However, he stated he ce of these initial		909	T 17 120			
	is performed once a ye employs an outside ve	ordinarily the facility orgonized ground test on each bed ear. He stated the facility ndor to perform the annual ated this test includes bed						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
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more the more at	ROVIDER OR SUPPLIER BURY REHABILITATION 8	HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODI 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	E	01,	10/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		SHOULD BE		(X5) COMPLETION DATE
F 909	test was not performed during 2021. He did in lack of inspections. We policy regarding bed if facility does not have inspections, but the farmaintenance policy to manufacturers' instructive residents identified with manufactured by [nand On 1/12/22 at 5:00 p.m. staff member) #1, the director of nursing concerns. On 1/13/22 confirmed understand residents included in the No further information 4. Resident #148 was 6/19/20. Resident #14 were not limited to dia disease and COVID-1 quarterly minimum datassessment reference the resident's cognition on 1/11/22 at 2:16 p.m. observed lying in bed. On 1/12/22 at 12:40 p.m. observed lying in bed. On 1/12/22 at 12:40 p.m. observed. Whe information regarding inspection of beds utility in the policy in the properties of the disease will information regarding inspection of beds utility in the policy in the policy in the policy in the properties of the properties	is. However, he knows this d on any bed in the facility of provide a reason for the then asked to provide a inspections, he stated the a policy specific to bed cility follows the general maintain equipment per the stions. He stated all beds for the this concern are the of bed manufacturer]. In., ASM (administrative administrator, and ASM #2, were informed of these at 1:24 p.m., ASM #1 ing of the number of this concern. Was presented prior to exit. admitted to the facility on the set as a set assessment with an date of 12/20/21, coded in as severely impaired. In., Resident #148 was In., OSM (other staff and director of plant #6, maintenance director, en asked to provide	FS	909			

	OF DEFICIENCIES F CORRECTION	IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING	((X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER BURY REHABILITATION 8	HEALTH CARE CENTER	1	STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238		01/	13/2022
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		JLD BE	E	(X5) COMPLETION DATE
F 909	bed rails. He stated hi staff does an initial ins rails are initially appliedoes not retain evider inspections. He stated makes certain a load to is performed once a yemploys an outside vebed inspections. He stated frames and mattresse test was not performed during 2021. He did not lack of inspections. We policy regarding bed infacility does not have a inspections, but the famaintenance policy to manufacturers' instruct residents identified with manufactured by [name on 1/12/22 at 5:00 p.m. staff member) #1, the state director of nursing, concerns. On 1/13/22 confirmed understanding residents included in the No further information 5. Resident #146 was 9/17/20 with diagnoses limited to: non-traumathemorrhage (bleeding	of residents do not utilize storically, the maintenance spection of the bed when and. However, he stated he ace of these initial ordinarily the facility to ground test on each bed the ear. He stated the facility endor to perform the annual stated this test includes bed as. However, he knows this do nany bed in the facility of provide a reason for the then asked to provide a nespections, he stated the apolicy specific to bed cility follows the general maintain equipment per the tions. He stated all beds for this concern are the of bed manufacturer]. In., ASM (administrative administrator, and ASM #2, were informed of these at 1:24 p.m., ASM #1 and of the number of his concern. Was presented prior to exit. admitted to the facility on a that included but were not ic intracerebral within the brain) (1), sility of insulin to function 2) and chronic kidney notion of the kidneys	F	909			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION		(X3) DAT	E SURVEY PLETED
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		495272	B. WING		:	01	/13/2022
	ROVIDER OR SUPPLIER BURY REHABILITATION 8	L HEALTH CARE CENTER		STREET ADDRESS, CITY, STA 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	TE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	(EACH CORRECT CROSS-REFERENCE	PLAN OF CORRECTION TIVE ACTION SHOULD B CED TO THE APPROPRIA EFICIENCY)	E ATE	(X5) COMPLETION DATE
	Resident #146's most data set) assessment with an assessment recoded the resident as BIMS (brief interview findicating the resident MDS Section G- Func resident as requiring emobility, transfers, drepersonal hygiene; sup Observation of Reside 1/12/22 at 2:30 PM wit raised on bed. A list was provided to member) #1, the admir PM. The list consisted of the documentation of inspection. Resident # list. There was no evidence documentation for Resident # list. There was no evidence documentation for Resident # list.	recent MDS (minimum, a quarterly assessment, eference date of 12/17/21, scoring 15 out of 15 on the for mental status) score, was cognitively intact. tional Status, coded the extensive assistance in bed assing, bathing, toileting and ervision in eating. ASM (administrative staff nistrator, on 1/12/22 at 5:00 of a request for evidence of the annual bed safety 4146 was included on this as of requested dident #146. Bucted on 1/12/22 at 2:05 aff member) #5, the ent operations. When aspections, OSM #5 stated, aspections since August and none for 2022. Walk and one for 2022.		909			

			ATE SURVEY				
		495272	B. WING				C 01/13/2022
	PROVIDER OR SUPPLIER BURY REHABILITATION &	& HEALTH CARE CENTER		1776	EET ADDRESS, CITY, STATE, ZIP CODE 6 CAMBRIDGE DRIVE CHMOND, VA 23238		II IJIZVZE
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	stated, "They are all to On 1/13/22 at 2:15 Pt member) #1, the admidirector of nursing we concerns. No further information References: (1) Barron's Dictionary Non-Medical Reader, Chapman, page 304. (2) Barron's Dictionary Non-Medical Reader, Chapman, page 160. (3) Barron's Dictionary Non-Medical Reader, Chapman, page 119. 6. Resident #131 was 9/12/20 with diagnose limited to: cerebral infablockage of blood ves a lack of oxygen) (1) haffecting one side of thatherosclerotic cardiox consisting of lipids and arterial walls) (3). Resident #131's most data set) assessment, with an assessment recoded the resident as BIMS (brief interview findicating the resident MDS Section G- Functions	M, ASM (administrative staff ninistrator and ASM #2, the ere made aware of the above in was provided prior to exit. Ty of Medical Terms for the staff of the dition, Rothenberg and the provided prior to exit. Ty of Medical Terms for the staff of the dition, Rothenberg and the provided prior to exit. Ty of Medical Terms for the staff of the dition, Rothenberg and the dition, Rothenberg and the dition, Rothenberg and the dition, Rothenberg and the dition, Rothenberg and the dition (hemorrhage or existence of the brain leading to	FS	909			

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	PROVIDER OR SUPPLIER BURY REHABILITATION 8	HEALTH CARE CENTER	B. WIIVO	STREET ADDRESS, CITY, STATE, ZIP CODI 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	01/13/2022 E
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	Observation of Reside 1/11/22 at 11:30 AM w raised on bed. A list was provided to A member) #1, the admin PM. The list consisted of the documentation of inspection. Resident # list. There was no evidence documentation for Resident at regional director of plar asked about the bed in "I don't have any bed in 2020, none for 2021 and through of the rails and do a yearly inspection, not been done since 8/2 mattress, load to groun outside vendor comes in When asked to review the guidelines for Resident stated, "They are all the con 1/13/22 at 2:15 PM, member) #1, the administractor of nursing were concerns.	ependent in eating and total g. Int #131 resting in bed on ith bilateral upper handrails ASM (administrative staff nistrator, on 1/12/22 at 5:00 of a request for evidence of the annual bed safety e131 was included on this For of requested ident #131. Fucted on 1/12/22 at 2:05 aff member) #5, the int operations. When spections, OSM #5 stated, ispections since August ind none for 2022. Walk is out of date, it has 20. Includes the frame, did railing, for which an into the facility." The manufacturer's #146's bed, OSM #5	F	909	

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References: (1) Barron's Dictionary of Mon-Medical Reader, 5th et Chapman, page 111. (2) Barron's Dictionary of Mon-Medical Reader, 5th et Chapman, page 264. (3) Barron's Dictionary of Mon-Medical Reader, 5th et Chapman, page 264. (3) Barron's Dictionary of Mon-Medical Reader, 5th et Chapman, page 52. 7. Resident #22 was admit 11/14/20 with diagnoses the not limited to: cerebrovase (hemorrhage of blockage of brain leading to a lack of ormellitus (inability of insuling the body) (2) and post-traut (mood disorder occurring at (3)). Resident #22's most recent set) assessment, a quarter assessment reference date the resident as scoring 03 of (brief interview for mental set) the resident was severely of MDS Section G- Functional resident as requiring extens mobility, transfers, dressing personal hygiene; supervisite dependence in bathing. Observation of Resident #2 1/11/22 at 11:40 AM with bilitaised on bed.	Medical Terms for the edition, Rothenberg and Medical Terms for the edition, Rothenberg and Medical Terms for the edition, Rothenberg and Medical Terms for the edition, Rothenberg and ted to the facility on eat included but were cular accident of the vessels of the exygen) (1), diabetes to function normally in ematic stress disorder effer a traumatic event) It MDS (minimum datally assessment, with an experience of 10/20/21, coded out of 15 on the BIMS estatus) score, indicating cognitively impaired. I Status, coded the sive assistance in bed on to in eating / total	F9	009		

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	A list was provided to member) #1, the adm PM. The list consisted of the documentation inspection. Resident list. There was no evidence documentation for Resident state. There was no evidence documentation for Resident state. An interview was concept with OSM (other states and documentation for Resident states and documentation for Resident states, load to ground asked about the bed in "I don't have any bed in 2020, none for 2021 atthrough of the rails and documentation and the states, load to ground outside vendor comes. When asked to review guidelines for Residen stated, "They are all the On 1/13/22 at 2:15 PM member) #1, the admindirector of nursing were concerns. No further information of References: (1) Barron's Dictionary Non-Medical Reader, 5 Chapman, page 111. (2) Barron's Dictionary Dict	ASM (administrative staff inistrator, on 1/12/22 at 5:00 d of a request for evidence of the annual bed safety #22 was included on this #22 was included on this #22 was included on this #22 was included on this #23 was included on this #24 was included on this #25 was included on this #25 was included on this #25 was included on this #25 was included on the factor #26 was included with the factor was included with the f	F	909		

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F 909	Non-Medical Reader, Chapman, page 467. 8. Resident #13 was a 4/2/21 with diagnoses limited to: chronic obs [COPD] (chronic non-diabetes mellitus (inat normally in the body) disease (decreased furequently as a compliance of the resident #13's most reset) assessment, a quassessment reference the resident was cognically for the resident was cognically of the resident was cognically of the resident was cognically of the resident was cognically of the resident was cognically of the resident was cognically of the resident was cognically of the resident was cognically of the resident was cognically of the resident was cognically of the resident was cognically of the resident was cognically of the resident was cognically of the resident was provided to was provid	y of Medical Terms for the 5th edition, Rothenberg and admitted to the facility on that included but were not tructive pulmonary disease reversible lung disease) (1), bility of insulin to function (2) and chronic kidney inction of the kidneys cation of diabetes) (3). eccent MDS (minimum data arterly assessment, with an edate of 12/17/21, coded of 15 out of 15 on the BIMS intal status) score, indicating itively intact. MDS Section coded the resident as sistance in bed mobility, ithing, toileting and ervision in eating. ent #13 resting in bed on ifth bilateral upper handrails ASM (administrative staff inistrator, on 1/12/22 at 5:00 if of a request for evidence of the annual bed safety if 13 was included on this	F	909			

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F 909	PM with OSM (other s regional director of pla asked about the bed i "I don't have any bed 2020, none for 2021 a through of the rails and o a yearly inspection not been done since 8 mattress, load to grou outside vendor comes. When asked to review guidelines for Resider stated, "They are all the On 1/13/22 at 2:15 PM member) #1, the admidirector of nursing were concerns. No further information. References: (1) Barron's Dictionary Non-Medical Reader, Chapman, page 120. (2) Barron's Dictionary Non-Medical Reader, Chapman, page 160. (3) Barron's Dictionary Non-Medical Reader, Chapman, page 119. 9. Resident #15 was a 8/5/20 with diagnoses limited to: chronic obs	ducted on 1/12/22 at 2:05 staff member) #5, the ant operations. When inspections, OSM #5 stated, inspections since August and none for 2022. Walk d do the rail inspection. We but it is out of date, it has f/20. Includes the frame, and railing, for which an into the facility." The manufacturer's at #13's bed, OSM #5 are same bed." M, ASM (administrative staff inistrator and ASM #2, the are made aware of the above was provided prior to exit. Tof Medical Terms for the both edition, Rothenberg and are of Medical Terms for the both edition, Rothenberg and are of Medical Terms for the both edition, Rothenberg and and did did to the facility on that included but were not tructive pulmonary disease eversible lung disease) (1),	F 90	9	

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	changes in the joints) Resident #15's most rest) assessment, a quassessment reference the resident as scoring (brief interview for me the resident was cogned. Functional Status, requiring extensive as transfers, dressing, to hygiene; supervision in bathing. Observation of Reside 1/12/22 at 2:40 PM wire raised on bed. A list was provided to member) #1, the admit PM. The list consisted of the documentation of inspection. Resident # list. There was no evidence documentation for Resident # list. There was no evidence documentation for Resident # list. There was no evidence documentation for Resident # list. There was no evidence documentation for Resident # list. There was no evidence documentation for Resident # list. There was no evidence documentation for Resident # list. There was no evidence documentation for Resident # list. There was no evidence documentation for Resident # list. There was no evidence documentation for Resident # list. There was no evidence documentation for Resident # list. There was no evidence documentation for Resident # list. There was no evidence documentation for Resident # list. There was no evidence documentation for Resident # list.	ecent MDS (minimum data parterly assessment, with an edate of 10/12/21, coded graterly assessment, with an edate of 15 on the BIMS intal status) score, indicating itively intact. MDS Section coded the resident as sistance in bed mobility, graterly graterl	F	909			
	PM. The list consisted of the documentation of inspection. Resident # list. There was no evidence documentation for Resident # list. An interview was cond PM with OSM (other stregional director of platasked about the bed in "I don't have any bed in 2020, none for 2021 at through of the rails and do a yearly inspection,	of a request for evidence of the annual bed safety #15 was included on this e of requested sident #15. ucted on 1/12/22 at 2:05 raff member) #5, the ent operations. When respections, OSM #5 stated, respections since August and none for 2022. Walk is do the rail inspection. We but it is out of date, it has 20. Includes the frame,					

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F 909	member) #1, the admidirector of nursing were concerns. No further information References: (1) Barron's Dictionary, Non-Medical Reader, Chapman, page 120. (2) Barron's Dictionary, Non-Medical Reader, Chapman, page 50. (3) Barron's Dictionary, Non-Medical Reader, Chapman, page 420. 10. Resident #168 was 5/28/20 with diagnoses limited to: intracerebra within the brain) (1), he affecting one side of the cerebrovascular diseas consisting of cholester vessels) (3). Resident #168's most data set) assessment, with an assessment recoded the resident as a set of the concerns of the concerns of the concerns of the concerns of the cerebrovascular diseas consisting of cholester vessels) (3).	the manufacturer's at #15's bed, OSM #5 he same bed." M. ASM (administrative staff inistrator and ASM #2, the re made aware of the above was provided prior to exit. Of Medical Terms for the 5th edition, Rothenberg and of Medical Terms for the 5th edition, Rothenberg and of Medical Terms for the 5th edition, Rothenberg and of Medical Terms for the 5th edition, Rothenberg and of Medical Terms for the 5th edition, Rothenberg and of Medical Terms for the 5th edition, Rothenberg and se admitted to the facility on a that included but were not all hemorrhage (bleeding emiplegia (paralysis se body) (2) and se (buildup of plaque of and lipids in the cerebral recent MDS (minimum a quarterly assessment, ference date of 12/17/21, scoring 15 out of 15 on the or mental status) score,	F	909			

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F 909	resident as requiring emobility, transfers, drepersonal hygiene; suppersonal divided to member) #1, the admit PM. The list consisted of the documentation inspection. Resident is list. There was no evidence documentation for Resident in the resident in the propersonal director of place asked about the bed in asked about the bed in asked about the bed in asked about the bed in the reals and the average of the rails and the average of the rails and the propersonal director comes. When asked to review guidelines for Resident stated, "They are all the on 1/13/22 at 2:15 PM member) #1, the admit the personal hygienes for Resident stated, "They are all the on 1/13/22 at 2:15 PM member) #1, the admit the personal hygienes for Resident stated, "They are all the personal hygienes for Resident stated," They are all the personal hygienes for Resident stated, "They are all the personal hygienes for Resident stated," They are all the personal hygienes for Resident stated, "They are all the personal hygienes for Resident stated," They are all the personal hygienes for Resident stated, "They are all the personal hygienes for Resident stated," They are all the personal hygienes for Resident stated, "They are all the personal hygienes for Resident stated," They are all the personal hygienes for Resident stated, "They are all the personal hygienes for Resident stated," They are all the personal hygienes for Resident stated, "They are all the personal hygienes for Resident stated," They are all the personal hygienes for Resident stated, "They are all the personal hygienes for Resident stated," They are all the personal hygienes for Resident stated, "They are all the personal hygienes for Resident stated," They are all the personal hygienes for Resident stated, "They are all the personal hygienes for Resident stated," They are all the personal hygienes for Resident stated, "They are all the personal hygiene	extional Status, coded the extensive assistance in bed assing, bathing, toileting and pervision in eating. ent #168 resting in bed on with bilateral upper handrails ASM (administrative staff inistrator, on 1/12/22 at 5:00 do f a request for evidence of the annual bed safety #168 was included on this ducted on 1/12/22 at 2:05 taff member) #5, the ent operations. When inspections, OSM #5 stated, inspections since August and none for 2022. Walk do the rail inspection. We hout it is out of date, it has 1/20. Includes the frame, and railing, for which an into the facility." the manufacturer's the first was 1/20 and 1/	F	909			

PRINTED: 01/23/2022 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING_ C 495272 B. WING 01/13/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE **CANTERBURY REHABILITATION & HEALTH CARE CENTER** RICHMOND, VA 23238 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 909 Continued From page 141 F 909 No further information was provided prior to exit. References: (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 304. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 264. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and 2/8/2022 Chapman, page 111. F 947 Required In-Service Training for Nurse Aides F 947 SS=D CFR(s): 483.95(g)(1)-(4) F947 SS=D Required In-Service Training for Nurse Aides §483.95(g) Required in-service training for nurse aides. CFR(s): 483.95(g)(1)-(4) In-service training must-§483.95(g)(1) Be sufficient to ensure the Nursing Assistant #4, #5, and #6 completed annual continuing competence of nurse aides, but must education dementia training, and abuse prevention be no less than 12 hours per year. training. §483.95(g)(2) Include dementia management Residents who reside at Canterbury Rehab and training and resident abuse prevention training. Healthcare have potential to be affected by this practice. An audit was conducted for current Nursing §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews Assistants to ensure completion of annual dementia and facility assessment at § 483.70(e) and may and abuse prevention training. Nursing assistants address the special needs of residents as identified that are not in compliance will be assigned determined by the facility staff. dementia and abuse training. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by:

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	review, it was determing failed to evidence mannursing assistant) and training and abuse prefive CNA records review CNA #6. The findings include: During the sufficient and facility task, CNA (certic education for dementia were not evidenced in months. Per CMS it is requirements for 42CF facilities to ensure that demonstrate competer necessary to care for reidentified through residuescribed in the plantocompeter were hired as a CNA we CNA #4's education releither in-service training dementia and abuse processed to the competer were hired as a CNA we CNA #5's education releither in-service training dementia and abuse processed to the competer were hired as a CNA we CNA #6's employee releither in-service training dementia and abuse processed to the competer were hired as a CNA we CNA #6's employee releventing as a CNA we CNA #6's education relevant to the competer were hired as a CNA we CNA #6's education relevant to the competer were hired as a CNA we CNA #6's education relevant to the competer were hired as a CNA we CNA #6's education relevant to the competer were hired as a CNA we CNA #6's education relevant to the competer were hired as a CNA we CNA #6's education relevant to the competer were hired as a CNA we CNA #6's education relevant to the competer were hired as a CNA we CNA #6's education relevant to the competer were hired as a CNA we CNA #6's education relevant to the competer were hired as a CNA we CNA #6's education relevant to the competer were hired as a CNA we CNA #6's education relevant to the competer were hired as a CNA we CNA #6's education relevant to the competer were hired as a CNA we CNA #6's education relevant to the competer were hired as a CNA we CNA #6's education relevant to the competer were hired as a CNA we CNA #6's education relevant to the competer were hired as a CNA we CNA #6's education relevant to the competer were hired to the competer were hired to the competer were hired to the competer were hired to the competer were hired to the competer were hired to the competer wer	ew and facility document ned that the facility staff ndatory CNA (certified ual education in dementia evention training for three of ewed, CNA #4, CNA #5, and and abuse prevention the previous twelve and abuse prevention the previous twelve and abuse are able to not waiving the ER483.35[c], which requires an urse aides are able to not in skills and techniques residents' needs, as dent assessments, and of care. Cord documented they with the facility on 10/1/20. Cords failed to evidence g or on line training in revention. Cord documented they with the facility on 4/9/19. Cords failed to evidence g or on line training in revention. Cord documented they with the facility on 4/9/19. Cords failed to evidence g or on line training in revention.		Edu Adn Dire requ Assi con Coo mor com file edu are Fir	ninistrator/Designee for the Human Resor	for ts. A they	

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		& HEALTH CARE CENTER		1776 CAM	ddress, city, state, zip code Ibridge drive ND, VA 23238		
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F 947	On 1/12/22 at 4:45 PM member) #1, the adm the employee files we ASM #1 stated, "Oh, was an interview was condad with RN (registered development coordinated action for CNA #4, #4 stated, "CNA #4 do completed, CNA #5 di CNA #6 does not have training, and she may check. I started a QA improvement) project completed yet. My plated action to unit manal on 1/13/22 at 3:45 PM CNA #6 was evidence training.	M, ASM (administrative staff inistrator was informed of re not evidencing education. we'll get it to you." ducted on 1/13/22 at 11:33 at nurse) #4, the staff ator. When asked about the CNA #5 and CNA #6, RN pes not have any education d not have any completed, any record in on line have some in person. I will PI (quality process on 1/3/22 it is not an is to audit, provide	F	947			
				1			