#### PRINTED: 07/07/2023 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES 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 06/22/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE CANTERBURY REHABILITATION AND HEALTHCARE CENTER RICHMOND, VA 23238 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (X5)**PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE. COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 000 INITIAL COMMENTS F 000 July 24, 2023 An unannounced Medicare/Medicaid abbreviated survey was conducted 6/21/23 through 6/22/23. Six complaints were investigated (VA00059030-substantiated with no deficiency; VA00057522-substantiated with deficiency; VA00057467-substantiated with no deficiency: VA00056763-substantiated with deficiency; VA00056757- substantiated with no deficiency; VA00059088-substantiated with deficiency). Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The census in this 190 certified bed facility was 174 at the time of the survey. The survey sample consisted of nine current resident reviews and two closed record reviews. F 550 Resident Rights/Exercise of Rights F 550 SS=D CFR(s): 483.10(a)(1)(2)(b)(1)(2) F550 Residents Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, SS=D self-determination, and communication with and access to persons and services inside and CNA#3 was educated on Resident Rights outside the facility, including those specified in and upholding the residents' privacy and this section. dignity during activities of daily living. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or Resident #10 - the facility staff will uphold her quality of life, recognizing each resident's individuality. The facility must protect and the resident's privacy and dignity during ADL promote the rights of the resident. care, and will provide privacy while §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, accomplishing person care/shaving. LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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

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

Event ID: S1N311

Facility ID: VA0034

#### PRINTED: 07/07/2023 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES 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 495272 B. WING 06/22/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE CANTERBURY REHABILITATION AND HEALTHCARE CENTER RICHMOND, VA 23238 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION DATE (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 550 Continued From page 1 F 550 severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the All residents who reside at Canterbury provision of services under the State plan for all residents regardless of payment source. Rehabilitation and Healthcare who receive §483.10(b) Exercise of Rights. ADL have the potential to be affected by this practice. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. C N A staff / Nursing Staff were educated by the §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without Staff Development Coordinator/Designee on Resident interference, coercion, discrimination, or reprisal from the facility. Rights/Exercise of Rights and upholding the residents' §483.10(b)(2) The resident has the right to be privacy and dignity during activities of daily living / having. free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this The Unit Manager/designee on all three units will subpart. This REQUIREMENT is not met as evidenced audit 5 residents per week x 3 weeks x 1 month, by: Based on observation, staff interview, clinical then 5 residents per month x 3 months to ensure record review, and facility document review, it was determined that the facility staff failed to ongoing compliance with this practice. uphold the resident's privacy and dignity during ADL (activities of daily living) care for one of 11 residents in the survey sample, Resident #10. The DON/Designee will conduct random audit of The findings include: 10 residents per month x 3 months to ensure

For Resident #10 (R10), the facility staff failed to

R10 was admitted to the facility with diagnoses that included but were not limited to: Parkinson's

provide privacy while shaving him.

ongoing compliance with this process.

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documented in part, "Federal and state law guarantees certain basic rights to all residents of this facility. These rights include the resident's

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

	AN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	DNSTRUCTION	(X3) DATE SURVEY COMPLETED
		495272	B. WING		C
NAME	OF PROVIDER OR SUPPLIER		STRE	EET ADDRESS, CITY, STATE, ZIP CODE	06/22/2023
CAN	ERBURY REHABILITATION	AND HEALTHCARE CENTER	1	CAMBRIDGE DRIVE HMOND, VA 23238	
(X4) PRE TA	FIX (EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F	with respect, kindne The facility's policy " "Each resident shall promotes and enhar well-being, level of s feeling of self-worth Residents are treate all times."  On 06/22/23 at approprint (administrative staff and ASM #2, directo aware of the above for the above for the self-worth and ASM #2, directo aware of the above for the self-well-well-well-well-well-well-well-w	d existence. B. be treated ss, and dignity."  Dignity" documented in part, be cared for in a manner that nees his or her sense of atisfaction with life, and and self-esteem. 1. d with dignity and respect at eximately 1:50 p.m., ASM member) #1, administrator of nursing, were made indings.  In was provided prior to exit.  This ined from the website: gov/medlineplus/parkinsonsdi (R11), the facility staff failed shaving him.  The facility with diagnoses e not limited to: stroke.  ADS (minimum data set), a twith an ARD (assessment //22/2023, the resident 15 on the BIMS (brief tatus), indicating the impaired of cognition for its. Section G "Functional"	F 550		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED
	495272 B. WING_			C 06/22/2023		
NAME OF PROVIDER OR SUPPLIER  CANTERBURY REHABILITATION AND HEALTHCARE CENTER			•	STREET ADDRESS, CITY, STATE, ZIP COD 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	DE	00/22/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		N SHOULD BE APPROPRIA	
F 580 SS=D	was observed sitting in next to the door to the next to (R11) shaving observation revealed I and a female resident in the hallway outside CNA #3 shave R11.  On 06/22/2023 at apportelephone interview was When informed of the previous day, CNA #3 (R11). When asked if personal care or personal car	roximately 4:00 p.m., R11 In a wheelchair at the sink room and CNA #3 standing his face. Further R11's room door was open was sitting in a wheelchair of R11's room watching  roximately 1:06 p.m., a as conducted with CNA #3. observation from the stated she recalled shaving shaving was considered anal hygiene CNA #3 stated are should have closed by and that it did not provide  imately 1:50 p.m., ASM amber) #1, administrator of nursing, were made dings.  was provided prior to exit. ary/Decline/Room, etc.) (i)-(iv)(15)	F 5	O Notify of Changes (Injury/Dec	cline/Roc	om)
	representative(s) when (A) An accident involving results in injury and hat physician intervention;	there is-		dent #4 was discharged from		

		MEDICAID SERVICES				MAPPROVED	
					OMB NO	O. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			A. BUILDIN	PLE CONSTRUCTION  G	СОМ	E SURVEY PLETED	
		495272	B. WING			C /22/2023	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
CANTEDE	NIDV DELLA DU IZAZIONI.		1	1776 CAMBRIDGE DRIVE			
_		AND HEALTHCARE CENTER		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 APPROPED DEFICIENCY)	) BE	(X5) COMPLETION DATE	
F = 0.0							
F 580	Continued From page	: 5	F 58	30			
	mental, or psychosoci	al status (that is. a					
	deterioration in health	, mental, or psychosocial					
	status in either life-thr	eatening conditions or	Canterbo	ury Rehabilitation and Healthcare on	6/12/22		
	clinical complications)		ì	, remadification and relatificate on	0/13/23		
	(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of		RN #1 was educated on Notification of Changes				
			in recide	nt status, and notification to the ph	a .	i	
	commence a new form	rse consequences, or to	iii reside	ysician			
	commence a new form		of a need to alter resident treatment /				
	(D) A decision to trans	iter or discharge the	or a need	to alter resident treatment /			
1	resident from the facili	ty as specified in	holding of resident weekly weight.				
	§483.15(c)(1)(ii).						
	(II) When making notif	ication under paragraph (g)		3			
ĺ	(14)(i) of this section, i	the facility must ensure that	All reside	ents who reside at Canterbury Rehal			
	all pertinent informatio	n specified in §483.15(c)(2)					
	is available and provid physician.	ed upon request to the	and Hea	lthcare who have orders for weights	have		
	(iii) The facility must all resident and the reside	so promptly notify the ent representative, if any,	the pote	ntial to be affected by this practice.	á		
	when there is-	on opiocontativo, il ariy,	7				
	(A) A change in room	or roommate assignment		dit was accomplished by the Unit Ma			
	as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and		/Designee o	of all current residents that their wei	ghts		
			are accomp	llished per physician order, and to er	nsure		
			if on hold fo	or medical reasons that there is docu	mentatio	on	
	phone number of the representative(s).	esident		cal record that the physician has bee			
	71. 17		made aware	e and a hold order has been obtained	. 1		
	§483.10(g)(15)			and a field order flas been obtained	ı.	1	
		site distinct part. A facility			Ť		
	that is a composite dis	tinct part (as defined in				1	
	§483.5) must disclose	in its admission agreement				1	
	its physical configuration	on, including the various	1			1	
	locations that comprise	the composite distinct					
	part, and must engoing	the policies that apply to			İ		
	room changes betweer	its different leastions					
1.	under §483.15(c)(9).	i its different locations	1		1		
	ander 3400.10(c)(8).		4	İ	進		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 07/07/2023

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intervals..."

tube]) in place. Obtain weights at ordered

On 6/22/23 at 9:41 a.m., an interview was

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On 6/22/23 at 9:44 a.m., a telephone interview was conducted with RN (registered nurse) #1. who was the nurse who documented, "5=Hold" on the MARs. RN #1 stated R4's respiratory status was compromised, and the resident was so fragile that she felt that putting the resident on a Hoyer mechanical lift scale was too compromising for the resident's health. RN #1 stated she was sure she discussed this with a physician or nurse practitioner, but she could not recall who she talked to.

Further review of R4's clinical record, which included nurses' notes and physician/nurse practitioner notes, failed to reveal documentation that RN #1 made a physician or nurse practitioner aware that weights were not obtained for R4.

On 6/22/23 at 12:13 p.m., an interview was conducted with ASM (administrative staff member) #5 (a nurse practitioner). ASM #5 stated no nurse had spoken with her regarding R4's weights.

On 6/22/23 at 12:54 p.m., a telephone interview was conducted with ASM #6 (another nurse practitioner). ASM #6 could not recall R4 or any discussions regarding the resident.

On 6/22/23 at 1:54 p.m., ASM #1 (the

Audits will be submitted to QAPI committee monthly for review and recommendation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	FIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
405272			NO		С	
	495272	B. WING			6/22/2023	
NAME OF PROVIDER OR SUPPLIER  CANTERBURY REHABILITATION AND HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238			
PREFIX (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT X (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
On 6/22/23 at 2:45 p.r conducted with ASM # medical director). ASI that RN #1 made a nu aware that R4's weigh #1 said she did this, b discussing this with him.  The facility policy titled Condition or Status" d will notify the resident' physician on call when need to alter the resident's ignificantly"  Baseline Care Plan CFR(s): 483.21(a)(1)-6 §483.21 Comprehensi Planning §483.21(a) Baseline Complement a baseline of that includes the instruction of the instruction of the seline care plan (i) Be developed within admission.	is in #2 (the director of laware of the above concern.  Im., an interview was #4 (R4's physician, and the M #4 stated he believed arse practitioner or physician has were not obtained if RN at the could not recall RN #1 m.  Id., "Change in a Resident's ocumented, "1. The nurse is attending physician or in there has been a (an): e. ent's medical treatment  (3)  Ive Person-Centered Care  Care Plans Illity must develop and care plan for each resident actions needed to provide tentered care of the resident standards of quality care. In mustandards of a resident's in the althcare information care for a resident end to-	F 6 F655 SS=D Reside Rehab All resi and He orders	Baseline Care Plan  The sent #4 was discharged from Canterbuilitation and Healthcare on 6/13/23 dents who reside at Canterbury Refealthcare who are Care Planned and for weights which are care planned to be affected by this proposed to the potential to be affected by this proposed to the potential to be affected by this proposed to the potential to be affected by this proposed to the potential to be affected by this proposed to the potential to be affected by this proposed to the potential to be affected by this proposed to the potential to be affected by this proposed to the potential to be affected by this proposed to the potential to be affected by this proposed to the potential to be affected by this proposed to the potential to be affected by this proposed to the potential to be affected by this proposed to the potential to be affected by this proposed to the potential to be affected by this proposed to the potential to be affected by this proposed to the potential to be affected by this proposed to the potential to be affected by this proposed to the potential to be affected by this proposed to the potential to the potenti	abilitatior have		

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES 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 06/22/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE CANTERBURY REHABILITATION AND HEALTHCARE CENTER RICHMOND, VA 23238 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 655 Continued From page 9 F 655 (E) Social services. (F) PASARR recommendation, if applicable. A 100% audit was accomplished by the Unit §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline Manager/Designee of all current residents care plan if the comprehensive care planthat their weights are accomplished per (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph physician order, and to ensure if on hold for (b) of this section (excepting paragraph (b)(2)(i) of medical reasons that there is documentation in this section). the medical record that the physician has been §483.21(a)(3) The facility must provide the resident and their representative with a summary made aware and a hold order has been obtained, of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. and the implementation of the baseline (ii) A summary of the resident's medications and care plan has occurred. dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to implement the baseline care plan for one of 11 residents in the survey sample, Resident #4. The findings include: For Resident #4 (R4), the facility staff failed to implement the resident's baseline care plan for obtaining weights. A review of R4's clinical record revealed a

physician's order dated 5/25/23 for weekly

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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOR MEDICARE & MEDICAID SERVICES 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 495272 B. WING 06/22/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE CANTERBURY REHABILITATION AND HEALTHCARE CENTER RICHMOND, VA 23238 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX COMPLETION DATE (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 655 Continued From page 10 F 655 weights every Monday for four weeks. R4's The Staff Development Coordinator provided baseline care plan dated 6/1/23 documented, "I have a nutritional problem r/t (related to) NPO education to the Licensed Nursing staff on (nothing by mouth) requiring enteral infusion to meet nutrition & hydration needs, altered skin Notification of Changes in resident status, integrity, dx (diagnosis) of stroke, respiratory failure, malnutrition, dementia, HTN and notification to the physician of a need (hypertension), anemia, tracheostomy, and PEG (percutaneous endoscopic gastrostomy [feeding to alter resident treatment / holding of resident tube]) in place. Obtain weights at ordered intervals..." weekly weight and implementation of the Further review of R4's clinical record failed to baseline care plan / obtaining of weights. reveal any weights after 5/25/23. R4's May 2023 and June 2023 MARs (medication administration records) documented the code, "5=Hold" on 5/29/23, 6/5/23 and 6/12/23. R4 was discharged An audit will be accomplished by the UM/Designee on 6/13/23. on all three units of 5 residents per week x 3 weeks, On 6/22/23 at 8:48 a.m., an interview was conducted with LPN (licensed practical nurse) #1. then 5 residents per month x 3 months to ensure LPN #1 stated the purpose of the care plan is, "To dictate their [residents'] care, follow their plan. It's ongoing compliance with this practice. an overall picture of their care and how things are supposed to go." LPN #1 stated the staff updates residents' care plans every day as things happen, and care plans are available for nurses' review. On 6/22/23 at 9:44 a.m., a telephone interview was conducted with RN (registered nurse) #1 who was the nurse who documented, "5=Hold" on the MARs. RN #1 stated R4's respiratory status was compromised, and the resident was so fragile that she felt that putting the resident on a Hoyer mechanical lift scale was too compromising for the resident's health.

On 6/22/23 at 12:13 p.m., an interview was conducted with ASM (administrative staff

NAME OF PROVIDER OR SUPPLIER  CANTERBURY REHABILITATION AND HEALTHCARE CENTER  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 655  Continued From page 11 member) #5 (a nurse practitioner). ASM #5 stated the facility did not have a bed scale so a Hoyer lift would have to be used to obtain R4's weight. ASM #5 stated R4 was in a vegetative state and had a tracheostomy so obtaining a weight would have been difficult but she didn't see why the resident could not tolerate it. ASM #5 stated obtaining R4's weight may have caused increased stress on R4, while moving the resident and making sure the resident's tracheostomy collar stayed in place, but it wouldn't have caused too much distress. ASM #5 stated it is important to obtain weights to monitor a resident with malnutrition.  E 655  STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238  ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  F 655  A monthly audit will be conducted by the DON/Designee of 10 residents per month x 3 months to ensure ongoing compliance with this practice.  Audits will be submitted to QAPI committee monthly for review and recommendation.	STATEMENT ( AND PLAN OF	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
CANTERBURY REHABILITATION AND HEALTHCARE CENTER  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 655  Continued From page 11  member) #5 (a nurse practitioner). ASM #5 stated the facility did not have a bed scale so a Hoyer lift would have been difficult but she didn't see why the resident could not tolerate it. ASM #5 stated obtaining R4's weight may have caused increased stress on R4, while moving the resident and making sure the resident's tracheostomy collar stayed in place, but it wouldn't have caused too much distress. ASM #5 stated it is important to obtain weights to monitor a resident with			495272	B. WING		200	
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On 6/22/23 at 1:54 p.m., ASM #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.  The facility policy titled, "Care Planning-Interdisciplinary Team" failed to document specific information regarding care plan implementation.  F 658 Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)  §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by:  Based on staff interview, facility document review and clinical record review, the facility staff failed to follow professional standards of practice for one of 11 residents in the survey sample, Resident #4.	F 658 SS=D ()	member) #5 (a nurse stated the facility did r Hoyer lift would have the weight. ASM #5 state state and had a trache weight would have been see why the resident of #5 stated obtaining R4 increased stress on R4 and making sure the recollar stayed in place, too much distress. AS to obtain weights to memalnutrition.  On 6/22/23 at 1:54 p.m administrator) and ASM nursing) were made as a made and the facility policy titled Planning-Interdisciplinated document specific information.  Services Provided Meen CFR(s): 483.21(b)(3) Compress Provided Meen to the services provided for so outlined by the company.  (i) Meet professional states and clinical record reviews of follow professional states of	practitioner). ASM #5 not have a bed scale so a to be used to obtain R4's d R4 was in a vegetative electory so obtaining a en difficult but she didn't could not tolerate it. ASM this weight may have caused 4, while moving the resident esident's tracheostomy but it wouldn't have caused SM #5 stated it is important conitor a resident with  n., ASM #1 (the M #2 (the director of ware of the above concern.  , "Care ary Team" failed to rmation regarding care  est Professional Standards  nensive Care Plans or arranged by the facility, prehensive care plan, andards of quality. is not met as evidenced  w, facility document review ew, the facility staff failed tandards of practice for	A monthly DON/Designments to Audits will I monthly fo  F 658  F 658 Service SS=D  Resident #4 v	audit will be conducted by the gnee of 10 residents per month ensure ongoing compliance with be submitted to QAPI committee or review and recommendation.  The provided Meet Professional States are submitted to the provided Meet Professional States are submitted to the provided Meet Professional States are submitted to the provided Meet Professional States are submitted to the provided Meet Professional States are submitted to the provided Meet Professional States are submitted to the provided Meet Professional States are submitted to the provided Meet Professional States are submitted to the provided Meet Professional States are submitted to the provided Meet Professional States are submitted to the provided Meet Professional States are submitted to the provided Meet Professional States are submitted to the professional States are submitted to t	tandards	

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	s==	495272	B. WING		C 06/22/2023	
	PROVIDER OR SUPPLIER BURY REHABILITATION A	AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	3000000	
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F 658	Continued From page	12	F 658	3		
	The findings include:		RN #1	L was educated on Notification of Cl	hanges	
	For Resident #4 (R4),	, the facility staff failed to	in res	sident status, Professional Standard	s,	
	obtain physician order		and notification to the physician of a need			
	diagnosis of malnutriti	ne facility on 5/24/23 with a ion. R4's weight on 5/24/23		to alter resident treatment and holding of		
100	was 149.8 pounds.			ent weekly weight without an order.	and the second s	
	A review of R4's clinic		All reside	ents who reside at Canterbury Reha	bilitation	
	1 555 55	y for four weeks. Further	and Hea	althcare who have orders for weight	:S	
	weights after this date	record failed to reveal any R4's May 2023 and June	have the	e potential to be affected by this pra	ctice.	
	2023 MARs (medication administration records) documented the code, "5=Hold" on 5/29/23, 6/5/23 and 6/12/23. R4 was discharged on 6/13/23.		A 100%	A 100% audit was accomplished by the		
			Unit Ma	anager/Designee of all current		
		m., a telephone interview	resident	s that their weights are accomplishe	ed	
	who was the nurse wh	N (registered nurse) #1 no documented, "5=Hold" on	per phy	sician order, and to ensure if on hol	ld	
	was compromised, and		for med	dical reasons that there is document	tation	
İ	Hoyer mechanical lift s		in the medical record that the physician has been			
	compromising for the r		made aware and a hold order has been obtained.			
	On 6/22/23 at 12:13 p. conducted with ASM (a	administrative staff	The Staf	ff Development Coordinator provid	ed	
		not have a bed scale so a	education to the Licensed Nursing staff on			
	weight. ASM #5 stated	to be used to obtain R4's d R4 was in a vegetative	Notifica			
		en difficult but she didn't	Professional Standards, and notification to			
		could not tolerate it. ASM 4's weight may have caused				

STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
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495272			B. WING		06/22/2023		
NAME OF PROVIDER OR SUPPLIER  CANTERBURY REHABILITATION AND HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238			
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F 658	P-30 .		F 658 the physician of a need to alter resident				
	and making sure the r	4, while moving the resident esident's tracheostomy		treatment / holding of resident we	ekly weights		
	too much distress AS	but it wouldn't have caused SM #5 stated it is important	/ and obtaining orders for changes.				
	to obtain weights to m			An audit will be accomplished by th	ne		
	malnutrition.		UM/Designee on all three units of 5				
	On 6/22/23 at 1:54 p.m., ASM #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.  The facility policy titled, "Weight Assessment and Intervention" documented, "Resident weights are monitored for undesirable or unintended weight		residents per week x 3 weeks, then				
			5 residents per month x 3 months to				
			ensure ongoing compliance with this practice.				
	loss or gain. 1. Reside	able or unintended weight ents are weighed upon	A monthly audit will be conducted by the DON				
	admission and at inter- interdisciplinary team a	at intervals established by the y team and/or as ordered by the		/Designee of 10 residents per month x 3			
F 677	physician"		months to ensure ongoing compliance with this practice.				
SS=D	ADL Care Provided for CFR(s): 483.24(a)(2)	Dependent Residents	F 67	Audits will be submitted to QAPI Co	ommittee		
	§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by:		monthly for review and recommendation.				
				F 677 ADL Care Provided for Depend	lent Residents		
ĺ			SS=D				
	Based on clinical reco	rd review, staff interview eview it was determined	Resident #3 was provided incontinent care.				
	that the facility staff fail (activities of daily living	ed to provide ADL		C N A staff member assigned to Resi	dent #3		
	residents in the survey	sample, Resident #3.	on 9/26/22 day shift/night shift and C N A				
	The findings include:			staff member on 6/27/22 evening s	hift were		
	For Resident #3 (R3), t	the facility staff failed to		educated on providing ADL care to o	dependent		
	provide incontinence Ca	ai 6.		residents and documentation of AL	)L care.		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495272	B. WING		1	C /22/2023	
	ROVIDER OR SUPPLIER  BURY REHABILITATION A	AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238		ZZIZUZJ	
(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 CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 677	On the most recent M admission assessmen	e facility with diagnoses that limited to: hemiplegia (1).  DS (minimum data set), an it with an ARD (assessment	1	dents who reside at Canterbury		1	
	reference date) of 09/27/2022, the resident scored 3 (three) out of 15 on the BIMS (brief interview for mental status), indicating the resident was severely impaired of cognition for making daily decisions. Section G "Functional Status" coded R3 as being totally dependent for toileting and requiring "Two + (plus) person physical asst (assistance)." Section H0300 "Urinary Incontinence" coded R3 as "Always incontinent."		An a resid ADL c	al risk to be affected by this praudit will be accomplished for all ents over the last 7 days to ensare / incontinence care is docue medical record.	ll current		
	The facility's ADL (actitization tracking sheet for R3 of revealed blanks (no do 09/26/2022 for the day p.m.) and on the night a.m.) and on 06/27/202 (3:00 p.m 11:00 p.m.	lated September 2022 ocumentation) on shift (7:00 a.m 3:00 shift (11:00 p.m 7:00 22 on the evening shift	educa	raff Development Coordinator pation to the C N A staff on provi			
	On 06/22/2023 at approximately 1:50 p.m., an interview was conducted with ASM (administrative staff member) #2, director of nursing. When asked how staff evidenced incontinence care was provided for a resident, ASM #2 stated that it is documented on the ADL tracking sheets. ASM #2 was asked to provide evidence that incontinence care was provided to R3 for the dates and shifts listed above.  On 06/22/2023 at approximately 4:00 p.m., a review of the documentation provided by the facility failed to evidence that incontinence care was proved to R3 on the dates and shifts listed		An auc	nentation of care provided. Hit will be accomplished by the three units of ADL care provide			

above.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
495272			B. WING		С		
NAME OF F	PROVIDER OR SUPPLIER		,	STREET ADDRESS, CITY, STATE, ZIP CODE	06/22/2023		
CANTERBURY REHABILITATION AND HEALTHCARE CENTER				1776 CAMBRIDGE DRIVE RICHMOND, VA 23238			
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F 677	F 677 Continued From page 15  The facility's policy "Activities of Daily Living (ADLs), Supporting" documented in part, "Policy		F 677	endent resident and the documenta	ution		
	StatementResidents out activities of daily liv	s who are unable to carry ving independently will	i	are provided. This audit will be cond			
	nutrition, grooming, an hygiene." Under "Police	cy and Implementation" it	on 5 residents on each unit per week x 3 weeks and then 5 residents per month x 3 months.				
	participate in ADLs and during ADL care and re	nented in part, "3. The resident's ability to pate in ADLs and the support provided ADL care and resident-specific tasks will cumented each shift by Certified Nursing ants in the medical record."	A mo	onthly audit will be accomplished by	/ the		
	Assistants in the medic		DON,	/Designee monthly of ADL care prov	vided		
	On 06/22/23 at approx (administrative staff me and ASM #2, director of	mately 1:50 p.m., ASM ember) #1, administrator f nursing, were made		ne dependent resident and the mentation of care provided.	æ		
	aware of the above find	dings. was provided prior to exit. function in part of your	4	audit will be conducted on			
	References:		1	esidents monthly x 3 months.			
1	body. This information		Audit	s will be submitted to the QAPI			
,			comm	nittee monthly for review and recom	mendation.		
				ě			