STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495272	A. BUILDING _____ B. WING _____	C 05/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANTERBURY REHABILITATION & HEALTH CARE CENTER	1776 CAMBRIDGE DRIVE RICHMOND, VA 23238

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness COVID-19 Focused Survey was conducted 5/10/2022 to 5/11/2022. The facility was in compliance with E0024 of 42 CFR Part 483.73, Requirements for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare / Medicaid abbreviated survey was conducted 5/10/22 through 5/11/22. Two complaints was investigated during the survey (VA00055137 and VA00055076). The facility was in substantial compliance with / Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The census in this 190 certified bed facility was 167 at the time of the survey. The survey sample consisted of 9 current resident review and 2 closed record reviews.	F 000		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident	F 842	Resident Records – Identifiable Information 1. The resident was discharged from the facility on 4/24/2022.	5/27/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE: Administrator

(X6) DATE: 5/26/2022

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

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F 842	Continued From page 1 that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain-	F 842	LPN #2 was provided 1:1 education by the Director of Nursing or designee on the on the process of completing her documentation in the medical record to include documentation eINTERACT/ Progress Note on residents who are transferred to the hospital. 2. All residents who reside at Canterbury Rehabilitation on Healthcare have the potential to be affected by this process. A 30-day lookback audit on the transfers from the facility to include the eINTERACT and/or progress note on transfer was completed. Any variances found were rectified. 3. Licensed Nursing staff education will be completed by the DON or designee on the process of completing eINTERACT (Interventions to Reduce Acute Care Transfers) and/or progress note in the medical record upon transfer to the hospital. Transfers to the hospital will be reviewed for completion of eINTERACT and/or progress note for those residents	

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F 842	Continued From page 2 (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observations, resident / staff interviews and facility document review, it was determined the facility staff failed to maintain a complete and accurate medical record for one of 11 residents in the survey sample, Resident #2. The findings include: The facility failed to have a progress note or eINTERACT (Interventions to Reduce Acute Care Transfers) form in the medical record of Resident #2 upon transfer to the hospital on 4/24/22. Resident #2 was admitted to the facility on 4/18/22 with diagnosis that included but were not limited to: encephalopathy, repeated falls, COPD and pacemaker. The most recent MDS (minimum data set) assessment, a Medicare 5 day assessment, with an ARD (assessment reference date) of 4/21/22, coded the resident as unable to answer questions and severely impaired with no numerical score on the BIMS (brief interview for mental status) score. A review of the MDS Section G-functional status coded the resident as requiring extensive	F 842	transferred to the hospital daily 5 days per week as part of the Clinical Morning Meeting process. 4. An audit will be completed by the Director of Nursing or Designee weekly x 4 and then monthly x 2 months to ensure with the ongoing practice of completing eINTERACT and/or progress note for those residents who are transferred to the hospital. Findings of the audit will be submitted to the QAPI committee by the Director of Nursing monthly for review and recommendation as indicated.	

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F 842	Continued From page 3	F 842		

assistance for bed mobility, eating and hygiene; total dependence for transfer, dressing, eating and locomotion. A review of Section J-health conditions, reveals that there were no falls since admission and unable to determine fall history in the one month or two to six months prior to admission. A review of Section M-skin conditions, reveals skin tears on forearms and knees present on admission.

A review of the comprehensive care plan dated 4/19/22 documented in part, "FOCUS: I am at risk for falls related to history of falls. INTERVENTIONS: Anticipate and meet my needs. Be sure my call light is within reach and encourage me to use it for assistance as needed. Place bed in low position when in bed."

An interview was conducted on 5/10/22 at 3:05 PM with LPN (licensed practical nurse) #1, the unit manager. When asked if she remembered Resident #2, LPN #1 stated, yes, I remember her. She went to the hospital and then did not come back here. When asked about the progress note for the incident, LPN #1 stated, there is no progress note. The nurse that had her, tried to do a late entry note, but the record was closed.

An interview was conducted on 5/11/22 at 7:00 AM, with LPN (licensed practical nurse) #2. When asked if a transfer note or transfer form are missing in the resident medical record, is the medical record complete and accurate, LPN #2 stated, no it is not complete and accurate if my note and transfer form are not in the medical record. Everything must be there in the record.

An interview was conducted with ASM (administrative staff member) #1, the

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F 842	Continued From page 4 administrator at 7:55 AM on 5/11/22. When asked about the late entry notes, ASM #1 stated, our practice is that once a record is closed, we do not go back into the record to do a late entry note. The auditors do not think it is a good idea and sends up red flags. On 5/11/22 at 12:15 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing were made aware of the above concerns. The facility's "Charting and Documentation" policy with no date, which reveals, "Documentation in the medical record will be objective, complete and accurate. The following information is to be documented in the resident medical record: objective observations, medication administered, treatments or services performed, changes in the resident's condition, events/incidents/accidents involving the resident and progress toward or changes in the care plan goals and objectives." No further information was provided prior to exit.	F 842		