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 08/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANTERBURY REHABILITATION AND HEALTHCARE 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 survey was conducted 8/7/2023 through 8/11/2023 and 08/14/2023 through 08/16/2023. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 08/07/23 through 08/ 11/23 and 08/14/23 through 08/16/23. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Ten complaints were investigated during the survey (VA00059039-unsubstantiated; VA00058087 - substantiated with deficiency; VA00059308-substantiated with no deficiency; VA00057805-substantiated with deficiency; VA00057567-substantiated with deficiency; VA00057829-substantiated with deficiency; VA00057841-substantiated with deficiency; VA00057975-substantiated with no deficiency; VA00059374-substantiated with deficiency; VA00058758-substantiated with deficiency). The Life Safety Code survey report will follow. The census in this 190 certified bed facility was 183 at the time of the survey. The survey sample consisted of 47 current resident reviews and 10 closed record reviews.	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and	F 550		9/26/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 09/08/2023

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 550

Continued From page 1

access to persons and services inside and outside the facility, including those specified in this section.

§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 her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.

§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.

§483.10(b) Exercise of Rights.
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.

§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be 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 subpart.
This REQUIREMENT is not met as evidenced by:
Based on observation, resident interview, staff

F 550

F550 Resident Rights / Exercise Rights

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F 550

Continued From page 2

interview, facility document review, and clinical record review, the facility staff failed to maintain resident dignity for four of 57 residents in the survey sample, Residents #74, #48, #5, and #86.

The findings include:

1. For Resident #74 (R74), the facility staff failed to provide incontinence care in a dignified manner.

On the most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date of 6/23/23), R74 was coded as having no cognitive impairment for making daily decisions, having scored 15 out of 15 on the BIMS (brief interview for mental status). R74 was coded as requiring the extensive assistance of two staff members for toileting, and coded as being always incontinent of both bowel and bladder.

On 8/7/23 at 3:38 p.m., the surveyor entered R74's room. CNA (certified nursing assistant) #10 opened the door from the bathroom (shared with the two residents in the adjacent room), and stated: "I'm going to do this resident [pointing to a resident standing with her in the bathroom], then do him [pointing to Resident #48, R74's roommate], and them him [pointing to R74]. CNA #10 then closed the bathroom door. R74 was lying in his bed with the television on. He stated: "I have been waiting for an hour to get changed." He stated he was aware of needing to have his incontinence brief changed around 3:00 p.m., and he rang the bell. Another CNA whom he could not identify by name came in "a little after 3," (3:00 p.m.), cut his call light off, and told him it was "change of shift," and that someone else would

F 550

SS=E

1) Resident # 74 was reviewed with no adverse effects related to cited occurrence with incontinence care provided per care plan in a dignified manner.

Resident # 48 was reviewed with no adverse effects related to cited occurrence, incontinence care provided per care plan and resident dressed as indicated to maintain dignity.

CNA #10, CNA #5, LPN #7, and LPN #10 were re-educated by the Staff Development Coordinator/Designee on treating each resident with respect and dignity and care, in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident□s individuality. This includes but is not limited to providing timely incontinence care and properly dressing and/or covering residents as indicated to maintain dignity.

Resident # 5 was reviewed with no adverse effects related to cited occurrence. Resident #5 was evaluated by therapy for positioning and enhanced utensils as indicated with meals.

LPN #6 was re-educated by the Staff Development Coordinator/Designee on treating each resident with respect and dignity and care, in a manner and in an

F 550

Continued From page 3

have to come in and change him later. He stated: "No one has still come back in. I really need to be changed." He stated: "It certainly does not feel very good to be a grown man and need my pants changed."

On 8/7/23 at 3:45 p.m., seven staff members were observed standing at the desk for R74's unit. Two of the seven were tapping and scrolling on their cell phones.

On 8/7/23 at 4:12 p.m., CNA #10 began preparing R74 to have his incontinence brief changed.

A review of R74's care plan dated 6/25/23 revealed, in part: "I have urinary incontinence r/t (related to) physical limitations...provide incontinence care and apply moisture barrier as needed...check resident approximately every 2 hours and provide incontinence care as needed."

On 8/9/23 at 4:11 p.m., CNA #10 was interviewed. When asked about the observations on 8/7/23, and how she handled three residents who simultaneously needed incontinence brief changes, she stated: "I knew the suite mate would be quick in the bathroom, so I did him first. Then I did [Resident 48]. Then I did [R74]." When asked if having to wait over an hour for incontinence care leads to resident dignity, she stated: "No, it certainly does not."

On 8/10/23 at 3:26 p.m., CNA # 5 was interviewed. When asked if having to wait over an hour for incontinence care leads to resident dignity, she stated it does not.

On 8/14/23 at 11:59 a.m., LPN (licensed practical nurse) # 7 was interviewed. She stated the

F 550

environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident□s individuality. This includes setting up meal trays and overbed table in a manner that the resident can maintain dignity while eating.

Resident #86 was reviewed with no adverse effect related to cited occurrence. Resident #86 external urinary catheter collection canister is covered in a dignified manner.

LPN #7 was re-educated by the Staff Development Coordinator/Designee on treating each resident with respect and dignity and care, to include maintaining a cover on urinary catheter collection canisters.

2) Current residents that require incontinence assistance, require tray set up for meals and /or use a urinary catheter collection canister have the potential to be affected. A list of residents that receive incontinent care, require set up for meal service and utilize an external urinary catheter collection canister.

A walking round audit was conducted during change of shift, care, and mealtimes by Unit Manager/Designee of residents who require incontinence care and /or tray set up for meals to validate care was timely, residents were dressed, resident positioned, and meal tray set up and provided in a manner that maintained resident dignity. Rounds also include

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 08/16/2023

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F 550	Continued From page 4 maximum wait time for a resident who needs a brief change is "five to ten minutes, at the most." She stated she would help a CNA with incontinence care if she were asked, and if she were not in the middle of administering medications to residents. When asked if having to wait over an hour for incontinence care leads to resident dignity, she stated it does not. On 8/14/23 at 2:20 p.m., LPN #10, a unit manager was interviewed. She stated if she were aware of three residents who needed incontinence care at the same time, she stated: "I would get to the most dire one first. The second and third one would have to wait." She added: "If possible, I would ask somebody to help me, if anyone was available." She stated the time of shift change does not alter the facility's responsibility to meet resident needs. She stated: "If it was me, I would not want to wait any more than 10 minutes to be changed." When asked if having to wait over an hour for incontinence care leads to resident dignity, she stated it does not. On 8/14/23 at 4:01 p.m., ASM (administrative staff member) #1, the administrator, ASM #4, the regional risk consultant, ASM #8, the regional consultant, and ASM #7, the director of nursing, were informed of these concerns. A review of the facility policy, "Dignity," revealed, in part: "Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem...Residents are treated with dignity and respect at all times...The facility culture supports dignity and respect for residents by honoring resident goals, choices, preferences,	F 550	validating Residents that use urinary catheter collection canister were provided with covers. No further variances were identified. 3) Licensed Nursing and C N A staff members were re-educated by the Staff Development Coordinator / Designee on treating each resident with respect and dignity and care, in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident□s individuality this includes but is not limited to providing timely incontinence care per care plan, dressing or covering resident as indicated, positioning residents prior to meals and setting up tray and overbed table per preference if resident chooses to eat in their bed, maintain covering urinary catheter collection canister devices in a dignified manner. 4) An audit of 3 residents will be conducted via walking round audits during change of shift, care and/or mealtimes by Unit Manager/Designee of residents who require incontinence care and /or tray set up for meals to validate care was timely, residents were dressed, resident positioned, and meal tray set up and provided in a manner that maintained resident dignity. Rounds also include validating Residents that use urinary catheter collection canister were provided with covers. Variance will be addressed. These audits will be conducted weekly x 4 weeks, then monthly x 2 months. The findings of the audits will be submitted by	

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

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F 550	Continued From page 5	F 550		

values and beliefs...Demeaning practices and standards of care that compromise dignity are prohibited. Staff are expected to promote dignity and assist residents, for example...promptly responding to a resident's request for toileting assistance."

No further information was provided prior to exit.

2. For Resident #48 (R48), the facility staff failed provide a dignified view of the resident, and failed to provide incontinence care in a dignified manner.

On the most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 6/9/23, R48 was coded as being cognitively intact for making daily decisions, having scored 13 out of 15 on the BIMS (brief interview for mental status). R48 was coded as requiring the extensive assistance of two staff members for toileting, as being frequently incontinent of bladder and always incontinent of bowel. R48 was admitted to the facility with a diagnosis of intellectual disability/autism.

On 8/7/23 at 3:38 p.m., the surveyor entered R48's room. CNA (certified nursing assistant) #10 opened the door from the bathroom (shared with the two residents in the adjacent room), and stated: "I'm going to do this resident [pointing to a resident standing with her in the bathroom], then do him [pointing to R48]. CNA #10 then closed the bathroom door. R48 was sitting in his wheelchair, and the wheelchair was fully facing the door to the hallway. R48 was wearing only a shirt and incontinence briefs. There was a strong odor of feces surrounding R48. When asked how

the DON/Designee to the QAPI Committee for review and recommendation monthly for 3 months or ongoing until compliance sustained.

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 08/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 6	F 550		

long he had been waiting to be changed, R48 stated: "It burns down there [pointing to his incontinence brief]."

On 8/7/23 at 3:45 p.m., seven staff members were observed standing at the desk for R48's unit. Two of the seven were tapping and scrolling on their cell phones.

On 8/7/23 at 4:00 p.m., CNA #10 began preparing R48 to have his incontinence brief changed.

A review of R48's care plan dated 6/12/23 revealed, in part: "I have urinary incontinence r/t (related to) physical limitations...Provide incontinence care...as needed...Check resident approximately every 2 hours and provide incontinence care as needed...I have bowel incontinence r/t (related to) physical incontinence...Provide incontinence care...as needed."

On 8/9/23 at 4:11 p.m., CNA #10 was interviewed. When asked about the observations on 8/7/23, and how she handled three residents who simultaneously needed incontinence brief changes, she stated: "I knew the suite mate would be quick in the bathroom, so I did him first. Then I did [R48]." She stated she was aware that R48 had been incontinent of bowel when and needed to be changed. She stated: "They had just changed him, and he messed his pants again. I needed to do somebody else first." She stated: "We usually have three CNAs for the whole unit. That day, we had five. I'm not sure why." She stated she does not usually ask for help from other CNAs because "it's just not there." She stated she does not usually think to ask a nurse for help because "they are usually

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495272	A. BUILDING ______ B. WING ______	C 08/16/2023

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

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F 550	Continued From page 7	F 550		

busy passing meds (medications)." When asked if sitting with no pants in clear view of passersby, and having to wait over 22 minutes for incontinence care after being incontinent of bowel leads to resident dignity, she stated: "No, doesn't."

On 8/10/23 at 3:26 p.m., CNA # 5 was interviewed. When asked if sitting with no pants in clear view of passersby, and having to wait over 22 minutes for incontinence care after being incontinent of bowel leads to resident dignity, she stated it does not.

On 8/14/23 at 11:59 a.m., LPN (licensed practical nurse) # 7 was interviewed. She stated the maximum wait time for a resident who needs a brief change is "five to ten minutes, at the most." She stated she would help a CNA with incontinence care if she were asked, and if she were not in the middle of administering medications to residents. When asked if sitting with no pants in clear view of passersby, and having to wait over 22 minutes for incontinence care after being incontinent of bowel leads to resident dignity, she stated it does not.

On 8/14/23 at 2:20 p.m., LPN #10, a unit manager was interviewed. She stated if she were aware of three residents who needed incontinence care at the same time, she stated: "I would get to the most dire one first. The second and third one would have to wait." She added: "If possible, I would ask somebody to help me, if anyone was available." She stated the time of shift change does not alter the facility's responsibility to meet resident needs. She stated: "If it was me, I would not want to wait any more than 10 minutes to be changed." When asked if

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 08/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 8	F 550		

sitting with no pants in clear view of passersby, and having to wait over 22 minutes for incontinence care after being incontinent of bowel leads to resident dignity, she stated it does not.

On 8/14/23 at 4:01 p.m., ASM (administrative staff member) #1, the administrator, ASM #4, the regional risk consultant, ASM #8, the regional consultant, and ASM #7, the director of nursing, were informed of these concerns.

No further information was provided prior to exit.

3. For Resident #5 (R5), the facility staff failed to provide the resident with dignity while she was eating.

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 7/22/23, R5 was coded as being moderately cognitively impaired for making daily decisions. R5 was coded as requiring the extensive assistance of two staff members for transfers from bed to chair, and as requiring the supervision of one person (physical assistance) for eating.

On 8/7/23 at 12:14 p.m., R5 was sitting in bed with the head of the bed elevated and attempting to feed herself food from her lunch tray, which was on the overbed table. The overbed table was positioned across R5's bed. R5 was positioned so that her nose was at the level of the plate on the lunch tray. R5's plate contained chopped meat and vegetables. She was attempting to feed herself using only her fingers. Some of the food was going into the resident's mouth; however, most of the food was landing on the resident's

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 08/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 9	F 550		

face, clothing, bed linens, and floor.

On 8/8/23 at 7:55 a.m., LPN (licensed practical nurse) #6, a unit manager, delivered R5's breakfast tray, and positioned the overbed table across R5's bed. R5 was in approximately the same position as she had been on 8/7/23 at the lunch observation. LPN #6 made no attempt to reposition the resident. LPN #6 set up the breakfast tray, including putting sugar on the oatmeal, jelly on the toast, and opening the milk. at 7:59 a.m., R5 attempted unsuccessfully to use her fork to feed herself eggs. She put the fork down, and began attempting to eat the eggs with her fingers. Some of the eggs went into her mouth; most of the eggs landed on her clothing, bed linens, and the floor.

A review of R5's care plan dated 12/15 20 revealed, in part: "Feeds herself after tray set up."

On 8/14/23 at 9:16 a.m., CNA (certified nursing assistant) #11 was interviewed. She stated: "When I take care of [R5], I usually feed her. I work with her as part of the restorative program." She stated R5 is not able to feed herself. She stated a resident's dignity is not maintained when a resident gets food all over her clothing and bed linens while she is eating.

On 8/14/23 at 11:25 a.m., OSM #12, the director of rehab and an occupational therapist, was interviewed. She stated R5 was last screened, evaluated, and treated from 1/8/23 through 7/21/23. She stated R5 was not evaluated or treated for eating/self-feeding. She stated the most recent eating/self-feeding evaluation had been on 6/16/22, and the resident was documented as being independent for feeding.

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 08/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 10	F 550		

She added: "That's our only baseline." She stated "independent" means that the resident is able to manipulate the utensils, bring hand to mouth with no physical assistance, and eat. She stated: "If the resident is missing the mouth, it warrants an evaluation. She stated: "If she is overshooting, we can evaluate for a possible adaptive eating device." She added: "That is not a dignified way for her to eat."

On 8/14/23 at 4:01 p.m., ASM (administrative staff member) #1, the administrator, ASM #4, the regional risk consultant, ASM #8, the regional consultant, and ASM #7, the director of nursing, were informed of these concerns.

No further information was provided prior to exit.
4. For Resident #86 (R86), the facility staff failed to store the resident's external urinary catheter collection canister in a dignified manner. On multiple dates, the resident's external urinary catheter canister was observed on the resident's nightstand and contained urine.

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 7/17/23, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact for making daily decisions.

On 8/7/23 at 12:37 p.m., R86 was observed sitting upright in bed eating lunch. The resident's external urinary catheter collection canister was observed beside the bed, on the nightstand, and was approximately three fourths full of urine.

On 8/8/23 at 7:27 a.m., R86 was observed lying in bed. The resident's external urinary catheter

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 08/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 11 canister was observed beside the bed, on the nightstand, and was approximately one tenth full of urine. At this time, an interview was conducted with R86. R86 stated the canister of urine on the nightstand made the resident feel a little undignified and the resident would feel better if the canister was covered or in a more private location. On 8/8/23 at 4:18 p.m., R86 was observed lying in bed. The resident's external urinary catheter canister was observed beside the bed, on the nightstand, and was approximately one third full of urine. On 8/10/23 at 7:50 a.m., R86 was observed lying in bed. The resident's external urinary catheter canister was observed beside the bed, on the nightstand, and was approximately one half full. On 8/10/23 at 2:19 p.m., an interview was conducted with LPN (licensed practical nurse) #7 (a nurse who cares for R86). LPN #7 stated R86's external urinary catheter canister has not been covered. On 8/11/23 at 9:57 a.m., ASM (administrative staff member) #1 (the administrator) and ASM #4 (the regional risk consultant) were made aware of the above concern.	F 550		
F 580 SS=E	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-	F 580		9/26/23

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 08/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 12 (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various	F 580		

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 08/16/2023

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

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

F 580 Continued From page 13
locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review, and clinical record review, it was determined the facility staff failed to physician notification for seven of 57 residents in the survey sample, Residents #90, #63, #86, #115, #360, #95 and #358.

The findings include:

1. For Resident #90, the facility staff failed to notify the physician, per the physician order, of elevated blood sugar levels.

The physician orders dated 3/24/2023 included, Novolin R (regular) Flex Pen Solution Pen Injector 100 UNIT/ML (milliliters) (Insulin Regular Human) inject as per sliding scale: if 0 - 150 = 0; 151 - 199 = 1; 200 - 249 = 2; 251 - 299 = 3; 300 - 349 = 4; 350 - 399 = 5; 400 - 450 = 6; > (greater than) 450 give 8 units and inform attending, subcutaneously at bedtime for dm (diabetes) bedtime ssi (sliding scale insulin).

The physician orders dated 3/24/2023 included, "Novolin R (regular) Flex Pen Solution Pen Injector 100 UNIT/ML (milliliters) (Insulin Regular Human) inject as per sliding scale: if 0 - 150 = 0 units; 151 - 199 = 2 units; 200 - 249 = 4 units; 250 - 299 = 6 units; 300 - 349 = 8 units; 350 - 399 = 10 units; 400+ CALL MD (medical doctor) FOR ORDERS; subcutaneously before meals for diabetes."

F 580

F580 Notify of Changes (Injury/Decline/Room)

SS=E

1) Resident #90s physician was notified of the elevated blood sugar levels on 8/2/23, 8/3/23, 8/7/23, and 8/8/23. No new orders at this time.

LPN # 9 was re-educated by the Staff Development Coordinator / Designee on the need to notify the physician per the physician orders regarding elevated blood sugars.

Resident #63 was discharged from the facility on 8/8/23.

Resident #86s physician was notified that Levothyroxine sodium was not available for administration on 8/5/23 and 8/6/23. No new orders at this time.

Resident #115s physician was notified the following medications (Lisinopril, Allopurinol, and Diltiazem) were not available for administration on 7/9/23. No new orders at this time.

Resident #360 was discharged from the facility on 8/19/23.

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 08/16/2023

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

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

F 580 Continued From page 14

The August MAR (medication administration record) documented the above two orders. On 8/8/2023 at 2100 (9:00 p.m.) it was documented the blood sugar was 509. An "11" was documented in the box where the amount of the insulin administered was to be documented.

The August MAR documented the above two orders. On the following dates at 1600 (4:00 p.m.) the following was documented:
8/2/2023 - BS (blood sugar) was documented as 430. An "11" was documented in the box where the amount of the insulin administered was to be documented.
8/3/2023 - BS - was documented as 445. An "11" was documented in the box where the amount of the insulin administered was to be documented.
8/7/2023 - BS - was documented as 425. An "11" was documented in the box where the amount of the insulin administered was to be documented.
8/8/2023 - BS - was documented as 478. A "3" was documented in the box where the amount of the insulin administered was to be documented.

The chart codes on the MAR documented the following:
11 = Vitals Outside of Parameters.
3 = Absent from facility.

Review of the nurse's notes failed to evidence any documentation related to the resident's blood sugars, insulin or contact made with the doctor, per the physician orders.

The comprehensive care plan dated, 3/4/2023, documented in part, "Focus: I have Diabetes Mellitus." The review of the interventions failed to evidence any documentation related to the administration of insulin.

F 580

LPN # 11 was re-educated by the Staff Development Coordinator / Designee on the need to notify the physician if a stat lab in not completed timely per the physician orders.

Resident #95s physician was notified that the medication Xtampza was not available for administration on 6/1/23 6/4/23. No new orders at this time.

Resident #358s was discharged on 8/3023.

2) Residents that receive blood sugar monitoring, medication administration or that have stat lab

orders have the potential to be affected. Licensed nurses conducted an audit for the last 30 days for residents that had elevated blood sugars outside of order parameters, medications on hold, unavailable, or not given, and stat labs that were not completed timely to validate physician notification occurred. Variances were addressed.

3) Licensed Nursing staff were provided with re-education by the Staff Development Coordinator/Designee on Physician notification when elevated blood sugars outside of order parameters occur, medications on hold, unavailable, or not given, and when stat labs are not completed timely.

4) An Audit will be completed by the Unit Manager/Designee weekly on residents

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 08/16/2023

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

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

F 580

Continued From page 15

An interview was conducted with LPN (licensed practical nurse) #9, the nurse that documented the above information, on 8/9/2023 at 3:09 p.m. The documentation above was reviewed with LPN #9. When asked what the "11" stood for, LPN #9 stated that the blood sugar was out of the parameters. LPN #9 was asked if she gave the resident insulin on 8/2/2023, LPN #9 stated she had given the resident 10 units. When asked if she called the physician, LPN #9 stated she had not contacted the physician. LPN #9 was asked if she administered insulin to the resident on 8/7/2023 at 4:00 p.m., LPN #9 stated she gave the resident 10 units that day. When asked if she called the doctor, she stated, no. LPN #9 was asked if the resident was out of the facility on 8/8/2023 at 4:00 p.m., LPN #9 stated, no, she must have clicked the wrong button. LPN #9 was asked how much insulin she gave the resident, LPN #9 stated, eight units and no, she didn't call the doctor. When asked if she was following the physician orders, LPN #9 stated no. LPN #9 was asked if she was allowed to give medications without a physician order, LPN #9 stated, no.

The facility policy, "Change in Resident's Condition or Status," documented in part, "Policy Statement: Our facility promptly notified the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status. Policy Interpretation and Implementation: 1. The nurse will notify the resident's attending physician or physician on call when there has been a(an)...e. Need to alter the resident's medical treatments significantly...i. Specific instruction to notify the physician of changes in the resident's condition."

F 580

that had elevated blood sugars outside of ordered parameters, medications on hold, unavailable, or not given, and stat labs that were not completed timely to validate physician notification occurred. Variances will be addressed. These audits will be conducted weekly x 4 weeks, then monthly x 2 months. The findings of the audits will be submitted by the DON/Designee to the QAPI Committee for review and recommendation monthly for 3 months or ongoing until compliance sustained.

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 08/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 16	F 580		

ASM (administrative staff member) #1, the administrator, ASM #4, the regional risk consultant, and ASM #6, the clinical care consultant, were made aware of the above finding on 8/9/2023 at 5:30 p.m.

No further information was provided prior to exit.
2. For Resident #63 (R63), the facility staff failed to notify the physician that an antibiotic, Ceftriaxone Sodium (1), was not available for administration according to the physician's orders

R63 was admitted with diagnoses that included but were not limited to UTI (urinary tract infection).

The physicians order sheet dated August 2023 documented in part, "Ceftriaxone Sodium Solution Reconstituted 1(one) GM (gram). Use 1 gram intravenously every 24 hours for UTI for 5 Days. Order Date: 08/04/2023. Start Date: 0-8/04/2023."

The eMAR (electronic medication administration record) for R63 dated August 2023 documented the medication listed above. Review of the eMAR failed to evidence the administration of Ceftriaxone Sodium on 08/05/2023 and 08/06/2023; the number "22" was documented on 08/05/2023 and 08/06/2023. Under the eMAR "Chart Codes" it documented, "22=Drug / Treatment Not Administered."

The facility's nurse's progress notes documented in part,
"8/05/2023 nurse's progress note documented, "Ceftriaxone Sodium Solution Reconstituted 1 GM. Use 1 gram intravenously every 24 hours

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 08/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 17	F 580		

for UTI for 5 Days. unavailable. on next delivery per pharmacy."

"8/06/2023 nurse's progress note documented, "Ceftriaxone Sodium Solution Reconstituted 1 GM. Use 1 gram intravenously every 24 hours for UTI for 5 Days. unavailable. on next delivery per pharmacy." Further review of the nurse's progress notes failed to evidence notification to the physician that the medication was unavailable and not administered for the dates listed above.

On 08/14/2023 at approximately 11:40 a.m., an interview was conducted with LPN (licensed practical nurse) #6, unit manager. When asked to describe the procedure when a physician ordered medication is not available for administration LPN #6 stated that the nurse administering the medication would call the pharmacy, the physician and the resident's family or responsible party as soon as the nurse knows that the medication is not available. When asked if and where it should be documented that the physician was notified he stated that the nurse would be responsible for documenting in the nursing progress notes. After reviewing the nursing progress notes and eMAR for the dates stated above LPN #6 was asked if R63's physician was notified that the antibiotic was not available for administration. He stated there was no documentation notifying the physician.

On 08/14/2023 at approximately 9:50 a.m., ASM (administrative staff member) #1, administrator and ASM #4, regional risk consultant, were made aware of the above findings.

No further information was provided prior to exit.

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 08/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 18	F 580		

References:
(1) used to treat bacterial infections in many different parts of the body. This information was obtained from the website: Ceftriaxone (Injection Route) Description and Brand Names - Mayo Clinic.
3. For Resident #86 (R86), the facility staff failed to notify the physician when the medication levothyroxine sodium (1) was not available for administration on 8/5/23 and 8/6/23.

A review of R86's clinical record revealed a physician's order dated 4/1/23 for levothyroxine sodium 175 mcg (micrograms)- one tablet once a day for hypothyroidism.

A review of R86's August 2023 MAR (medication administration record) revealed the physician's order for levothyroxine sodium. On 8/5/23 and 8/6/23, the MAR documented the code, "5=Hold." Nurses' notes dated 8/5/23 and 8/6/23 documented, "Med on order." Further review of nurses' notes and the August 2023 MAR failed to reveal documentation that levothyroxine sodium was administered to R86 on 8/5/23 and 8/6/23, and failed to reveal documentation that R86's physician was notified.

On 8/11/23 at 8:23 a.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated that if a medication is not available for administration, then she goes to the facility backup medication supply and if the medication is not there then she calls the doctor. LPN #1 stated it is important to call the doctor because, "You don't want them [the residents] to miss a scheduled dosage. You want them [the physicians] to know so they can make a change."

F 580 Continued From page 19 F 580

A review of the facility backup medication supply list revealed levothyroxine sodium was not stocked in the supply.

On 8/11/23 at 9:57 a.m., ASM (administrative staff member) #1 (the administrator) and ASM #4 (the regional risk consultant) were made aware of the above concern.

The facility policy titled, "Unavailable Medication" documented, "2. In the event that a medication ordered for a resident is noted to be unavailable near or at the time it is to be dispensed, nursing staff shall: c. Notify the physician of the unavailable medication..."

Reference:
(1) "Levothyroxine is used to treat hypothyroidism (condition where the thyroid gland does not produce enough thyroid hormone)." This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682461.html.

4. For Resident #115 (R115), the facility staff failed to notify the physician when the medications lisinopril (1), allopurinol (2) and diltiazem (3) were not available for administration on 7/9/23.

A review of R115's clinical record revealed the following physician's orders:
4/1/23-lisinopril 40 mg (milligrams) once a day for high blood pressure
4/1/23-allopurinol 300 mg once a day for gout
4/4/23-diltiazem 30 mg (milligrams) every eight hours for high blood pressure

A review of R115's MAR (medication

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 08/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 20	F 580		

administration record) for July 2023 revealed the physician orders for lisinopril, allopurinol and diltiazem. On 7/9/23 for the morning doses, the MAR documented the code, "5=Hold." Nurses' notes dated 7/9/23 documented the medications were on order. Further review of nurses' notes and the July 2023 MAR failed to reveal documentation that the morning doses of lisinopril, allopurinol and diltiazem were administered to R115 on 7/9/23 and failed to reveal documentation that R115's physician was notified.

On 8/11/23 at 8:23 a.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated that if a medication is not available for administration, then she goes to the facility backup medication supply and if the medication is not there then she calls the doctor. LPN #1 stated it is important to call the doctor because, "You don't want them [the residents] to miss a scheduled dosage. You want them [the physicians] to know so they can make a change."

A review of the facility backup medication supply list revealed lisinopril, allopurinol and diltiazem were not stocked in the supply.

On 8/11/23 at 9:57 a.m., ASM (administrative staff member) #1 (the administrator) and ASM #4 (the regional risk consultant) were made aware of the above concern.

References:
(1) Lisinopril is used to treat high blood pressure. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a692051.html.
(2) Allopurinol is used to treat gout. This

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 08/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580		F 580		

Continued From page 21
information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682673.html.
(3) Diltiazem is used to treat high blood pressure. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a684027.html.

5. For Resident #360 (R360), the facility staff failed to notify the physician that STAT labs ordered on 8/3/23 were not able to be obtained until 8/4/23.

A review of R360's clinical record revealed a nurse practitioner's note dated 8/3/23 at 8:47 a.m. that documented, "Assessment and Plan: 1. Nausea and vomiting without abdominal pain or diarrhea. Regular bowel movements. No chills or fever. Vital signs are stable, abdominal exam is benign. Ordered Zofran (medication used to treat nausea and vomiting) 4 milligrams POQ (by mouth every) 6 hours PRN (as needed) nausea vomiting x3d (times three days), ordered stat BMP (basic metabolic panel) (1) to assess for dehydration given patients report of decreased fluid intake, we can do IV (intravenous) fluids if necessary, ordered clear liquid diet times 24 hours. Discussed with nurse." Further review of R360's clinical record revealed a physician's order dated 8/3/23 for a STAT BMP and CBC (complete blood count) (2) for nausea and vomiting.

A nurse's note dated 8/3/23 documented, "Lab out to draw stat CBC and BMP, but unable to obtain specimen, stated 'He's a hard stick', Lab notified, will send someone else to attempt to draw ordered labs today." Another nurse's note dated 8/3/23 documented, "Lab called back to

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 08/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANTERBURY REHABILITATION AND HEALTHCARE CENTER	**1776 CAMBRIDGE DRIVE RICHMOND, VA 23238**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 22	F 580		

facility stated they do not have anyone to come back out today to attempt the blood draw, lab to be drawn in AM with routine lab orders." A review of the BMP and CBC lab results revealed the labs were collected on 8/4/23 at 2:00 p.m. Further review of R360's clinical record failed to reveal documentation that R360's physician was notified on 8/3/23 and made aware that the STAT labs would not be obtained until 8/4/23.

On 8/10/23 at 10:51 a.m., an interview was conducted with LPN (licensed practical nurse) #11. LPN #11 stated phlebotomists from an outside company come to the facility to obtain labs. LPN #11 stated she believed someone comes from the company daily every day except for Sundays. LPN #11 stated nurses at the facility do not routinely draw blood but she guessed they could if someone who knew how to do it was available and present in the facility. LPN #11 stated that on 8/3/23, stat labs were ordered for R360 so she called the outside company, someone came out, said she couldn't obtain the labs, and asked LPN #11 to call the company and let them know. LPN #11 stated she called the company, then they called back to someone else at the facility and said no one could come out that day. LPN #11 could not recall that the physician or nurse practitioner was notified on 8/3/23 and made aware the STAT labs could not be obtained until 8/4/23.

On 8/11/23 at 8:23 a.m., an interview was conducted with LPN #1. LPN #1 stated STAT labs should be obtained within an hour of being ordered and if the labs cannot be obtained then nurses should call the physician because the orders are not being done in a timely fashion, and that can make a difference in the resident's care

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 08/16/2023

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

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

F 580

Continued From page 23

and condition.

On 8/11/23 at 9:57 a.m., ASM (administrative staff member) #1 (the administrator) and ASM #4 (the regional risk consultant) were made aware of the above concern.

The facility policy titled, "Change in a Resident's Condition or Status" documented, "1. The nurse will notify the resident's attending physician or physician on call when there has been a(an) e. need to alter the resident's medical treatment significantly..."

References:
(1) "A basic metabolic panel (BMP) is a test that measures eight different substances in your blood. It provides important information about your body's chemical balance and metabolism. Metabolism is the process of how the body uses food and energy. A BMP includes tests for the following: Glucose, a type of sugar and your body's main source of energy. Calcium, one of the body's most important minerals. Calcium is essential for proper functioning of your nerves, muscles, and heart. Sodium, potassium, carbon dioxide, and chloride. These are electrolytes, electrically charged minerals that help control the amount of fluids and the balance of acids and bases in your body.
BUN (blood urea nitrogen) and creatinine, waste products removed from your blood by your kidneys." This information was obtained from the website:
https://medlineplus.gov/lab-tests/basic-metabolic-panel-bmp/.
(2) "Your blood contains red blood cells (RBC), white blood cells (WBC), and platelets. Blood count tests (CBC) measure the number and types

F 580

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 08/16/2023

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

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F 580	Continued From page 24 of cells in your blood." This information was obtained from the website: https://medlineplus.gov/bloodcounttests.html. 6. For Resident #95 (R95), the facility staff failed to notify the physician when the medication Xtampza (1) was not available for administration 6/1/23 through 6/4/23. A review of R95's clinical record revealed a physician's order dated 6/24/22 for Xtampza 18 mg (milligrams) twice a day for pain. A review of R95's MAR (medication administration record) for June 2023 revealed the physician's order for Xtampza. For the evening dose on 6/1/23, both doses on 6/2/23 through 6/4/23 and the evening dose on 6/5/23, the MAR documented the code, "5=Hold." A nurse's note dated 6/1/23 documented the nurse would administer the medication upon arrival from the pharmacy. A nurse's note dated 6/2/23 documented the medication was on order. Nurses' notes dated 6/3/23 and 6/4/23 documented the nurse would administer the medication upon arrival from the pharmacy. Further review of nurses' notes and the June 2023 MAR failed to reveal documentation that the doses of Xtampza were administered to R95 6/1/23 through 6/5/23 and failed to reveal documentation that R95's physician was notified 6/1/23 through 6/4/23. On 8/11/23 at 8:23 a.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated that if a medication is not available for administration, then she goes to the facility backup medication supply and if the medication is	F 580		

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 08/16/2023

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

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F 580	Continued From page 25	F 580		

not there then she calls the doctor. LPN #1 stated it is important to call the doctor because, "You don't want them [the residents] to miss a scheduled dosage. You want them [the physicians] to know so they can make a change."

A review of the facility backup medication supply list revealed Xtampza not stocked in the supply.

On 8/14/23 at 4:06 p.m., ASM (administrative staff member) #1 (the administrator), ASM #4 (the regional risk consultant) and ASM #7 (the director of nursing) were made aware of the above concern.

Reference:
(1) Xtampza is used to treat pain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682132.html.

7. For Resident #358, the facility staff failed to notify the physician when the medication oxycodone (1) was not available for administration on 6/24/23.

A review of R358's clinical record revealed a physician's order dated 3/21/23 for oxycodone oral solution five mg (milligrams)/ five ml (milliliters)- five ml once a day for pain.

A review of R358's MAR (medication administration record) for June 2023 revealed the physician's order for oxycodone oral solution. On 6/24/23, the MAR documented the code, "5=Hold."

A nurse's note dated 6/24/23 documented, "medication on order, waiting for arrival." Further

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 08/16/2023

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

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F 580	Continued From page 26 review of nurses' notes and the June 2023 MAR failed to reveal documentation that the oxycodone was administered to R358 on 6/24/23 and failed to revealed documentation that R358's physician was notified. On 8/11/23 at 8:23 a.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated that if a medication is not available for administration, then she goes to the facility backup medication supply and if the medication is not there then she calls the doctor. LPN #1 stated it is important to call the doctor because, "You don't want them [the residents] to miss a scheduled dosage. You want them [the physicians] to know so they can make a change." A review of the facility backup medication supply list revealed oxycodone oral solution was not stocked in the supply. On 8/14/23 at 4:06 p.m., ASM (administrative staff member) #1 (the administrator), ASM #4 (the regional risk consultant) and ASM #7 (the director of nursing) were made aware of the above concern. Reference: (1) Oxycodone is used to treat pain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682132.html.	F 580		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including	F 584		9/26/23

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 08/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 27 but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, clinical	F 584	F584 Safe/Clean/Comfortable/Homelike	

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 08/16/2023

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

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F 584 Continued From page 28

record review and facility document review, it was determined the facility staff failed to provide a safe and homelike environment for one of 57 residents, Resident #129 and in one of six bathrooms on the Westham Unit.

The findings include:

1. The facility staff failed to maintain a clean and homelike environment for Resident #129. During the initial resident screening on 8/7/23 at 2:59 PM, the resident's room revealed a wall mounted hand sanitizer dispenser partially torn off the wall above and to the left of the resident's sink, a section of damaged dry wall containing a hole approximately six inches below and to the left of the resident's sink, missing flooring in the doorway between the resident room and bathroom, approximately 12 inches of cove base torn off the wall with additional tearing of the dry wall between the head of the residents beds and an approximate 12 inch piece of cove base falling off the wall to the left side the HVAC unit at the far side of the room.

Resident #129 was admitted to the facility on 6/20/23 with diagnoses that included but are not limited to: dementia and metabolic encephalopathy.

Resident #129's most recent MDS (minimum data set) assessment, a Medicare 5-day assessment, with an assessment reference date of 7/4/23, coded the resident as scoring 04 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired. MDS Section G- Functional Status: coded the resident with walking and locomotion requiring limited assistance.

F 584

Environment

SS=D

1) Resident #129s room hand sanitizer wall mount, dry wall, missing flooring, peeled wallpaper, and cove base and missing tiles were repaired in resident room area.

The bathroom between rooms 222 and 223 on the Westham Unit was cleaned to include toilet, under toilet and toilet seat.

2) Current residents who reside at Canterbury Rehabilitation and Healthcare have the potential to be affected by this practice. Walking rounds were made by the Administrator/Designee of resident rooms and bathrooms to validate clean and homelike environment for the residents with no further variances in cleanliness, mounted hand sanitizers, missing dry wall, missing flooring, peeled wallpaper, and cove base and missing tiles noted.

3) The Staff Development Coordinator/Designee will provide re-education to facility staff on a Clean and Homelike Environment and notification of maintenance and housekeeping staff of issues with cleanliness or environment such as but not limited to mounted hand sanitizers, missing dry wall, missing flooring, peeled wallpaper, and cove base and missing tiles.

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 08/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 584	Continued From page 29	F 584		

A review of the comprehensive care plan dated 6/20/23, revealed, "FOCUS: Resident is at risk for falls. INTERVENTIONS: Create a safe environment; floors clear of clutter, clean up spills, adequate lighting. Resident has poor/ impaired vision. Make sure that room has adequate lighting."

On 8/8/23 at 3:30 PM, an interview was conducted with CNA (certified nursing assistant) #2. When shown Resident #129's room with broken dry wall, peeled wallpaper and no tiles in doorway between resident room/ bathroom and asked if this was a clean, homelike environment, CNA #2 stated, no, this is not clean or homelike.

On 8/9/23 at 10:15 AM, an interview was conducted with OSM (other staff member) #3, the maintenance director. When shown Resident #129's room with broken dry wall, peeled wallpaper and no tiles in doorway between resident room/bathroom and asked if this was a safe, sanitary environment, OSM #3 stated, no, it is not. When asked if this is a homelike environment for the resident, OSM #3 stated, no it is not homelike.

On 8/14/23 at 4:00 PM, ASM (administrative staff member) #1, the administrator, ASM #4, the regional risk consultant, ASM #7, the director of nursing and ASM #8, the regional consultant was made aware of the findings.

According to the facility's "Homelike Environment" policy, "Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. The facility staff and

4) The Director of Maintenance and Director of Housekeeping and/or Designee will conduct a bi-weekly rounding of the facility to include resident rooms and bathrooms for cleanliness and environment to include but not limited to securely mounted hand sanitizers, missing dry wall, missing flooring, peeled wallpaper, and cove base and missing tiles. Variances will be addressed. These audits will be conducted weekly x 4 weeks, then monthly x 2 months. The findings of the audits will be submitted by the Administrator/Designee to the QAPI Committee for review and recommendation monthly for 3 months or ongoing until compliance sustained.

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 08/16/2023

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F 584 Continued From page 30 F 584

management maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include clean, sanitary and orderly environment and pleasant, neutral scents."

No further information was provided prior to exit.
2. The facility staff failed to provide a clean bathroom in the bathroom between rooms 222 and 223 on the Westham unit.

On 8/7/23 at 12:50 p.m., observation was made of the bathroom between rooms 222 and 223. The toilet was full to the brim with dark brown liquid and feces.

On 8/7/23 at 4:15 p.m., the top of the toilet seat in this bathroom was smeared with brown feces covering approximately sixty percent of the seat.

On 8/8/23 at 7:58 a.m., underneath the toilet seat in this bathroom, the toilet rim had brown feces smeared on it. The toilet bowl had a large amount of dark brown flecks that had settled to the bottom of the bowl.

On 8/8/23 at 10:30 a.m., LPN (licensed practical nurse) #6, the unit manager, and OSM #15, the district manager of environmental services, observed the bathroom and were interviewed. OSM #15 stated it looked like the toilet had plumbing issues that had caused it to overflow. He stated: "Debris comes up and overflows and leaves more debris. It needs cleaning." LPN #6 stated every staff member who is in and out of the room should be checking the condition of the bathroom, especially one that is shared by four residents. He added: "I am sure the aides are going in there frequently." When asked if the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495272	A. BUILDING ______ B. WING ______	C 08/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 31 bathroom was in homelike condition for resident used, both LPN #6 and OSM #15 stated it was not. On 8/14/23 at 4:01 p.m., ASM (administrative staff member) #1, the administrator, ASM #4, the regional risk consultant, ASM #8, the regional consultant, and ASM #7, the director of nursing, were informed of these concerns. No further information was provided prior to exit.	F 584		
F 622 SS=E	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the	F 622		9/26/23

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 08/16/2023

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

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

F 622 Continued From page 32 F 622

resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
(F) The facility ceases to operate.
(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.
(i) Documentation in the resident's medical record must include:
(A) The basis for the transfer per paragraph (c)(1)(i) of this section.
(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).
(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by-
(A) The resident's physician when transfer or

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 08/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 622	Continued From page 33 discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to provide, to the receiving facility, the required documents for four of 57 residents in the survey sample, Resident #155, #508, #3 and #106. The findings include: 1. For Resident #155, the facility staff failed to send the comprehensive care plan with the resident upon transfer to the hospital on 5/14/2023. The nurse's note dated 5/14/2023 at 7:26 a.m. documented, "At 0530 (5:30 a.m.) patient was noted unresponsive to verbal stimuli and sternum	F 622	F622 Transfer and Discharge Requirements SS=E Resident #155 was discharged from the facility on 5/14/23. Resident #508 was discharged from the facility on 3/27/23. Resident #3 Care plan is sent now sent with resident when transferred to hospital.	

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 08/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 622	Continued From page 34 rub...EMS [emergency medical services] was called and transported out of facility via stretcher. Hospital location unknown at time of departure..." The "Acute Care Transfer Document Checklist" dated 5/14/2023, failed to evidence any notation related to the care plan being sent to the hospital with the resident. An interview was conducted with LPN (licensed practical nurse) #4 on 8/9/2023 at 12:33 a.m. When asked what documents are sent with the resident upon transfer to the hospital, LPN #4 stated she sends the medication administration record, transfer sheet, DNR form, bed hold policy, list of doctor orders and a copy of her last nurse's note. LPN # 4 was asked if she sends the care plan with the resident, LPN # 4 stated, she does not usually send the care plan. When asked where she documents what documents are sent with the resident, LPN # 4 stated she documents in the nurse's note or on the SBAR (situation, background, assessment, and response) forms. The facility policy, "Transfer or Discharge, Facility-Initiated," documented in part, "Information Conveyed to Receiving Provider ... 1. Should a resident be transferred or discharged for any reason, the following information is communicated to the receiving facility or provider: a. The basis for the transfer or discharge. (1) If the resident is being transferred or discharged because his or her needs cannot be met at the facility, documentation will include: a) the specific resident needs that cannot be met. b) this facility's attempt to meet those needs; and c) the receiving facility's service(s) that are available to meet those needs.	F 622	Resident #106 was discharged from the facility on 8/21/23. LPN #4 was re-educated by the Staff Development Coordinator/Designee on the Transfer Discharge requirements to include sending the receiving facility a copy of the comprehensive care plan. Current residents who are transferred from the facility to another receiving Healthcare facility have the risk of being affected by this practice. An audit was conducted of residents that were transferred from the facility in the last 7 days by Unit Manager/Designee to validate the comprehensive care plan was included in the transfer/discharge packet with no further variance from policy noted. Licensed Nurses were re-educated by the Staff Development Coordinator/Designee on the Transfer Discharge requirements to include sending the receiving facility a copy of the comprehensive care plan. The Director of Nurse/Designee will complete a review of 3 resident transfers to the hospital per week to validate the appropriate documentation to include	

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 08/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 622	Continued From page 35 b. Contact information of the practitioner responsible for the care of the resident. c. Resident representative information including contact information. d. Advance directive information. e. All special instructions or precautions for ongoing care, as appropriate such as: (1) treatments and devices (oxygen, implants, IVs, tubes/catheters); (2) transmission-based precautions such as contact, droplet, or airborne. (3) special risks such as risk for falls, elopement, bleeding, or pressure injury; and/or (4) aspiration precautions. f. Comprehensive care plan goals; and g. All other information necessary to meet the resident's needs, including but not limited to: (1) resident status, including baseline and current mental, behavioral, and functional status, (2) recent vital signs. (3) diagnoses and allergies. (4) medications (including when last received); (5) most recent relevant labs, other diagnostic tests, and recent immunizations. (6) a copy of the resident's discharge summary; and (7) any other documentation, as applicable, to ensure a safe and effective transition of care." ASM (administrative staff member) #1, the administrator, ASM #4, the regional risk consultant, and ASM #6, the clinical care consultant, were made aware of the above finding on 8/9/2023 at 5:30 p.m. No further information was provided prior to exit. 2. For Resident #508, the facility staff failed to send the comprehensive care plan with the resident upon transfer to the hospital on 3/27/23.	F 622	comprehensive care plan was sent with the resident. Variances will be addressed. These audits will be conducted weekly x 4 weeks, then monthly x 2 months. The findings of the audits will be submitted by the DON/Designee to the QAPI Committee for review and recommendation monthly for 3 months or ongoing until compliance sustained.	

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 08/16/2023

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F 622	Continued From page 36	F 622		

There was no evidence of required clinical documents sent with the resident to the hospital on 3/27/23.

A review of the nursing note dated 3/27/23 at 3:38 AM, revealed, "...At 2:40am Resident complained of chest pain...Ordered Resident to be sent to E.R. [emergency room]. RP [responsible party] aware. Resident sent to hospital. Transported via 911 at 3:30 am."

An interview was conducted on 8/9/23 at 12:33 PM, with LPN (licensed practical nurse) #4. When asked what documents are sent with the resident upon transfer to the hospital, LPN (licensed practical nurse) #4 stated she sends the medication administration record, transfer sheet, DNR (do not resuscitate) form, bed hold policy, list of MD (physician) orders and a copy of her last nurse's note. LPN # 4 was asked if she sends the care plan with the resident, LPN # 4 stated, she does not usually send the care plan. When asked where she documents what documents are sent with the resident, LPN # 4 stated she documents in the nurse's note or on the SBAR (situation, background, assessment and response) forms.

On 8/15/23 at 5:00 PM, ASM (administrative staff member) #1, the administrator, ASM #4, the regional risk consultant, ASM #5, the regional director of case management, ASM #6, the clinical care consultant, ASM #7, the director of nursing and ASM #8, the regional consultant was made aware of the findings.

A review of the facility's "Transfer-Discharge" policy, revealed, "Information Conveyed to

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 08/16/2023

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

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F 622	Continued From page 37 Receiving Provider: Should a resident be transferred or discharged for any reason, the following information is communicated to the receiving facility or provider: a. The basis for the transfer or discharge; (1) If the resident is being transferred or discharged because his or her needs cannot be met at the facility, documentation will include: a) the specific resident needs that cannot be met; b) this facility's attempt to meet those needs; and c) the receiving facility's service(s) that are available to meet those needs; b. Contact information of the practitioner responsible for the care of the resident; c. Resident representative information including contact information; d. Advance directive information; e. All special instructions or precautions for ongoing care, as appropriate such as: (1) treatments and devices (oxygen, implants, IVs, tubes/catheters); (2) transmission-based precautions such as contact, droplet, or airborne; (3) special risks such as risk for falls, elopement, bleeding, or pressure injury; and/or (4) aspiration precautions; f. Comprehensive care plan goals; and g. All other information necessary to meet the resident's needs, including but not limited to: (1) resident status, including baseline and current mental, behavioral, and functional status, (2) recent vital signs; (3) diagnoses and allergies; (4) medications (including when last received); (5) most recent relevant labs, other diagnostic tests, and recent immunizations; (6) a copy of the resident's discharge summary; and	F 622		

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 08/16/2023

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

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F 622 Continued From page 38 F 622

(7) any other documentation, as applicable, to ensure a safe and effective transition of care.

No further information was provided prior to exit.

3. For Resident #3, the facility staff failed to send the comprehensive care plan with the resident upon transfer to the hospital on 7/21/23.

There was no evidence of required clinical documents sent with the resident to the hospital on 7/21/23.

A review of the physician progress note dated 7/21/23 at 7:36 PM, revealed, "...patient was seen staring and not responding and suspected to be postictal. She returned to the room to check blood sugar and pt was noted to have 2 tonic-clonic seizures. She was transferred to the ED [emergency room] for seizures."

An interview was conducted on 8/9/23 at 12:33 PM, with LPN (licensed practical nurse) #4. When asked what documents are sent with the resident upon transfer to the hospital, LPN (licensed practical nurse) #4 stated she sends the medication administration record, transfer sheet, DNR (do not resuscitate) form, bed hold policy, list of MD (physician) orders and a copy of her last nurse's note. LPN # 4 was asked if she sends the care plan with the resident, LPN # 4 stated, she does not usually send the care plan. When asked where she documents what documents are sent with the resident, LPN # 4 stated she documents in the nurse's note or on the SBAR (situation, background, assessment and response) forms.

On 8/14/23 at 4:00 PM, ASM (administrative staff

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 08/16/2023

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

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F 622	Continued From page 39	F 622		

member) #1, the administrator, ASM #4, the regional risk consultant, ASM #7, the director of nursing and ASM #8, the regional consultant was made aware of the findings.

No further information was provided prior to exit.

4. For Resident #106, the facility staff failed to send the comprehensive care plan with the resident upon transfer to the hospital on 6/29/23.

There was no evidence of required clinical documents sent with the resident to the hospital on 6/29/23.

A review of the nursing progress note dated 6/29/23 at 9:43 PM, revealed, "Resident was sent to ED (emergency department) by daughter. 911 was called by daughter because resident was having crying spells, and complained of pain in her back, legs and sacrum. Ambulance arrived in unit at 4:00 PM. Transported resident via stretcher."

An interview was conducted on 8/9/23 at 12:33 PM, with LPN (licensed practical nurse) #4. When asked what documents are sent with the resident upon transfer to the hospital, LPN (licensed practical nurse) #4 stated she sends the medication administration record, transfer sheet, DNR (do not resuscitate) form, bed hold policy, list of MD (physician) orders and a copy of her last nurse's note. LPN # 4 was asked if she sends the care plan with the resident, LPN # 4 stated, she does not usually send the care plan. When asked where she documents what documents are sent with the resident, LPN # 4 stated she documents in the nurse's note or on the SBAR (situation, background, assessment and

F 622

Continued From page 40

response) forms.

On 8/14/23 at 4:00 PM, ASM (administrative staff member) #1, the administrator, ASM #4, the regional risk consultant, ASM #7, the director of nursing and ASM #8, the regional consultant was made aware of the findings.

No further information was provided prior to exit.

F 641 SS=D

Accuracy of Assessments
CFR(s): 483.20(g)

Completion date: 9/26/23

§483.20(g) Accuracy of Assessments.
The assessment must accurately reflect the resident's status.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and clinical record review, the facility staff failed to maintain an accurate MDS (minimum data set) assessment for one of 57 residents in the survey sample, Resident #86.

The findings include:

For Resident #86 (R86), the facility staff failed to accurately code the resident as having an external urinary catheter on the quarterly MDS with an ARD (assessment reference date) of 7/17/23.

On 8/7/23 at 12:37 p.m., 8/8/23 at 7:27 a.m., 8/9/23 at 4:18 p.m., and 8/10/23 at 7:50 a.m., R86 was observed lying in bed with an external urinary catheter draining to a collection canister.

A review of R86's clinical record failed to reveal a physician's order for an external urinary catheter.

Provider's Plan of Correction:

F641 Accuracy of Assessment

SS=D

Resident # 86□s quarterly MDS with an ARD of 7/17/23 was modified to include the use of an external urinary catheter. Resident # 86 orders were updated to include the use of an external urinary catheter.

The Regional MDS Clinical Consultant/Designee provided re-education to RN #3 (the facility MDS Coordinator) on coding accuracy to include external urinary catheters.

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 08/16/2023

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CANTERBURY REHABILITATION AND HEALTHCARE CENTER	1776 CAMBRIDGE DRIVE RICHMOND, VA 23238

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F 641	Continued From page 41 A review of section H100- bladder and bowel appliances of R86's quarterly MDS with an ARD of 7/17/23, revealed the resident was coded as having an indwelling urinary catheter and not coded as having an external urinary catheter. A review of section H100-bladder and bowel appliances of the modified quarterly MDS with an ARD of 7/17/23 revealed the resident was not coded as having any urinary catheter. On 8/10/23 at 1:57 p.m., an interview was conducted with RN (registered nurse) #3 (the MDS coordinator). RN #3 stated R86's external urinary catheter should be coded as an external catheter on the MDS assessment. RN #3 stated she references the CMS (Centers for Medicare and Medicaid Services) RAI (Resident Assessment Instrument) manual when completing MDS assessments. On 8/11/23 at 8:14 a.m., an interview was conducted with LPN (licensed practical nurse) #6. LPN #6 stated R86 has had the external urinary catheter for at least a few months. The CMS RAI manual defined an external urinary catheter as a receptacle pouch that fits around the labia majora for females and connected to a drainage bag. On 8/11/23 at 9:57 a.m., ASM (administrative staff member) #1 (the administrator) and ASM #4 (the regional risk consultant) were made aware of the above concern.	F 641	Current Residents who reside at Canterbury Rehabilitation and Healthcare and utilize an external urinary catheter have the potential to be affected by this practice. A list of residents that utilize external urinary catheters was obtained and coding was reviewed for their last quarterly MDS for accuracy. No further variances were noted. The Regional MDS Clinical Consultant/Designee provided re-education to the licensed nurses that complete the MDS on coding accuracy to include external urinary catheters. An audit will be completed of 3 resident quarterly MDS weekly to validate coding accuracy of appliances to include external catheters. Variances will be addressed. These audits will be conducted weekly x 4 weeks, then monthly x 2 months. The findings of the audits will be submitted by the Administrator/Designee to the QAPI Committee for review and recommendation monthly for 3 months or ongoing until compliance sustained.	
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care	F 655		9/26/23

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 08/16/2023

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F 655	Continued From page 42	F 655		

Planning
§483.21(a) Baseline Care Plans
§483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must-
(i) Be developed within 48 hours of a resident's admission.
(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-
(A) Initial goals based on admission orders.
(B) Physician orders.
(C) Dietary orders.
(D) Therapy services.
(E) Social services.
(F) PASARR recommendation, if applicable.

§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-
(i) Is developed within 48 hours of the resident's admission.
(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).

§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:
(i) The initial goals of the resident.
(ii) A summary of the resident's medications and dietary instructions.
(iii) Any services and treatments to be administered by the facility and personnel acting

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 08/16/2023

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

F 655 Continued From page 43

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, clinical record review, and facility document review, it was determined that the facility staff failed to develop and/or implement the baseline care plan for one of 57 residents in the survey sample, Resident #160.

The findings include:

1. For Resident #160 (R160), the facility staff failed to A) implement the care plan to provide non-pharmacological interventions prior to administration of as needed pain medications, B) implement the care plan to monitor for adverse effects of anticoagulant use and C) develop a care plan for diabetes and the use of insulin.

R160 was admitted to the facility on 7/27/2023 with diagnoses that included but were not limited to Type 2 Diabetes Mellitus, major depressive disorder and pain, unspecified.

On the admission assessment for R160 dated 7/27/2023 the resident was assessed as being alert and oriented to person, place and time. The assessment documented R160 being cognitively able to report pain, having pain less than weekly with preferred pain relief measures of narcotic pain relievers.

The progress notes for R160 documented in part, - "8/2/2023 9:37 a.m. Initial Navigation Guide Meeting... Notified that in approx 2 weeks a comprehensive care plan will be held."

F 655

F655 Baseline Care Plan

SS=D

Resident #160 Care Plan and MAR were updated to include Non-Pharmacological Interventions prior to the use of unscheduled pain medication administration, Anticoagulant side effect monitoring, and Diabetes and the use of insulin.

LPN # 6, LPN#7 were re-educated by the Staff Development Coordinator / Designee on Development of the Base line Care Plan to include but not limited to updating the resident□s plan to reflect implementing non-pharmacological interventions prior to the use of unscheduled pain medication administration, anticoagulant side effect monitoring, and diabetes diagnosis and the use of insulin for resident that require diabetes management.

Residents that received unscheduled pain medication, are on anticoagulant medication and/or have diabetes/receive insulin have the potential to be affected. An audit was conducted by the Unit Manager/Designee of current residents who receive unscheduled pain medication, are on anticoagulants, diabetic and who receive insulin to

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 08/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 655	Continued From page 44 The baseline care plan for R160 documented in part, - "I have pain and/or potential for pain r/t (related to) being a dialysis patient. Date Initiated: 07/27/2023." Under "Interventions" it documented in part, "...Encourage me to try non-pharmacological interventions for pain relief as applicable e.g. positioning, relaxation therapy, bathing, heat and cold application, muscle stimulation, ultrasound. Date Initiated: 07/27/2023..." - "I am on anticoagulant therapy. Date Initiated: 07/28/2023." Under "Interventions" it documented in part, "... Monitor/record/report PRN [as needed] s/sx [signs/symptoms] of anticoagulant complications: blood tinged or frank blood in urine, black tarry stools, dark or bright red blood in stools, bruising, sudden severe headaches, nausea, vomiting, muscle joint pain, lethargy, blurred vision, SOB [shortness of breath], loss of appetite, sudden changes in mental status, significant or sudden changes in vital signs. Date Initiated: 07/28/2023... Report to nurse PRN signs/symptoms of side effects including: bruising, bleeding, blood in urine, blood in stool, black tarry stools, nausea, vomiting, blurred vision, pain, shortness of breath, sudden changes in mental status, weakness, lethargy. Date Initiated: 07/28/2023." The care plan failed to evidence documentation of diabetes or the use of insulin. The physician orders for R160 documented in part, - "Hydrocodone-Acetaminophen Oral Tablet 10-325 MG (milligram) (Hydrocodone-Acetaminophen) Give 1 tablet by mouth every 4 hours as needed for Pain related	F 655	validate Baseline Care Plans were developed and/or implemented to meet the resident current care need. Variances were addressed as indicated. Licensed Nursing staff were re-educated by the Staff Development Coordinator / Designee on development and/or implementation of the Base line Care Plan to meet the resident needs to include but not limited to updating the residents□ plan to reflect implementing non-pharmacological interventions prior to the use of unscheduled pain medication administration, anticoagulant side effect monitoring, and diabetes diagnosis and the use of insulin for resident that require diabetes management. The Unit Manager/Designee will audit 3 residents who receive unscheduled pain medication, are on anticoagulants, diabetic and who receive insulin to validate Baseline Care Plans were developed and/or implemented to meet the resident current care need. Variances were addressed as indicated. These audits will be conducted weekly x 4 weeks, then monthly x 2 months. The findings of the audits will be submitted by the DON/Designee to the QAPI Committee for review and recommendation monthly for 3 months or	

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 08/16/2023

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

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F 655	Continued From page 45 to Pain, Unspecified (). Order Date: 07/27/2023." - "Percocet Oral Tablet 5-325 MG (Oxycodone w/Acetaminophen) Give 1 tablet by mouth every 6 hours as needed for pain. Order Date: 07/28/2023." - "Apixaban Oral Tablet 5 MG (Apixaban) Give 1 tablet by mouth two times a day for atrial fib (fibrillation). Order Date: 07/27/2023." - "Humalog KwikPen Subcutaneous Solution Peninjector 100 UNIT/ML (unit per milliliter) (Insulin Lispro) Inject as per sliding scale: if 151 - 199 = 2 UNITS; 200 - 249 = 4 UNITS; 250 - 299 = 6 UNITS; 300 - 349 = 8 UNITS; 350 - 399 = 10 UNITS; 400+ CALL MD (medical doctor) for further instructions, subcutaneously before meals and at bedtime related to Type 2 Diabetes Mellitus with Diabetic Chronic Kidney Disease (E11.22)." The eMAR (electronic medication administration record) for R160 dated 7/1/2023-7/31/2023 documented the Hydrocodone-Acetaminophen administered on 7/29/2023 at 1:36 a.m. for a pain level of 8, at 5:24 p.m. for a pain level of 7, at 9:24 p.m. for a pain level of 7, on 7/30/2023 at 3:27 a.m. for a pain level of 8, at 9:45 a.m. for a pain level of 8, at 4:58 p.m. for a pain level of 7 and on 7/31/2023 at 9:41 a.m. for a pain level of 9. The eMAR further documented the Percocet administered on 7/30/2023 at 9:09 p.m. for a pain level of 6 and on 7/31/2023 at 5:17 p.m. for a pain level of 0. The eMAR documented Apixaban administered to R160 each day as ordered beginning on 7/27/2023 at 5:00 p.m. The eMAR documented the Humalog sliding scale insulin administered as required for blood sugar reading each day beginning on 7/27/2023 at 4:00 p.m.	F 655	ongoing until compliance sustained.	

F 655 Continued From page 46 F 655

The eMAR failed to evidence documentation of non-pharmacologic interventions attempted prior to administration of the as needed pain medication. The eMAR failed to evidence documentation of monitoring for anticoagulant adverse effects.

The eMAR for R160 dated 8/1/2023-8/31/2023 documented the Hydrocodone-Acetaminophen administered on 8/1/2023 at 11:37 a.m. for a pain level of 3, on 8/4/2023 at 7:07 p.m. for a pain level of 4, on 8/5/2023 at 5:20 a.m. for a pain level of 6, at 5:42 p.m. for a pain level of 7, on 8/6/2023 at 11:43 a.m. for a pain level 0, at 5:48 a.m. for a pain level 7 and 8/8/2023 at 11:36 a.m. for a pain level of 3. The eMAR further documented the Percocet administered on 8/1/2023 at 4:36 p.m. for a pain level of 4, on 8/2/2023 at 9:15 a.m. for a pain level of 8, at 4:48 p.m. for a pain level of 4, on 8/3/2023 at 8:00 a.m. for a pain level of 5, at 2:30 p.m. for a pain level of 5, on 8/5/2023 at 11:00 a.m. for a pain level of 5, on 8/7/2023 at 11:00 a.m. for a pain level of 5, and on 8/8/2023 at 7:07 p.m. for a pain level of 5. The eMAR failed to evidence documentation of non-pharmacologic interventions attempted prior to administration of the as needed pain medication.
The eMAR documented Apixaban administered to R160 as ordered at 9:00 a.m. and 5:00 p.m. The eMAR documented the Humalog sliding scale insulin administered as required for blood sugar reading each day beginning on 8/1/2023 at 6:30 a.m., 11:00 a.m., 4:00 p.m. and 9:00 p.m.

The eMAR failed to evidence documentation of non-pharmacologic interventions attempted prior to administration of the as needed pain

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 08/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 655	Continued From page 47 medication. The eMAR failed to evidence documentation of monitoring for anticoagulant adverse effects. The progress notes including medication administration notes failed to evidence documentation of non-pharmacologic interventions attempted prior to administration of the as needed pain medication for the dates listed above with the exception of 7/30/2023 at 9:09 p.m. where repositioning was attempted prior to administration. The progress notes failed to evidence monitoring for anticoagulant adverse effects. On 8/8/2023 at 3:50 p.m., an interview was conducted with LPN (licensed practical nurse) #7. LPN #7 stated that the purpose of the care plan was to let the staff know about each resident and the particulars of the resident. She stated that the care plan should be implemented and they should be able to go to the care plan when they need to know what to do for that resident if not familiar with their care. She stated that anticoagulant monitoring was done every shift and was not sure where it was documented. LPN #7 reviewed R160's eMAR and stated that she was taking an anticoagulant but she did not see where there was documentation of monitoring for adverse effects on there. She stated that normally there was an area on the eMAR to document the monitoring. She stated that R160 was alert and oriented to person, place and time and requested pain medication when they needed it. LPN #7 stated that they attempted non-pharmacological interventions like repositioning prior to the medications. She stated that they did this to see if the non-pharmacological interventions would help	F 655		

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 08/16/2023

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CANTERBURY REHABILITATION AND HEALTHCARE CENTER	1776 CAMBRIDGE DRIVE RICHMOND, VA 23238

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F 655	Continued From page 48	F 655		

and to avoid the resident having to get pain medications. She stated that these were attempted each time prior to administration of the medication and should be documented in the medication administration notes.

On 8/9/2023 at 12:47 p.m., an interview was conducted with LPN #6, unit manager. LPN #6 stated that the staff monitored residents on anticoagulants for bleeding and it was documented on the eMAR with the medication. He stated that R160 was on the medication for atrial fibrillation and not ordered for monitoring of bleeding although they were still monitoring them for it.

On 8/9/2023 at 1:20 p.m., a follow up interview was conducted with LPN #6, unit manager. LPN #6 stated that the baseline care plan was triggered on the admission assessment and then the nurses went in and added to the care plan as needed. He reviewed R160's care plan and stated that there should be a care plan related to diabetes and insulin use however it would not be considered a baseline care plan and would be added by the MDS (minimum data set) staff because they add anything based on the resident diagnoses.

On 8/9/2023 at 1:28 p.m., an interview was conducted with RN (registered nurse) #3, MDS director. RN #3 stated that MDS staff conducted the baseline care plan meeting initially and then the comprehensive care plan seven days after the MDS assessment was completed. RN #3 stated that they added care plans that triggered in the assessment CAA's (care area assessment). She stated that on admission the nurse would create the baseline care plan based on the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495272	A. BUILDING ______ B. WING ______	C 08/16/2023

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

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F 655	Continued From page 49 admission assessment, the physician orders and the resident's diagnoses. She stated that the nurses on the floor would add the care plan related to diabetes and insulin use. The facility policy "Care plans, comprehensive Person-Centered" dated October 2022 documented in part, "A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident..." On 8/9/2023 at 5:40 p.m., ASM #1, the administrator, ASM #4, the risk consultant and ASM #6, the clinical care consultant were made aware of the concern. No further information was provided prior to exit.	F 655		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and	F 656		9/26/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 656	Continued From page 50 (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to develop and/or implement the comprehensive care plan for 19 of 57 residents in the survey sample, Resident #90, #144, #106, #358, #86, #74, #48, #37, #43, #409, 118, #5, #54, #149, #142, #133, #34, #63, and #127.	F 656	F656 Develop/Implement Comprehensive Care Plan SS=E Resident #90s Care Plan and MAR were updated to include monitoring for side effects for the use of anticoagulants.	

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F 656	Continued From page 51 The findings include: 1. For Resident #90, the facility staff failed to implement the comprehensive care plan for monitoring the resident for side effects for the use of anticoagulants, Resident #90 had diagnoses that included but were not limited to: atrial fibrillation, history of a stroke, diabetes, and status post left below the knee amputation. The comprehensive care plan dated, 3/13/2023, documented in part, "Focus: I am on anticoagulant therapy." The "Interventions" documented in part, "Monitor/record/report PRN (as needed) s/sx (signs and symptoms) of anticoagulant complications: blood tinges or frank blood in urine, black tarry stools, dark or bright red blood in stools, bruising, sudden severe headaches, nausea, vomiting, muscle joint pain, lethargy, blurred vision, SOB (shortness of breath), loss of appetite, sudden changes in mental status, significant or sudden changes in vital signs. Report to nurse PRN signs/symptoms of side effects including bruising, bleeding, blood in urine, blood in stool, black tarry stools, nausea, vomiting, blurred vision, pain, shortness of breath, sudden changes in mental status, weakness, lethargy." The physician order dated, 3/3/2023, documented, Apixaban Oral (1) tablet 5 mg (milligram); Give 1 tablet by mouth two times a day for blood thinner. The July and August 2023 MAR (medication administration record) documented the above	F 656	Resident #144s fall mat was placed at bedside as ordered. The podiatry consult was completed on 8/12/23. Urinary Catheter care is documented on the TAR and is completed as ordered. Resident #106 was discharged from the facility on 8/21/23. Resident #358 was discharged from the facility on 8/30/23. Resident #86s physician was notified that Levothyroxine sodium was not available for administration on 8/5/23 and 8/6/23. No new orders at this Resident #86 documentation to support Levothyroxine sodium administration is in the medical record with no further variances noted at this time. Resident # 74 is provided with incontinence care per the Care Plan with no further variances.	

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	495272	A. BUILDING ______ B. WING ______	C 08/16/2023

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

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F 656 Continued From page 52

order. The medication was documented as having been administered per the physician order. There was no documentation of monitoring of side effects for the use of an anticoagulant.

The July and August 2023 TAR (treatment administration record) failed to evidence documentation of monitoring of side effects for the use of an anticoagulant.

An interview was conducted with LPN (licensed practical nurse) #9 on 8/9/2023 at 3:09 p.m. When asked the purpose of the care plan LPN #9 stated it's how we give care to the patient. LPN #9 was asked if the care plan includes to monitor for side effects of anticoagulants, and it's not being documented, is that following the care plan, LPN #9 stated, no.

The facility policy, "Care Plans, Comprehensive Person - Centered," documented in part, "A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident."

ASM (administrative staff member) #1, the administrator, ASM #4, the regional risk consultant, and ASM #6, the clinical care consultant, were made aware of the above finding on 8/9/2023 at 5:30 p.m.

No further information was provided prior to exit.

(1) Eliquis (Apixaban) Apixaban is used help prevent strokes or blood clots in people who have atrial fibrillation (a condition in which the heart beats irregularly, increasing the chance of clots

F 656

Resident #48 is provided with incontinence care per the Care Plan with no further variances.

Resident #48 was evaluated for contractures to fingers by 8/23/23, and the Care Plan was updated to reflect flection contracture.

Resident #37 Care Plan was updated to include Trauma Informed Care.

Resident #37 has been seen by the Psychiatry team at the VA 8/14/23.

Resident #43 Care Plan was updated with resident preferences for offloading heels and implemented. Heels offloaded with HLSB as tolerated and pillows at times with resident preference /tolerance. Resident #43 Physician orders were updated to include HLSB as tolerated.

Resident #409 was discharged from the facility on 1/23/23.

Resident #118 POC documentation indicates turning, repositioning, and provision of incontinence care and barrier

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 08/16/2023

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F 656	Continued From page 53 forming in the body and possibly causing strokes) that is not caused by heart valve disease. Apixaban is also used to prevent deep vein thrombosis (DVT; a blood clot, usually in the leg) and pulmonary embolism (PE; a blood clot in the lung) in people who are having hip replacement or knee replacement surgery. Apixaban is also used to treat DVT and PE and may be continued to prevent DVT and PE from happening again after the initial treatment is completed. Apixaban is in a class of medications called factor Xa inhibitors. It works by blocking the action of a certain natural substance that helps blood clots to form. This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a613032.html 2. For Resident #144, the facility staff failed to implement the comprehensive care plan for fall mats as ordered, podiatry consults as ordered, and urinary catheter care. 2. a. Observations of Resident #144 on the following dates and times revealed no floor mats on either side of the bed: on 8/7/23 at 11:40 AM, 8/7/23 at 2:45 PM, 8/8/23 at 7:45 AM, 8/8/23 at 11:30 AM, and 8/10/23 9:15 AM. A review of the comprehensive care plan dated 4/27/23 and revised 6/11/23, revealed, "FOCUS: Resident is at risk for falls related to confusion, deconditioning/ weakness, history of falls, poor safety awareness. Resident has an ADL (activities of daily living) Self Care Performance Deficit related to Cognitive Impairment, Impaired Balance, Impaired Mobility...INTERVENTIONS: Bilateral fall mats..."	F 656	cream application per the Care Plan. C N A and Licensed nursing staff assigned to the resident on the dates outlined in the citation were re-educated by the Staff Development Coordinator/Designee on following the Care Plan for Pressure Ulcer Prevention, turning and repositioning, application of barrier cream as ordered by the physician, and documentation of the care in the medical record. Resident #5 was provided with Palm Guard. Resident #5 was provided with music at bedside per her listening preference. Resident #54 was reviewed with clinical provider with oxygen order revised to reflect current assessed need to include oxygen saturation monitoring every shift. Resident#149s care plan was updated to include monitoring for side effects of the usage of Mood Stabilizer. Resident #149 Lithium Level was completed on 6/27/23.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 656	Continued From page 54 An interview was conducted on 8/9/23 at 2:20 PM, with RN (registered nurse) #1. When asked about the fall mats for Resident #144, RN #1 observed there were no fall mats and stated he used to have fall mats, and believed they took them to give to another resident who was more active. When asked if fall mats were not in place, was the care plan being implemented, RN #1 stated, no, it is not being implemented. On 8/14/23 at 4:00 PM, ASM (administrative staff member) #1, the administrator, ASM #4, the regional risk consultant, ASM #7, the director of nursing and ASM #8, the regional consultant was made aware of the findings. According to the facility's "Comprehensive Care Plan" policy, "The comprehensive, person-centered care plan: a. includes measurable objectives and timeframes; b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including: (1) services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment; (2) any specialized services to be provided as a result of PASARR recommendations; and (3) which professional services are responsible for each element of care; c. includes the resident's stated goals upon admission and desired outcomes; d. builds on the resident's strengths; and e. reflects currently recognized standards of practice for problem areas and conditions." No further information was provided prior to exit.	F 656	Resident #142 Care Plan was revised to include monitoring of anticoagulation medication, and side effects monitoring. Resident #142 Orders were updated to include supplementary documentation for pain location and/or characteristic as well as non-pharmacological approach attempts prior to administration of unscheduled pain medication. Resident #133 MAR was updated to include evidence of pain location and/or pain characteristics and attempts at nonpharmacological interventions. Resident #133 MAR was updated to include anticoagulant side effect monitoring. Resident #34 Podiatry care/service was provided on 8/12/23. Resident #63 was discharged from the facility on 8/8/23.	

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

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

F 656

Continued From page 55

2. b. For Resident #144, the facility staff failed to implement the comprehensive care plan for podiatry consults as ordered.

Observation on 8/8/23 at 11:23 AM, of Resident #144's toenails, revealed the following: right foot - all toenails needed a trim being 1/4 - 1/2 second toe is pressing into the underneath of his big toe. Left foot - all nails needed a trim.

A review of the physician order, dated 4/24/23, revealed, "Podiatry Consult and Treatment."

A review of the comprehensive care plan dated 4/27/23 and revised 6/11/23, revealed, "FOCUS: Resident is at risk for falls related to confusion, deconditioning/ weakness, history of falls, poor safety awareness. Resident has an ADL (activities of daily living) Self Care Performance Deficit related to Cognitive Impairment, Impaired Balance, Impaired Mobility...Resident has Diabetes Mellitus. INTERVENTIONS: Bilateral fall mats...Podiatry consults for Diabetic Foot Care. Proper foot care daily. Avoid tight, pinching shoes. Report any redness, blistering, open areas to physician or designee promptly."

A review of the podiatry appointments for Resident #144, revealed, no appointment for April or May 2023. A review of the podiatry note for 6/26/23, revealed, "Toenails trim/care." There was no evidence of toenail care provided in July 2023.

An interview was conducted on 8/8/12 at 12:30 PM, with LPN (licensed practical nurse) #2, when asked who provides nail care for the residents, LPN #2 stated, if the resident is diabetic or has thick toenails, podiatry cuts the toenails.

F 656

Resident #127 was discharged from the facility on 8/17/23.

Current Residents have the potential to be affected by this practice.

An audit was completed by the Unit Manager/Designee of current residents that utilize anticoagulation therapy, to validate the development of a comprehensive Care Plan to include side effect monitoring.

An audit was completed for current residents by Unit Manager/Designee of current residents care planned for the utilization of fall mats to validate implementation.

An audit was completed for current residents by Unit Manager/Designee of current residents for the need for podiatry services as ordered/care planned.

An audit was completed for current residents by the Unit Manager/Designee that utilizes urinary catheters for documentation to support completion of catheter care.

An audit was completed for current

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	495272	A. BUILDING ______ B. WING ______	C 08/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 656	Continued From page 56 On 8/8/23 at 3:30 PM, an interview was conducted with CNA (certified nursing assistant) #2. When asked who provides toenail care, CNA #2 stated, "We look at them when they are getting bathed. If they are a diabetic or have thick toenails, we let the nurse know to put them on the podiatry list. If they are not diabetic or thick, we can trim them." An interview was conducted on 8/10/23 at 9:41 AM, with OSM (other staff member) #5, the director of social services. When asked about podiatry appointments, OSM #5 stated, if there are too many residents, they roll them over to the next visit and those residents are the priority. Podiatry did not come in July, so they are coming 8/16/23 and there is a second date they are coming in August. An interview was conducted on 8/9/23 at 2:20 PM, with RN (registered nurse) #1. When asked about the podiatry care for Resident #144, RN #1 stated, there was podiatry visit in June. When asked if podiatry consults for diabetic foot care was not consistently in place, was the care plan being implemented, RN #1 stated, no, it is not being implemented. On 8/14/23 at 4:00 PM, ASM (administrative staff member) #1, the administrator, ASM #4, the regional risk consultant, ASM #7, the director of nursing and ASM #8, the regional consultant was made aware of the findings. No further information was provided prior to exit. 2. c. For Resident #144, the facility staff failed to implement the comprehensive care plan for	F 656	residents by the Unit Manager/Designee that utilizes oxygen therapy to validate monitoring of pulse oximetry is completed per Order/Care Plan. An audit was completed for current residents by the Unit Manager/Designee of current residents with orders for low air mattresses to validate implementation per orders and care plan. An audit was completed for current residents by the Unit Manager/ Designee for the last 30 days of medications on hold, unavailable, or not given for variances in comprehensive care plan implementation and physician notification. An audit was completed for current residents by the Unit Managers/designee for variances in timeliness of incontinence care, care with respect/dignity, and for implementation of incontinence care, incontinence care products, turning and repositioning per the Care Plan. An audit will be conducted for current residents by the Unit Manager/Designee who have contractures to validate care plan interventions including splints are implemented as ordered. A trauma informed care review was completed for current residents by the Social Service Director/Designee to	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANTERBURY REHABILITATION AND HEALTHCARE CENTER	**1776 CAMBRIDGE DRIVE RICHMOND, VA 23238**

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

F 656

Continued From page 57
urinary catheter care.

A review of the physician order dated 6/27/23, revealed, "Foley Output every shift for Foley Cath related to obstructive and reflux uropathy."

A review of the comprehensive care plan dated 4/27/23 and revised 6/11/23, revealed, "FOCUS:...Resident has an indwelling urinary catheter related to Obstructive Uropathy. Resident has Diabetes Mellitus. INTERVENTIONS:... Provide urinary catheter care every shift and as needed..."

A review of the July and August 2023 TAR (treatment administration record) revealed urine output documented each shift, however there was no evidence of urinary catheter care documented for Resident #144 for July and August 2023.

An interview was conducted on 8/9/23 at 2:25 PM, with RN (registered nurse) #1. When asked where urinary catheter care is documented, RN #1 state, it is on the TAR. When asked if there is no documentation of urinary catheter care for Resident #144, was the care plan implemented, RN #1 stated, no, it is not being implemented.

An interview was conducted on 8/14/23 at 10:20 AM, with LPN (licensed practical nurse) #13. When asked were urinary catheter care is documented, LPN #13 stated, it is documented on the TAR. When asked if there is no documentation of urinary catheter care, was the care plan implemented, LPN #13 stated, no, it is not being implemented.

On 8/14/23 at 4:00 PM, ASM (administrative staff member) #1, the administrator, ASM #4, the

F 656

identify residents with the need for further development of the Care Plan, and psychological support systems to meet the resident needs.

An audit was completed for current residents by the Unit Manager/Designee to identify residents who are care planned for or requiring pressure injury preventions measures to validate intervention are recorded and in place.

An audit was completed for current residents by the Unit Manager/Designee of current residents requiring wound/skin treatment for current orders, for following the Care Plan for pressure injury prevention and documentation to support care and treatments were provided.

An audit was completed for current residents by the Unit Manager/Designee of current residents who utilize palm guards for implementation of device per the Plan of Care.

An audit was completed for current residents by the Activities Director/Designee of current residents activity Plan of Care for implementation of activities to meet the resident needs.

An audit was completed for current residents by the Respiratory Therapist/Unit Manager of oxygen administration orders, oxygen saturation level monitoring and documentation there of to meet the resident Plan of Care needs.

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 08/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 58 regional risk consultant, ASM #7, the director of nursing and ASM #8, the regional consultant was made aware of the findings. No further information was provided prior to exit. 3. For Resident #106, the facility staff failed to implement the comprehensive care plan for monitoring pulse oximetry as ordered. Resident #106 was admitted to the facility on 10/10/22 with diagnoses that include but are not limited to: COPD (chronic obstructive pulmonary disease), OSA (obstructive sleep apnea), and CHF (congestive heart failure). A review of the comprehensive care plan dated 7/2/23, revealed, "FOCUS: Resident requires supplemental oxygen. INTERVENTIONS: Change tubing as per facility protocol. 02 per MD order. Monitor vital signs, including pulse oximeter [oxygen saturation level], as ordered and clinically indicated. Monitor and document breath sounds, breathing patterns, and dyspnea with exertion or while lying flat. Report abnormal findings to physician or designee." A review of the physician orders dated 7/1/23, revealed, "Oxygen at 2-4 liters/minute via nasal cannula to attain SPO2 (peripheral capillary oxygen saturation) above 88% every 24 hours as needed for Shortness of Breath maintain SPO2 sat above 88%." A review of Resident #106's oxygen saturation summary revealed oxygen saturation were documented at least every 24 hours from 7/1/23 to 7/17/23. There was no oxygen saturation levels documented from 7/18/23 -8/10/23 under	F 656	An audit was completed for current residents by the Unit Manager/Designee of current residents on Psychotropic medication to ensure a comprehensive Care Plan is developed to include side effect monitoring, and labs as indicated. An audit was conducted for current residents by the Unit Manager/Designee for those residents who utilize prn pain medication for the documentation of location, characteristics, non-pharmacological intervention attempted prior to administration of prn pain medication and the development of the comprehensive Care Plan. An audit was completed for current residents by the Unit Manager/Designee of current residents for bathing/showering per resident preference assignment to the POC. Variances were addressed. The Staff Development Coordinator/Designee will provide nursing staff with the re-education on the Develop/Implement Comprehensive Care Plan to include but not limited to: Addressing utilization of anticoagulation therapy, to include side effect monitoring implementation of fall mats and fall prevention device as ordered, foot care, trimming of nails and the need for podiatry services as ordered/Care planned, Urinary catheter care, and documentation to	

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 08/16/2023

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

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

F 656 Continued From page 59

vital signs tab, TAR (treatment administration record) or progress notes.

On 8/9/23 at 2:15 PM, an interview was conducted with RN (registered nurse) #1. When asked the purpose of the care plan, RN #1 stated, it is to define the care for the patient. When asked if oxygen saturation/pulse oximeter as ordered are not evidenced in Resident #106's medical record, is the care plan being implemented, RN #1 stated, no, it is not implemented.

On 8/14/23 at 4:00 PM, ASM (administrative staff member) #1, the administrator, ASM #4, the regional risk consultant, ASM #7, the director of nursing and ASM #8, the regional consultant was made aware of the findings.

No further information was provided prior to exit.
4. For Resident #358 (R358), the facility staff failed to implement the resident's comprehensive care plan for a low air loss mattress.

R358's comprehensive care plan dated 1/2/23 documented, "The resident has a pressure ulcer or has the potential for pressure ulcer development r/t (related to) history of pressure ulcers, PVD (peripheral vascular disease) and immobility. Interventions: [low] Air Loss Mattress to bed at all times..."

On 8/7/23, 8/8/23 and 8/9/23, observations of R358 lying in bed were conducted. The resident was on a standard facility mattress and was not on an air loss mattress.

On 8/10/23 at 1:57 p.m., an interview was conducted with RN (registered nurse) #3. RN #3

F 656

support urinary catheter care is accomplished, Oxygen administration orders, pulse oximetry monitoring and documentation thereof to meet the resident current Plan of Care needs, Pressure Ulcer prevention, orders for low air mattresses, HLSB, Offloading and preventative measures, Administration of medications and documentation to support whether medication is given on hold, unavailable, or not given, physician notification, and timely obtainment of orders. Timely incontinence care, bathing/showering per resident preference, and the documentation of the care provided, use of splints/palm guards as ordered, Trauma Informed care and implementation of psychological support systems to meet the resident needs, obtaining timely wound/skin treatment orders, and following the Care Plan for pressure injury prevention, documentation to support care and treatments were provided, offering of Activities to meet the residents□ current needs per plan of care, psychotropic medication use are care planned to include side effect monitoring, and labs as indicated, and the need for the development of the comprehensive Care Plan for PRN pain medication usage, to include the documentation of location, characteristics, and non-pharmacological intervention attempts prior to administration of prn pain medication.

The DON/Designee will complete an audit

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 08/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 60 stated a resident's care plan should be reflective of the resident so it should be informative and a good picture of the resident to let staff know what's going on, what's needed, what the resident is at risk for, and what is current. RN #3 stated, "We always want to make sure we are doing the best for the resident. It's always an ongoing process for the IDT (interdisciplinary team)." RN #3 stated care plans should be implemented because the goal is to have what's best for the resident. On 8/14/23 at 4:06 p.m., ASM (administrative staff member) #1 (the administrator), ASM #4 (the regional risk consultant) and ASM #7 (the director of nursing) were made aware of the above concern. 5. For Resident #86 (R86), the facility staff failed to implement the resident's comprehensive care plan for thyroid replacement therapy. R86's comprehensive care plan dated 11/15/22 documented, "I have hypothyroidism. Give thyroid replacement therapy as ordered..." A review of 86's clinical record revealed a physician's order dated 4/1/23 for levothyroxine sodium 175 mcg (micrograms)- one tablet once a day for hypothyroidism. A review of R86's August 2023 MAR (medication administration record) revealed the physician's order for levothyroxine sodium. On 8/5/23 and 8/6/23, the MAR documented the code, "5=Hold." Nurses' notes dated 8/5/23 and 8/6/23 documented, "Med on order." Further review of nurses' notes and the August 2023 MAR failed to	F 656	of 3 residents to validate the development of the comprehensive Care Plan was completed per resident needs, orders, and preferences. Variances will be addressed. These audits will be conducted weekly x 4 weeks, then monthly x 2 months. The findings of the audits will be submitted by the DON/Designee to the QAPI Committee for review and recommendation monthly for 3 months or ongoing until compliance sustained.	

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 08/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 61	F 656		

reveal documentation that levothyroxine sodium was administered to R86 on 8/5/23 and 8/6/23.

On 8/10/23 at 1:57 p.m., an interview was conducted with RN (registered nurse) #3. RN #3 stated a resident's care plan should be reflective of the resident so it should be informative and a good picture of the resident to let staff know what's going on, what's needed, what the resident is at risk for, and what is current. RN #3 stated, "We always want to make sure we are doing the best for the resident. It's always an ongoing process for the IDT (interdisciplinary team)." RN #3 stated care plans should be implemented because the goal is to have what's best for the resident.

On 8/11/23 at 9:57 a.m., ASM (administrative staff member) #1 (the administrator) and ASM #4 (the regional risk consultant) were made aware of the above concern.

6. For Resident #74 (R74), the facility staff failed to follow the resident's care plan for incontinence care.

On the most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date of 6/23/23), R74 was coded as having no cognitive impairment for making daily decisions, having scored 15 out of 15 on the BIMS (brief interview for mental status). R74 was coded as requiring the extensive assistance of two staff members for toileting, and was coded as being always incontinent of both bowel and bladder.

On 8/7/23 at 3:38 p.m., the surveyor entered R74's room. CNA (certified nursing assistant) #10

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 08/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 62	F 656		

opened the door from the bathroom (shared with the two residents in the adjacent room), and stated: "I'm going to do this resident [pointing to a resident standing with her in the bathroom], then do him [pointing to Resident #48, R74's roommate], and them him [pointing to R74]. CNA #10 then closed the bathroom door. R74 was lying in his bed with the television on. He stated: "I have been waiting for an hour to get changed." He stated he was aware of needing to have his incontinence brief changed around 3:00 p.m., and he rang the bell. Another CNA whom he could not identify by name came in "a little after 3," (3:00 p.m.), cut his call light off, and told him it was "change of shift," and that someone else would have to come in and change him later. He stated: "No one has still come back in. I really need to be changed." He stated: "It certainly does not feel very good to be a grown man and need my pants changed."

On 8/7/23 at 3:45 p.m., seven staff members were observed standing at the desk for R74's unit. Two of the seven were tapping and scrolling on their cell phones.

On 8/7/23 at 4:12 p.m., CNA #10 began preparing R74 to have his incontinence brief changed.

A review of R74's care plan dated 6/25/23 revealed, in part: "I have urinary incontinence r/t (related to) physical limitations...provide incontinence care and apply moisture barrier as needed...check resident approximately every 2 hours and provide incontinence care as needed."

On 8/10/23 at 1:57 p.m., an interview was conducted with RN (registered nurse) #3. RN #3 stated a resident's care plan should be reflective

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 08/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 63	F 656		

of the resident so it should be informative and a good picture of the resident to let staff know what's going on, what's needed, what the resident is at risk for, and what is current. RN #3 stated, "We always want to make sure we are doing the best for the resident. It's always an ongoing process for the IDT (interdisciplinary team)." RN #3 stated care plans should be implemented because the goal is to have what's best for the resident.

On 8/14/23 at 11:59 a.m., LPN (licensed practical nurse) #7 was interviewed and stated a care plan tells us about the resident's needs for care. She stated it should include any treatment and services that are specific to a resident. She stated everyone is responsible for implementing the care plan, and that floor nurses and management staff are able to update care plans in real time.

On 8/14/23 at 4:01 p.m., ASM (administrative staff member) #1, the administrator, ASM #4, the regional risk consultant, ASM #8, the regional consultant, and ASM #7, the director of nursing, were informed of these concerns.

No further information was provided prior to exit.

7. For Resident #48 (R48), the facility staff failed to follow the care plan for incontinence care, and failed to develop a care plan for the resident's hand contractures.

7. a. On the most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 6/9/23, R48 was coded as being cognitively intact for making daily decisions, having scored 13 out of 15 on the

F 656 Continued From page 64 F 656

BIMS (brief interview for mental status). He was coded as requiring the extensive assistance of two staff members for toileting, as being frequently incontinent of bladder and always incontinent of bowel.

On 8/7/23 at 3:38 p.m., the surveyor entered R48's room. CNA (certified nursing assistant) #10 opened the door from the bathroom [shared with the two residents in the adjacent room], and stated: "I'm going to do this resident [pointing to a resident standing with her in the bathroom], then do him [pointing to R48]. CNA #10 then closed the bathroom door. R48 was sitting in his wheelchair, and the wheelchair was fully facing the door to the hallway. R48 was wearing only a shirt and incontinence briefs. There was a strong odor of feces surrounding R48. When asked how long he had been waiting to be changed, R48 stated: "It burns down there [pointing to his incontinence brief]."

On 8/7/23 at 3:45 p.m., seven staff members were observed standing at the desk for R48's unit. Two of the seven were tapping and scrolling on their cell phones.

On 8/7/23 at 4:00 p.m., CNA #10 began preparing R48 to have his incontinence brief changed.

A review of R48's care plan dated 6/12/23 revealed, in part: "I have urinary incontinence r/t (related to) physical limitations...Provide incontinence care...as needed...Check resident approximately every 2 hours and provide incontinence care as needed...I have bowel incontinence r/t (related to) physical incontinence...Provide incontinence care...as needed."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495272	A. BUILDING ______ B. WING ______	C 08/16/2023

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

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

F 656 Continued From page 65 F 656

7. b. On the most recent MDS, an annual assessment with an ARD of 6/9/23, R48 was coded as being impaired for range of motion in both left and right upper extremities.

On the following dates and times, R48 was observed in his room. In each observation, both R48's left and right hand were contracted, and there was no evidence of a device to treat the contracture in either hand: 8/7/23 at 3:38 p.m., 8/8/23 at 7:29 a.m. and 10:22 a.m.; and 8/9/23 at 3:45 p.m.

A review of R48's care plan dated 4/20/23 revealed no information related to the resident's hand contractures.

On 8/10/23 at 1:57 p.m., an interview was conducted with RN (registered nurse) #3. RN #3 stated a resident's care plan should be reflective of the resident so it should be informative and a good picture of the resident to let staff know what's going on, what's needed, what the resident is at risk for, and what is current. RN #3 stated, "We always want to make sure we are doing the best for the resident. It's always an ongoing process for the IDT (interdisciplinary team)." RN #3 stated care plans should be implemented because the goal is to have what's best for the resident.

On 8/14/23 at 11:59 a.m., LPN (licensed practical nurse) #7 was interviewed. She stated a care plan tells us about the resident's needs for care. She stated it should include any treatment and services that are specific to a resident. She stated everyone is responsible for implementing the care plan, and that floor nurses and management staff

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 08/16/2023

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

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

F 656 Continued From page 66

are able to update care plans in real time.

On 8/14/23 at 4:01 p.m., ASM (administrative staff member) #1, the administrator, ASM #4, the regional risk consultant, ASM #8, the regional consultant, and ASM #7, the director of nursing, were informed of these concerns.

No further information was provided prior to exit.

8. For Resident #37 (R37), the facility staff failed to develop a care plan for trauma informed care.

On the most recent MDS (minimum data set). an annual assessment with an ARD (assessment reference date) of 5/21/23, R37 was coded as being moderately impaired for making daily decisions, having scored 11 out of 15 on the BIMS (brief interview for mental status). He was scored a zero on the mood severity evaluation, indicating he had no symptoms of mood dysfunction during the look back period. He was coded as having demonstrated no behaviors during the look back period. R37 was admitted to the facility with diagnoses including depression, chronic PTSD (post-traumatic stress disorder) (1), and visual hallucinations.

A review of R37's clinical record revealed a progress note from a licensed clinical social worker who was no longer employed at the facility, OSM (other staff member) #17. The note was dated 7/19/22. A review of the note revealed, in part: "The patient was doing well today...He did state that he had some depression from his familial issues, but otherwise has been in a good mood...The psychotherapist and patient discussed focusing on positive thinking,

F 656

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 08/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 67	F 656		

especially when it concerns family. They resolved that the patient will be mindful when talking to family...The psychotherapist will monitor over the following weeks, continuing to build rapport...Treatment Plan Progress/Goals...This psychotherapist will work with the patient on establishing coping mechanisms to feel less depressed...This psychotherapist will work to engage patient in combating emotional distress and adjusting to the unit well. This psychotherapist will encourage use of mindfulness to reduce anxiety through deep breathing exercises...Prescribed Frequency: Weekly."

Further review of R37's clinical record revealed no evidence that R37 had received any counseling services since he was seen on 7/19/22.

A review of R37's care plan dated 11/27/22 revealed no information related to trauma informed services for R37.

On 8/10/23 at 1:57 p.m., an interview was conducted with RN (registered nurse) #3. RN #3 stated a resident's care plan should be reflective of the resident so it should be informative and a good picture of the resident to let staff know what's going on, what's needed, what the resident is at risk for, and what is current. RN #3 stated, "We always want to make sure we are doing the best for the resident. It's always an ongoing process for the IDT (interdisciplinary team)." RN #3 stated care plans should be implemented because the goal is to have what's best for the resident.

On 8/11/23 at 8:31 a.m., OSM #5, the director of

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 08/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANTERBURY REHABILITATION AND HEALTHCARE CENTER	**1776 CAMBRIDGE DRIVE RICHMOND, VA 23238**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 68	F 656		

Continued From page 68

social services, was interviewed. She stated her role in trauma informed care is limited to completing the assessments that are required for the MDSs. She stated: "We ask the questions about the resident's mood and if they have experienced any trauma." She stated she does not have a role in developing a care plan for trauma informed care, and was not sure who was responsible for that.

On 8/14/23 at 11:59 a.m., LPN (licensed practical nurse) #7 was interviewed. She stated a care plan tells us about the resident's needs for care. She stated it should include any treatment and services that are specific to a resident. She stated everyone is responsible for implementing the care plan, and that floor nurses and management staff are able to update care plans in real time.

On 8/14/23 at 4:01 p.m., ASM (administrative staff member) #1, the administrator, ASM #4, the regional risk consultant, ASM #8, the regional consultant, and ASM #7, the director of nursing, were informed of these concerns.

No further information was provided prior to exit.

Reference:
(1) "Post-traumatic stress disorder (PTSD) is a disorder that develops in some people who have experienced a shocking, scary, or dangerous event...Those who continue to experience problems may be diagnosed with PTSD. People who have PTSD may feel stressed or frightened, even when they are not in danger." This information is taken from the website https://www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd.

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 08/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANTERBURY REHABILITATION AND HEALTHCARE CENTER	**1776 CAMBRIDGE DRIVE RICHMOND, VA 23238**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 69	F 656		

9. For Resident #43 (R43), the facility staff failed to follow the care plan for pressure injury prevention.

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 5/2/23, R43 was coded as being at risk of developing pressure injuries, and as currently having a pressure injury.

On the following dates and times, R43 was observed sitting up in her bed with both heels in direct contact with pillows which had been placed underneath her feet: 8/7/23 at 12:35 p.m. and 4:16 p.m.; 8/8/23 at 10:39 a.m.; 8/9/23 at 11:01 a.m. and 4:20 p.m. There was no evidence of heel suspension boots for R43.

On 8/9/23 at 4:20 p.m., CNA (certified nursing assistant) #6 was observed standing at R43's bedside. When asked if R43's heels were currently being floated (elevated so they were not in contact with any surface), she stated: "No, her heels aren't floated." When asked why it is important to float this resident's heels, she stated the heels should be floated to prevent skin breakdown. When asked if she was aware of a heel lift device for the resident, she stated: "No. We just float them." She stated she usually rolls a pillow or uses a wedge to prevent the resident's heels from coming into direct contact with the bed or a pillow.

A review of R43's clinical record revealed the following order written 10/21/22: "Bilateral heel lift suspensions when in bed every shift."

A review of R 43's care plan dated 10/21/22

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 08/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 70	F 656		

revealed, in part: "Administer treatments as ordered...Heel lift boots to bilateral heels."

On 8/10/23 at 1:57 p.m., an interview was conducted with RN (registered nurse) #3. RN #3 stated a resident's care plan should be reflective of the resident so it should be informative and a good picture of the resident to let staff know what's going on, what's needed, what the resident is at risk for, and what is current. RN #3 stated, "We always want to make sure we are doing the best for the resident. It's always an ongoing process for the IDT (interdisciplinary team)." RN #3 stated care plans should be implemented because the goal is to have what's best for the resident.

On 8/14/23 at 11:59 a.m., LPN (licensed practical nurse) #7 was interviewed. She stated a care plan tells us about the resident's needs for care. She stated it should include any treatment and services that are specific to a resident. She stated everyone is responsible for implementing the care plan, and that floor nurses and management staff are able to update care plans in real time.

On 8/14/23 at 4:01 p.m., ASM (administrative staff member) #1, the administrator, ASM #4, the regional risk consultant, ASM #8, the regional consultant, and ASM #7, the director of nursing, were informed of these concerns.

No further information was provided prior to exit.

10. For Resident #409 (R409), the facility staff failed to follow the care plan for pressure injury treatment and prevention.

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 08/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 71	F 656		

On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 1/13/23, R409 was coded as being in a persistent vegetative state. He was coded as having two unstageable pressure injuries. Resident #409 was discharged from the facility on 1/13/23.

A review of R409's admission nursing assessment dated 1/6/23 revealed the resident had one pressure injury on admission, a sacral wound measuring 5 cm (centimeters) by 6 cm, with a depth of 0.3 cm.

A review of R409's baseline care plan dated 1/6/23 revealed, in part: "The resident has a pressure ulcer and is at risk for further development r/t (related to) immobility, bowel incontinence, admitted with an unstageable pressure ulcer on his sacrum ...Administer treatments as ordered and monitor for effectiveness." Further review of R409's clinical record failed to reveal treatment orders for this sacral wound until 1/9/23.

On 8/10/23 at 1:57 p.m., an interview was conducted with RN (registered nurse) #3. RN #3 stated a resident's care plan should be reflective of the resident so it should be informative and a good picture of the resident to let staff know what's going on, what's needed, what the resident is at risk for, and what is current. RN #3 stated, "We always want to make sure we are doing the best for the resident. It's always an ongoing process for the IDT (interdisciplinary team)." RN #3 stated care plans should be implemented because the goal is to have what's best for the resident.

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 08/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 72	F 656		

On 8/14/23 at 11:59 a.m., LPN (licensed practical nurse) #7 was interviewed. She stated a care plan tells us about the resident's needs for care. She stated it should include any treatment and services that are specific to a resident. She stated everyone is responsible for implementing the care plan, and that floor nurses and management staff are able to update care plans in real time.

On 8/14/23 at 4:01 p.m., ASM (administrative staff member) #1, the administrator, ASM #4, the regional risk consultant, ASM #8, the regional consultant, and ASM #7, the director of nursing, were informed of these concerns.

No further information was provided prior to exit.

11. For Resident #118 (R118), the facility staff failed to follow the care plan for pressure injury prevention.

On the most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 6/9/23, R118 was coded as requiring the extensive assistance of two staff members for bed mobility (turning/repositioning). He was coded as being at risk for developing a pressure injury, and having one unstageable pressure injury.

A review of R118's care plan dated 4/7/22 revealed, in part: "I have potential for pressure ulcer development...I need to turn/reposition at least every 2 hours, more often as needed...apply barrier cream after each incontinence care."

Further review of the clinical record revealed no evidence that R118 was turned and repositioned

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 08/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 73	F 656		

or had barrier cream applied on day shift on the following dates in June 2023: 6/1 through 6/16, 6/19 through 6/21, 6/23, 6/26 through 6/30; and in July 2023, 7/2 through 7/7, 7/7 through 7/11, 7/13, 7/14, 7/16 through 7/21, 7/24, 7/25, 7/27. and 7/28. The review revealed no progress notes related to the resident's refusal of care.

On 8/10/23 at 1:57 p.m., an interview was conducted with RN (registered nurse) #3. RN #3 stated a resident's care plan should be reflective of the resident so it should be informative and a good picture of the resident to let staff know what's going on, what's needed, what the resident is at risk for, and what is current. RN #3 stated, "We always want to make sure we are doing the best for the resident. It's always an ongoing process for the IDT (interdisciplinary team)." RN #3 stated care plans should be implemented because the goal is to have what's best for the resident.

On 8/14/23 at 11:59 a.m., LPN (licensed practical nurse) #7 was interviewed. She stated a care plan tells us about the resident's needs for care. She stated it should include any treatment and services that are specific to a resident. She stated everyone is responsible for implementing the care plan, and that floor nurses and management staff are able to update care plans in real time.

On 8/14/23 at 4:01 p.m., ASM (administrative staff member) #1, the administrator, ASM #4, the regional risk consultant, ASM #8, the regional consultant, and ASM #7, the director of nursing, were informed of these concerns.

No further information was provided prior to exit.

F 656 Continued From page 74 F 656

12. For Resident #5 (R5), the facility staff failed to follow the care plan for activities and palm guards.

12. a. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 7/22/23, R5 was coded as being moderately cognitively impaired for making daily decisions, and was coded as having impairment in range of motion for both left and right upper extremities.

On the following dates and times, R5 was observed in her bed, with no palm guard in her left hand: 8/7/23 at 12:24 p.m. and 4:14 p.m.; 8/8/23 at 7:55 a.m. and 10:20 a.m. On 8/9/23 at 4:13 p.m., R5 was observed in bed. She had a rolled washcloth in her left hand. At all observations, R5 had contractures in the fingers of her left hand.

A review of R5's care plan dated 12/8/22 revealed, in part: "I require assistive/adaptive device...resident to wear Left palm protector at all times, as tolerated with removal for hand hygiene and skin checks."

12. b. On the most recent annual MDS with an ARD of 3/9/23, R5 was coded as having expressed the following activities as "very important:" listening to music she likes, going outside when weather permits, and participating in religious services.

On the following dates and times, R5 was observed in her bed, with no music playing: 8/7/23 at 12:24 p.m. and 4:14 p.m.; 8/8/23 at 7:55 a.m. and 10:20 a.m.; and 8/9/23 at 4:13 p.m.

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 08/16/2023

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

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

F 656 Continued From page 75 F 656

A review of R5's care plan dated 1/2/23 revealed, in part: "I am dependent on staff for activities, cognitive stimulation, social interaction r/t (related to) I require assistance with activities/participation...I need 1 to 1 bedside/in-room visits and activities if unable to attend events."

On 8/10/23 at 1:57 p.m., an interview was conducted with RN (registered nurse) #3. RN #3 stated a resident's care plan should be reflective of the resident so it should be informative and a good picture of the resident to let staff know what's going on, what's needed, what the resident is at risk for, and what is current. RN #3 stated, "We always want to make sure we are doing the best for the resident. It's always an ongoing process for the IDT (interdisciplinary team)." RN #3 stated care plans should be implemented because the goal is to have what's best for the resident.

On 8/14/23 at 11:59 a.m., LPN (licensed practical nurse) #7 was interviewed. She stated a care plan tells us about the resident's needs for care. She stated it should include any treatment and services that are specific to a resident. She stated everyone is responsible for implementing the care plan, and that floor nurses and management staff are able to update care plans in real time.

On 8/14/23 at 4:01 p.m., ASM (administrative staff member) #1, the administrator, ASM #4, the regional risk consultant, ASM #8, the regional consultant, and ASM #7, the director of nursing, were informed of these concerns.

No further information was provided prior to exit.

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 08/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 76 13. For Resident #54 (R54), the facility staff failed to follow the care plan for oxygen administration. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 5/30/23, the resident was coded as receiving oxygen in the facility. On the following dates and times, R54 was observed in bed receiving oxygen through a nasal cannula via a concentrator at a rate of three liters per minute (3 lpm): 8/7/23 at 12:10 p.m. and 4:18 p.m. 8/8/23 at 10:38 a.m., and 8/9/23 at 11:14 a.m. and 12:27 a.m. A review of R54's orders revealed the following order dated 5/23/23: "O2 (oxygen) at 2 lpm for O2 sat (saturation) <90% (less than 90%)." A review of R54's August 2023 MAR (medication administration record) failed to reveal evidence that the resident's oxygen saturation was less than 90% without the supplemental oxygen therapy. A review of R54's care plan dated 5/31/23 revealed, in part: "I have altered respirator status...Administer oxygen as ordered." On 8/10/23 at 1:57 p.m., an interview was conducted with RN (registered nurse) #3. RN #3 stated a resident's care plan should be reflective of the resident so it should be informative and a good picture of the resident to let staff know what's going on, what's needed, what the resident is at risk for, and what is current. RN #3 stated, "We always want to make sure we are doing the	F 656		

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 08/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656		F 656		

Continued From page 77

best for the resident. It's always an ongoing process for the IDT (interdisciplinary team)." RN #3 stated care plans should be implemented because the goal is to have what's best for the resident.

On 8/14/23 at 11:59 a.m., LPN (licensed practical nurse) #7 was interviewed. She stated a care plan tells us about the resident's needs for care. She stated it should include any treatment and services that are specific to a resident. She stated everyone is responsible for implementing the care plan, and that floor nurses and management staff are able to update care plans in real time.

On 8/14/23 at 4:01 p.m., ASM (administrative staff member) #1, the administrator, ASM #4, the regional risk consultant, ASM #8, the regional consultant, and ASM #7, the director of nursing, were informed of these concerns.

No further information was provided prior to exit.
14. Facility staff failed to develop a comprehensive care plan for the use and monitoring of an antimanic medication for Resident #149.

A review of the clinical record revealed an order dated 6/16/23 for Lithium Carbonate 150 mg (milligrams) twice daily for schizoaffective disorder bipolar type.

Further review of the clinical record revealed an order dated 6/30/23 for Lithium Orotate 5 mg tabs and to administer 20 mg in the morning and 30 mg in the evening for bipolar disorder.

A review of the comprehensive care plan failed to reveal any evidence that the use, side effects,

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 08/16/2023

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

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

F 656 Continued From page 78 F 656

and monitoring for toxicity of Lithium was care planned.

On 8/14/23 at 12:18 PM, LPN #10 (Licensed Practical Nurse) was interviewed. She stated that there should be care plan for the use and monitoring of side effects and toxicity of Lithium.

On 8/15/23 at 9:24 AM, an interview was conducted with LPN #1. She stated that there should be care plan for the use and monitoring of side effects and toxicity of Lithium.

On 8/14/23 at 4:00 PM at an end-of-day meeting, ASM #1 (Administrative Staff Member) the Administrator, ASM #4 the Regional Risk Consultant, ASM #7 the Director of Nursing and ASM #8 the Regional Consultant, were made aware of the findings. No further information was provided by the end of the survey.

References:

(1) Lithium is used treat mania in people with bipolar disorder and for schizophrenia. Information obtained from https://medlineplus.gov/druginfo/meds/a681039.html

15. Facility staff failed to develop a comprehensive care plan for the use and monitoring of an anticoagulant medication for Resident #142.

A review of the clinical record revealed an order dated 6/9/23 for Enoxaparin (1) inject 40 mg (milligrams) subcutaneously daily to prevent blood clots.

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 08/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656		F 656		

Continued From page 79

A review of the comprehensive care plan failed to reveal any evidence that the use, side effects, and monitoring of an anticoagulant medication was care planned.

On 8/14/23 at 12:18 PM, LPN #10 (Licensed Practical Nurse) was interviewed. She stated that there should be a care plan for the use of an anticoagulant medication.

On 8/15/23 at 9:24 AM, an interview was conducted with LPN #1. She stated that there should be care plan for the use and monitoring of side effects of an anticoagulant medication.

On 8/14/23 at 4:00 PM at an end-of-day meeting, ASM #1 (Administrative Staff Member) the Administrator, ASM #4 the Regional Risk Consultant, ASM #7 the Director of Nursing and ASM #8 the Regional Consultant, were made aware of the findings. No further information was provided by the end of the survey.

References:

(1) Enoxaparin is used to prevent blood clots. Information obtained from https://medlineplus.gov/druginfo/meds/a601210.html

16. The facility staff failed to implement the comprehensive care plan related to (A) pain and (B) anticoagulant monitoring for Resident #133.

16. A. A review of the clinical record revealed the comprehensive care plan which included one dated 7/6/23 for "I have pain and/or potential for

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 08/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANTERBURY REHABILITATION AND HEALTHCARE CENTER	**1776 CAMBRIDGE DRIVE RICHMOND, VA 23238**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 80	F 656		

pain." This care plan included the intervention dated 5/1/23 for "Encourage me to try non-pharmacological interventions for pain relief as applicable e.g. positioning, relaxation therapy, bathing, heat and cold application, muscle stimulation, ultrasound."

A review of the clinical record revealed a physician's order dated 8/1/23 for Oxycodone (1) 5 mg (milligrams) one capsule every six hours as needed for moderate to severe pain.

A review of the August 2023 MAR (Medication Administration Record) revealed this medication was administered as follows:

8/1/23 at 8:19 PM
8/2/23 at 1:22 AM and 12:59 PM
8/3/23 at 5:29 AM
8/4/23 at 2:32 AM and 12:10 PM
8/5/23 at 12:00 AM and 9:00 PM
8/7/23 at 4:09 AM and 12:10 PM
8/8/23 at 10:41 PM
8/10/23 at 9:01 PM
8/11/23 at 2:03 AM
8/13/23 at 3:29 AM
8/14/23 at 4:35 AM

Further review of the clinical record failed to reveal evidence of pain location and/or pain characteristics, and/or attempts at non-pharmacological interventions.

On 8/14/23 at 12:18 PM, LPN #10 (Licensed Practical Nurse) was interviewed. She stated that given this resident's condition, the only non-pharmacological interventions that could really be offered is a change in position, which she stated the resident did not like to do. She

F 656

Continued From page 81

stated that the resident did not like to get up for anything else. She stated that pain location and characteristics and non-pharmacological interventions should be documented. She stated that if there was no evidence that non-pharmacological interventions were attempted, then the care plan was not followed.

On 8/14/23 at 4:00 PM at an end-of-day meeting, ASM #1 (Administrative Staff Member) the Administrator, ASM #4 the Regional Risk Consultant, ASM #7 the Director of Nursing and ASM #8 the Regional Consultant, were made aware of the findings. No further information was provided by the end of the survey.

References:
(1) Oxycodone is used to treat moderate to severe pain.
Information obtained from
https://medlineplus.gov/druginfo/meds/a682132.html

16. B. A review of the clinical record revealed an order dated 7/7/23 for Apixaban (1) 5 mg (milligrams) twice daily for the prevention of blood clots.

A review of the comprehensive care plan revealed one dated 5/9/23 for "Monitor/record/report PRN (as needed) s/sx (signs and symptoms) of anticoagulant complications: blood tinged or frank blood in urine, black tarry stools, dark or bright red blood in stools, bruising, sudden severe headaches, nausea, vomiting, muscle joint pain, lethargy, blurred vision, SOB (shortness of breath), loss of appetite, sudden changes in mental status,

F 656

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 08/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656		F 656		

Continued From page 82
significant or sudden changes in vital signs."

A review of the clinical record revealed that a weekly skin check was completed on 6/22/23 and then not again until 8/10/23. There were no weekly skin checks between these two dates to indicate monitoring for the use of an anticoagulant medication from 6/2/23 to 8/10/23.

On 8/14/23 at 12:18 PM, LPN #10 (Licensed Practical Nurse) was interviewed. She stated that the weekly skin checks would qualify as monitoring for signs of bruising related to the use of anticoagulant medication.

On 8/15/23 at 9:24 AM, an interview was conducted with LPN #1. She stated that skin checks was the only kind of monitoring she knew that could be done for signs and symptoms of bruising and bleeding related to the use of an anticoagulant medication, and that if they were not being done, then the care plan was not being followed.

On 8/14/23 at 4:00 PM at an end-of-day meeting, ASM #1 (Administrative Staff Member) the Administrator, ASM #4 the Regional Risk Consultant, ASM #7 the Director of Nursing and ASM #8 the Regional Consultant, were made aware of the findings. No further information was provided by the end of the survey.

References:

(1) Apixaban is used to prevent blood clots. Information obtained from https://medlineplus.gov/druginfo/meds/a613032.html

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 08/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANTERBURY REHABILITATION AND HEALTHCARE CENTER	**1776 CAMBRIDGE DRIVE RICHMOND, VA 23238**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 83 17. Facility staff failed to implement the comprehensive care plan related to grooming for Resident #34. Resident #34 had diagnoses that included "need for assistance with personal care." Of note, Resident #34 did not have a diagnosis of diabetes. On 8/08/23 at 11:55 AM, an observation was made of Resident #34's feet. The left foot big toenail was 1/2 to 3/4 inch long. On the right foot, all nails needed to be trimmed. The great toenail was 1/2 to 3/4 inch long. A review of the comprehensive care plan revealed one dated 11/1/22 for "I have an ADL (activities of daily living) Self Care Performance Deficit r/t (related to) Disease Process, External Devices/Medical Equipment." This care plan included an intervention dated 11/2/22 for "PERSONAL HYGIENE: I am dependent on staff for grooming/personal hygiene." A review of the clinical record revealed a physician's order dated 2/14/23 for "Podiatry consult and treatment as needed." A review of the clinical record failed to reveal any evidence of when the toenails were last trimmed. On 8/9/23 at 3:05 PM and on 8/14/23 at 5:00 PM, a request for evidence of all podiatry care/toenail care for Resident #34 since admission (11/1/22) was requested. A list was provided of residents who received podiatry care in June 2023, however Resident #34 was not on the list. No evidence was provided that Resident #34 had ever received any toenail care/podiatry services.	F 656		

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 08/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 84	F 656		

On 8/10/23 at 1:57 PM, an interview was conducted with RN #3 (Registered Nurse). RN #3 stated a resident's care plan should be reflective of the resident so it should be informative and a good picture of the resident to let staff know what's going on, what's needed, what the resident is at risk for, and what is current. RN #3 stated, "We always want to make sure we are doing the best for the resident. It's always an ongoing process for the IDT (interdisciplinary team)." RN #3 stated care plans should be implemented because the goal is to have what's best for the resident.

On 8/15/23 at 9:24 AM, an interview was conducted with LPN #1 (Licensed Practical Nurse) She stated that nail care is part of grooming, and if the resident is not diabetic, staff should attempt to trim the nails. She stated that if the nails are too thick, that they might be able to try and file them. She stated that they should have a podiatry consult and be seen by podiatry before they get too long. When asked if the care plan was followed, she stated that it was not.

On 8/14/23 at 4:00 PM at an end-of-day meeting, ASM #1 (Administrative Staff Member) the Administrator, ASM #4 the Regional Risk Consultant, ASM #7 the Director of Nursing and ASM #8 the Regional Consultant, were made aware of the findings. No further information was provided by the end of the survey.

18. For Resident #63 (R63), facility staff failed to develop a care plan to address pain.

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment

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 08/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 85	F 656		

reference date) of 05/21/2023, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact for making daily decisions.

The physician order for R63 documented in part, "Acetaminophen Tablet (1). Give 325 mg (milligrams) by mouth every 6 (six) hours as needed for pain not to exceed 3000mg per day. Order Date: 05/06/2022."

The eMAR (electronic medication administration record) for R63 dated July 2023 documented the physician's orders as stated above. The eMAR revealed that R63 received 325mgs of Acetaminophen with no evidence of non-pharmacological interventions being attempted or documentation of the location of R63's pain on 07/03/2023, 07/06/2023, 07/08/2023, 07/13/2023, 07/17/2023, 07/18/2023, 07/19/2023, 07/22/2023, 07/24/2023 and on 07/25/2023.

The eMAR (electronic medication administration record) for R63 dated August 2023 documented the physician's orders as stated above. The eMAR revealed that R63 received 325mgs of Acetaminophen with no evidence of non-pharmacological interventions being attempted or documentation of the location of R63's pain on 08/01/2023 and on 08/04/2023.

The nursing progress notes for R63 for the dates list above failed to evidence documentation of non-pharmacological interventions prior to the administration of Acetaminophen and the location of R63's pain.

Review R63's comprehensive care plan dated

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 08/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANTERBURY REHABILITATION AND HEALTHCARE CENTER	**1776 CAMBRIDGE DRIVE RICHMOND, VA 23238**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656		F 656		

Continued From page 86

01/21/2023 failed to evidence documentation to address R63's pain and documentation of pain interventions.

On 8/10/23 at 1:57 p.m., an interview was conducted with RN (registered nurse) #3, MDS coordinator. RN #3 stated a resident's care plan should be reflective of the resident so it should be informative and a good picture of the resident to let staff know what's going on, what's needed, what the resident is at risk for, and what is current. RN #3 stated, "We always want to make sure we are doing the best for the resident. It's always an ongoing process for the IDT (interdisciplinary team)." RN #3 stated care plans should be implemented because the goal is to have what's best for the resident. When asked about a care plan to address R63's pain RN # 3 stated that after reviewing his care plan there was no evidence that the care plan addressed R63's pain.

On 08/11/2023 at approximately 9:50 a.m., ASM (administrative staff member) #1, administrator and ASM #4, regional risk consultant, were made aware of the above findings.

No further information was provided prior to exit.

References:
(1) Used to relieve mild to moderate pain from headaches, muscle aches, menstrual periods, colds and sore throats, toothaches, backaches, and reactions to vaccinations (shots), and to reduce fever. This information was obtained from the website: https: https://medlineplus.gov/druginfo/meds/a681004.html.

F 656 Continued From page 87 F 656

19. For Resident #127 (R127), facility staff failed to implement the comprehensive care plan for bathing.

R127 was admitted with diagnoses that included but were not limited to Alzheimer's disease (1).

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 06/30/2023, the resident scored zero 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 R127 as requiring extensive assistance of one staff member for personal hygiene.

The facility's bathing POC (point of care) sheet for R127 dated February 2023 had blanks for the day shift (7:00 a.m. to 3:00 p.m.) on 02/14/2023, 02/15/2023, 02/16/2023 and on 02/23/2023.

The facility's bathing POC sheet for R127 dated March 2023 had a blank area for the day shift on (7:00 a.m. to 3:00 p.m.) on 03/10/2023 and documented "N/A (not applicable)" during the day shift on 03/10/2023, 03/11/2023, 03/19/2023 and on 03/26/2023.

The comprehensive care plan for R127 dated 06/17/2022 documented in part, "Focus. I have and ADL (activities of daily living) Self Care Performance Deficit. Date Initiated: 06/17/2022." Under "Interventions" it documented in part, "Provide me with short, simple instructions to promote independent bathing such as: Hold your washcloth in your hand. Put soap on your washcloth. Wash your face, etc. date Initiated: 06/22/2022."

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 08/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 88 On 8/10/23 at 1:57 p.m., an interview was conducted with RN (registered nurse) #3, MDS coordinator. RN #3 stated a resident's care plan should be reflective of the resident so it should be informative and a good picture of the resident to let staff know what's going on, what's needed, what the resident is at risk for, and what is current. RN #3 stated, "We always want to make sure we are doing the best for the resident. It's always an ongoing process for the IDT (interdisciplinary team)." RN #3 stated care plans should be implemented because the goal is to have what's best for the resident. On 08/15/2023 at approximately 2:26 p.m., an interview was conducted with LPN (licensed practical nurse) #1. After reviewing the POCs for R127's bathing and oral care for the dates listed above, LPN #1 stated that R127 did not receive bathing for the dates that were blank and coded as N/A. After informed of the care plan for R127, she was asked if the care plan was being followed for bathing. She stated that the care plan was not being followed. On 08/14/2023 at approximately 5:00 a.m., ASM (administrative staff member) #1, administrator, ASM #4, regional risk consultant, ASM #5, regional director of case management, ASM #6, clinical consultant, ASM #7, director of nursing, and ASM #8, regional consultant, were made aware of the above findings. No further information was provided prior to exit. References: (1) A brain disorder that seriously affects a person's ability to carry out daily activities) This	F 656		

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 08/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 89 information was obtained from the website: https://www.nlm.nih.gov/medlineplus/alzheimersdisease.html.	F 656		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to review and revise the	F 657	F657 Care Plan Timing and Revision SS=E	9/26/23

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 08/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 90 comprehensive care plan for four of 57 residents in the survey sample, Residents #95, #86, #358 and #510. The findings include: 1. For Resident #95 (R95), the facility staff failed to review and revise the resident's comprehensive care plan for bed rails. A review of R95's clinical record revealed a physician's order dated 10/6/20 for two grab bars (bed rails) to aide in positioning and mobility. R95's comprehensive care dated 10/22/20 failed to reveal documentation regarding bed rails. On 8/7/23 at 4:09 p.m., and 8/8/23 at 7:34 a.m., R95 was observed lying in bed with bilateral grab bars in the upright position. On 8/14/23 at 2:38 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated the purpose of the care plan is, "To give the care the patient needs; to personalize their care." LPN #1 stated the unit managers and nurses are responsible for updating care plans for anything that pertains to nursing. LPN #1 stated care plans should be reviewed and revised to include bed rails, "Because they [the residents] have to have consent for bed rails." On 8/14/23 at 4:06 p.m., ASM (administrative staff member) #1 (the administrator), ASM #4 (the regional risk consultant) and ASM #7 (the director of nursing) were made aware of the above concern. The facility policy titled, "Care Plans, Comprehensive Person-Centered" documented,	F 657	Resident #95 Resident Comprehensive Care Plan was revised to include the use of Bilateral Side Rails per the physician order. Resident #86 Resident Comprehensive Care Plan was revised to include use of external urinary catheter. Resident #358 was discharged from the facility on 8/30/23. Resident #510 Comprehensive Care Plan was revised to include current wound care needs / wound vac was discontinued. Current residents who utilize bedrails, use an external urinary catheter, develop pressure injuries and utilize a wound vac requiring revision of the care plan have the potential of being affected by this practice. An audit was accomplished by the Unit Manager/Designee on current residents who utilize side rails to validate the resident□s Care Plan reflects the use of bedrails. An audit was accomplished by the Unit Manager/Designee on current residents who utilize external catheters was completed to validate the resident□s Care Plan reflects the use of an external	

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 08/16/2023

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

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

F 657

Continued From page 91

"11. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change."

2. For Resident #86 (R86), the facility staff failed to review and revise the resident's comprehensive care plan for the use of an external urinary catheter.

On 8/7/23 at 12:37 p.m., 8/8/23 at 7:27 a.m., 8/9/23 at 4:18 p.m., and 8/10/23 at 7:50 a.m. R86 was observed lying in bed with an external urinary catheter.

A review of R86's comprehensive care plan dated 11/6/22 failed to reveal any documentation regarding an external urinary catheter.

On 8/10/23 at 1:57 p.m., an interview was conducted with RN (registered nurse) #3. RN #3 stated a resident's care plan should be reflective of the resident so it should be informative and a good picture of the resident to let staff know what's going on, what's needed, what the resident is at risk for, and what is current. RN #3 stated, "We always want to make sure we are doing the best for the resident. It's always an ongoing process for the IDT [interdisciplinary team]." RN #3 stated care plans should be reviewed and revised of the use of external urinary catheters.

On 8/15/23 at 5:06 p.m., ASM (administrative staff member) #1 (the administrator), ASM #4 (the regional risk consultant) and ASM #7 (the director of nursing) were made aware of the above concern.

3. For Resident #358 (R358), the facility staff failed to review and revise the resident's

F 657

catheter. An audit was accomplished by the Unit Manager/Designee on residents with current wound care to validate revision of the Comprehensive Care Plan has been accomplished to reflect the current residents need to include use of wound vac as indicated. Variances were addressed.

The Staff Development Coordinator provided re-education for the Licensed Nursing staff on the Care Plan Timing and Revision of the Care Plan with changes in the resident care needs to include side rails, catheter usage, and wound care to include wound vac use was completed.

The DON/Designee will complete an audit of 3 residents who utilize side rails to validate the resident s Care Plan reflects the use of bedrails. Audit will also include 3 residents who utilize external catheters to validate the resident s Care Plan reflects the use of an external catheter. In addition, an audit of 3 residents with current wound care orders will be completed to validate revision of the Comprehensive Care Plan has been accomplished to reflect the current residents need to include use of wound vac as indicated. Variances will be addressed. These audits will be conducted weekly x 4 weeks, then monthly x 2 months. The findings of the audits will be submitted by the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495272	A. BUILDING ______ B. WING ______	C 08/16/2023

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

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

F 657 Continued From page 92
comprehensive care plan when the resident developed pressure injuries on 2/21/23, 3/28/23 and 4/26/23.

A review of R358's clinical record revealed skin checks and wound reports that documented the resident developed pressure injuries on 2/21/23, 3/28/23 and 4/26/23. A review of R358's comprehensive care plan dated 1/2/23 failed to reveal the care plan was reviewed and revised for the pressure injuries that developed on 2/21/23, 3/28/23 and 4/26/23.

On 8/14/23 at 2:38 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated the purpose of the care plan is, "To give the care the patient needs; to personalize their care." LPN #1 stated the unit managers and nurses are responsible for updating care plans for anything that pertains to nursing. LPN #1 stated care plans should be reviewed and revised when a pressure injury is identified.

On 8/14/23 at 4:06 p.m., ASM (administrative staff member) #1 (the administrator), ASM #4 (the regional risk consultant) and ASM #7 (the director of nursing) were made aware of the above concern.
4. For Resident #510, the facility failed to revise the comprehensive care plan to include the use of a wound vac (1).

Resident #510 was observed in with wound vac in place on 8/7/23 at 12:00 PM.

A review of the comprehensive care plan dated 12/30/22 and revised 8/1/23, revealed, "FOCUS: Resident has a pressure ulcer or has the potential for pressure ulcer development related to

F 657
DON/Designee to the QAPI Committee for review and recommendation monthly for 3 months or ongoing until compliance sustained.

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 08/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 93	F 657		

immobility. INTERVENTIONS: Administer treatments as ordered and monitor for effectiveness. Offload my heels when in bed as tolerated using: (pillows). Monitor wound dressing during care to ensure it is intact and adhering. Report loose dressing to nurse. Resident need reminding/assistance to turn/reposition at least every 2 hours, more often as needed or requested. Keep resident's skin clean and moisturized as needed. Do not massage over bony prominences and use mild cleansers for peri-care and bathing."

A review of the physician orders dated 8/2/23, revealed, "SACRUM- Cleanse with 0.25% Dakin's solution. Apply black foam vac dressing to wound vac dressing to wound vac at 123mm Hg (millimeters of mercury) of suction. If VAC lose suction may apply Dakin's wet to dry dressing daily. One time a day every Tuesday, Thursday and Saturday."

On 8/9/23 at 2:15 PM, an interview was conducted with RN (registered nurse) #1. When asked the purpose of the care plan, RN #1 stated, it is to define the care for the patient. When asked if the wound vac should be included in the care plan, RN #1 stated, yes, it should.

On 8/10/23 at 1:57 p.m., an interview was conducted with RN #3. RN #3 stated a resident's care plan should be reflective of the resident so it should be informative and a good picture of the resident to let staff know what's going on, what's needed, what the resident is at risk for, and what is current. RN #3 stated, we always want to make sure we are doing the best for the resident. It's always an ongoing process for the IDT

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 08/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 94	F 657		

(interdisciplinary team). RN #3 stated care plans should be implemented because the goal is to have what's best for the resident.

On 8/14/23 at 4:00 PM, ASM (administrative staff member) #1, the administrator, ASM #4, the regional risk consultant, ASM #7, the director of nursing and ASM #8, the regional consultant was made aware of the findings.

A review of the facility's "Comprehensive Care Plan" policy, reveals, "The interdisciplinary team reviews and updates the care plan: a. when there has been a significant change in the resident's condition; b. when the desired outcome is not met; c. when the resident has been readmitted to the facility from a hospital stay; and d. at least quarterly, in conjunction with the required quarterly MDS assessment."

No further information was provided prior to exit.

Reference:
(1) Vacuum-assisted closure (VAC) is an alternative method of wound management, which uses the negative pressure to prepare the wound for spontaneous healing or by lesser reconstructive options. Method of VAC application includes thorough debridement, adequate haemostasis and application of sterile foams dressing. A fenestrated tube is embedded in the foam and wound is sealed with adhesive tape to make it air tight. The fenestrate tube is connected to a vacuum pump with fluid collection container. The machine delivers continuous or intermittent suction, ranging from 50 to 125 mmHg. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6739293/

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 08/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 95	F 658		
F 658 SS=D	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 observation, staff interview, facility document review and clinical record review, it was determined the facility staff failed to follow professional standards of practice for medication administration for two of 57 residents in the survey sample, Residents # 90 and #11. The findings include: 1. For Resident #90, the facility staff failed to administer insulin per the physician orders and failed to document what insulin was administered. The physician orders dated, 3/24/2023 documented, "Novolin R (regular) Flex Pen Solution Pen Injector 100 UNIT/ML (milliliters) (Insulin Regular Human) inject as per sliding scale: if 0 - 150 = 0; 151 - 199 = 1; 200 - 249 = 2; 251 - 299 = 3; 300 - 349 = 4; 350 - 399 = 5; 400 - 450 = 6; > (greater than) 450 give 8 units and inform attending, subcutaneously at bedtime for dm (diabetes) bedtime ssi (sliding scale insulin). The physician orders dated 3/24/2023 documented, ""Novolin R (regular) Flex Pen Solution Pen Injector 100 UNIT/ML (milliliters) (Insulin Regular Human) inject as per sliding scale: if 0 - 150 = 0 units; 151 - 199 = 2 units; 200 - 249 = 4 units; 250 - 299 = 6 units; 300 - 349 = 8	F 658	F658 Services Provided Meet Professional Standards SS=D Resident #90□s physician was notified of the elevated blood sugar levels on 8/2/23, 8/3/23, 8/7/23, and 8/8/23. No new orders at this time. LPN #9 was re-educated by the DON/Designee on Services Provided to Meet Professional Standards to include administration of medication per physician orders, notification of findings outside of ordered parameters, and documentation to support notification and medications that were administered. Resident #11□s clinical provider was made aware of cited occurrence, orders were reviewed and clarified with medication on hand to reflect ordered dose.	9/26/23

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 08/16/2023

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

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F 658 Continued From page 96

units; 350 - 399 = 10 units; 400+ CALL MD (medical doctor) FOR ORDERS; subcutaneously before meals for diabetes."

The August MAR (medication administration record) documented the above two orders. On 8/8/2023 at 2100 (9:00 p.m.) it was documented the blood sugar was 509. An "11" was documented in the box where the amount of the insulin administered was to be documented.

The August MAR documented the above two orders. On the following dates at 1600 (4:00 p.m.) the following was documented:
8/2/2023 - BS (blood sugar) was documented as 430. An "11" was documented in the box where the amount of the insulin administered was to be documented.
8/3/2023 - BS - was documented as 445. An "11" was documented in the box where the amount of the insulin administered was to be documented.
8/7/2023 - BS - was documented as 425. An "11" was documented in the box where the amount of the insulin administered was to be documented.
8/8/2023 - BS - was documented as 478. A "3" was documented in the box where the amount of the insulin administered was to be documented.

The chart codes on the MAR documented the following:
11 = Vitals Outside of Parameters.
3 = Absent from facility.

Review of the nurse's notes failed to evidence any documentation related to the resident's blood sugars, insulin or contact made with the doctor, per the physician orders.

The comprehensive care plan dated, 3/4/2023,

F 658

RN #2 was re-educated by the DON/Designee on Services Provided to Meet Professional Standards To include administration of medication per physician orders, communication to the physician when clarification is required. The 6 RIGHTS of medication administration. Right resident, right medication, right dosage, right time, right route, and right order.

Current residents who receive medications have the potential to be affected by this practice. An audit was completed of residents who have orders for sliding scale insulin was accomplished by the Unit Managers to validate notification to the physician was made and documentation is in place to support amount of insulin given in the medical record. Variances were addressed.

An audit was completed for residents on Lokelma single dose packs to validate order clarification obtained as needed and that the correct dosage is on hand and administered. Variances were addressed.

The Staff Development Coordinator/Designee will re-educate Licensed Nursing staff on Services

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 08/16/2023

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

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F 658 Continued From page 97

documented in part, "Focus: I have Diabetes Mellitus." The review of the interventions failed to evidence any documentation related to the administration of insulin.

An interview was conducted with LPN (licensed practical nurse) #9, the nurse that documented the above information, on 8/9/2023 at 3:09 p.m. The documentation was reviewed with LPN #9, and when asked what the "11" stood for, LPN #9 stated that the blood sugar was out of the parameters. LPN #9 was asked if she gave the resident insulin on 8/2/2023, LPN #9 stated she had given the resident 10 units. When asked if she called the physician, LPN #9 stated she had not contacted the physician. LPN #9 was asked if she administered insulin to the resident on 8/7/2023 at 4:00 p.m., LPN #9 stated she gave the resident 10 units that day. When asked if she called the doctor, she stated, no. LPN #9 was asked if the resident was out of the facility on 8/8/2023 at 4:00 p.m., LPN #9 stated, no, she must have clicked the wrong button. LPN #9 was asked how much insulin she gave the resident, LPN #9 stated, eight units and no, she didn't call the doctor. When asked if she was following the physician orders, LPN #9 stated no. LPN #9 was asked if she was allowed to give medications without a physician order, LPN #9 stated, no.

The facility policy, "Insulin Administration" documented in part, "Steps in the procedure (Insulin Injections via Syringe): 2. Check blood glucose per physician order or facility protocol...8. Check the order for the amount of insulin...12. Double check the order for the amount of insulin....15. Re-check that the amount of insulin drawn into the syringe matches the amount of insulin ordered...Documentation: 2. The dose and

F 658

Provided Meet Professional Standards, the RIGHTS of medication administration, the administration of medication/insulin per the physician order, documentation to support your administration amount, physician notification when medications are outside of parameters as directed and obtaining order clarification as needed to validate the correct dose is given.

The DON/Designee will accomplish an audit of 3 residents who have orders for sliding scale insulin to validate notification to the physician was made when results were outside of parameters and documentation is in place to support amount of insulin given in the medical record. Variances were addressed. In addition, an audit will be completed for 3 residents on Lokelma single dose packs to validate order clarification obtained as needed and that the correct dosage is on hand and administered. Variances will be addressed. These audits will be conducted weekly x 4 weeks, then monthly x 2 months. The findings of the audits will be submitted by the DON/Designee to the QAPI Committee for review and recommendation monthly for 3 months or ongoing until compliance sustained.

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 08/16/2023

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

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F 658	Continued From page 98 concentration of the insulin injection." The facility policy, "Mediation and Treatment Orders" documented in part, "1. Medications shall be administered only upon the written order of a person duly licensed and authorized to prescribe such medications in this state. ASM (administrative staff member) #1, the administrator, ASM #4, the regional risk consultant, and ASM #6, the clinical care consultant, were made aware of the above finding on 8/9/2023 at 5:30 p.m. No further information was provided prior to exit. 2. For Resident #11 (R11), the facility staff failed to verify the dosage of Lokelma (Sodium Zirconium Cyclosilicate) (1) prior to the administration on 8/8/2023. On 8/8/2023 at 8:35 a.m., an observation was made of RN (registered nurse) #2 administering medications at the facility. RN #2 was observed preparing medications for R11. RN #2 prepared scheduled medications to administer to R11 including a single dosing packed labeled "Lokelma 10 gm (gram)" which she was observed dissolving the entire packet contents into a cup of water and administering to the resident. Review of the physician orders for R11 documented in part, "Sodium Zirconium Cyclosilicate Oral Packet 5 GM (Sodium Zirconium Cyclosilicate) Give 1 packet by mouth one time a day for hyperkalemia. Order Date: 05/01/2023." The eMAR (electronic medication administration	F 658		

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 08/16/2023

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

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F 658	Continued From page 99	F 658		

record) for R11 dated 8/1/2023-8/31/2023 documented in part, "Sodium Zirconium Cyclosilicate Oral Packet 5 GM (Sodium Zirconium Cyclosilicate) Give 1 packet by mouth one time a day for hyperkalemia -Start Date- 05/02/2023 0900 (9:00 a.m.)." The eMAR documented RN #2 administered the medication scheduled for 9:00 a.m. on 8/8/2023.

On 8/8/2023 at 10:55 a.m., an interview was conducted with RN #2. RN #2 stated that prior to medication administration they checked to make sure they had the correct person, correct medication, correct dosage, correct time, correct route and correct documentation. RN #2 reviewed the physician order for the 5 GM of Sodium Zirconium Cyclosilicate Oral Packet and the 10 GM packets of the medications on the medication cart and stated that they should have checked the dosage closer because the resident was supposed to get 5 GM and they had received 10 GM.

The facility policy "Administering Medications" revised April 2019, documented in part, "...The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication..."

On 8/8/2023 at approximately 5:00 p.m., ASM (administrative staff member) #1, the administrator, ASM #4, the regional risk consultant and ASM #5, the regional director of case management were made aware of the findings.

No further information was presented prior to exit.

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 08/16/2023

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

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F 658	Continued From page 100 Reference: (1) Sodium zirconium cyclosilicate is used to treat hyperkalemia (high levels of potassium in the blood). Sodium zirconium cyclosilicate is not used for emergency treatment of life-threatening hyperkalemia because it takes some time to work. Sodium zirconium cyclosilicate is in a class of medications called potassium removing agents. It works by removing excess potassium from the body. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a618035.html	F 658		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §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: Based on observation, resident interview, family interview, staff interview, facility document review, and clinical record review, the facility staff failed to provide ADL (activities of daily living) care for seven of 57 residents in the survey sample, Residents #74, #48, #5, #118, #361, #358, and #127. The findings include: 1. For Resident #74 (R74), the facility staff failed to provide incontinence care in a timely manner on 8/7/23. On the most recent MDS (minimum data set), an	F 677	F677 ADL Care Provided for Dependent Residents SS=E Resident # 74 was reviewed with no adverse effects related to cited occurrence with incontinence care provided per care plan in a dignified manner. Resident # 48 was reviewed with no adverse effects related to cited	9/26/23

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 08/16/2023

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

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

F 677 Continued From page 101

annual assessment with an ARD (assessment reference date of 6/23/23), R74 was coded as having no cognitive impairment for making daily decisions, having scored 15 out of 15 on the BIMS (brief interview for mental status). He was coded as requiring the extensive assistance of two staff members for toileting. He was coded as being always incontinent of both bowel and bladder.

On 8/7/23 at 3:38 p.m., the surveyor entered R74's room. CNA (certified nursing assistant) #10 opened the door from the bathroom (shared with the two residents in the adjacent room), and stated: "I'm going to do this resident [pointing to a resident standing with her in the bathroom], then do him [pointing to Resident #48, R74's roommate], and them him [pointing to R74]." CNA #10 then closed the bathroom door. R74 was lying in his bed with the television on. He stated: "I have been waiting for an hour to get changed." He stated he was aware of needing to have his incontinence brief changed around 3:00 p.m., and he rang the bell. Another CNA whom he could not identify by name came in "a little after 3," (3:00 p.m.), cut his call light off, and told him it was "change of shift," and that someone else would have to come in and change him later. He stated: "No one has still come back in. I really need to be changed." He stated: "It certainly does not feel very good to be a grown man and need my pants changed."

On 8/7/23 at 3:45 p.m., seven staff members were observed standing at the desk for R74's unit. Two of the seven were tapping and scrolling on their cell phones.

On 8/7/23 at 4:12 p.m., CNA #10 began preparing

F 677

occurrence, incontinence care provided per care plan and resident dressed as indicated to maintain dignity.

C N A # 10 and C N A staff members identified as sitting at the desk on 8/7/23 were provided with re-education on ADL Care Provided for Dependent Residents in a timely manner, and use of cell phones while at work by the by the Staff Development Coordinator/Designee.

Resident # 5 was reviewed with no adverse effects related to cited occurrence. Resident #5 was evaluated by therapy for positioning and enhanced utensils as indicated with meals. Resident #5 care plan was also updated to reflect a schedule for resident to get out of bed.

LPN #6 was re-educated by the Staff Development Coordinator/Designee on ADL Care Provided for Dependent Residents, Meeting the resident needs, and evaluation and positioning of the resident during meals.

Resident #118 was provided with a shower. The shower/Bath schedule was reviewed and implemented to meet the resident preference with documentation in

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 08/16/2023

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

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F 677	Continued From page 102 R74 to have his incontinence brief changed. A review of R74's care plan dated 6/25/23 revealed, in part: "I have urinary incontinence r/t (related to) physical limitations...provide incontinence care and apply moisture barrier as needed...check resident approximately every 2 hours and provide incontinence care as needed." On 8/9/23 at 4:11 p.m., CNA #10 was interviewed. When asked about the observations on 8/7/23, and how she handled three residents who simultaneously needed incontinence brief changes, she stated: "I knew the suite mate would be quick in the bathroom, so I did him first. Then I did [Resident 48]. Then I did [R74]." She stated she was aware that another CNA had been R74's room and cut his call light off before she arrived for duty. She stated: "We usually have three CNAs for the whole unit. That day, we had five. I'm not sure why." She stated she does not usually ask for help from other CNAs because "it's just not there." She stated she does not usually think to ask a nurse for help because "they are usually busy passing meds [medications]." On 8/10/23 at 3:26 p.m., CNA # 5 was interviewed. She stated: "We have teamwork. If too many residents need something at the same time, I will ask for help." On 8/14/23 at 11:59 a.m., LPN (licensed practical nurse) # 7 was interviewed. She stated the maximum wait time for a resident who needs a brief change is "five to ten minutes, at the most." She stated she would help a CNA with incontinence care if she were asked, and if she were not in the middle of administering	F 677	place. C N A staff members noted to have not documented care on the dates outlined in the citation were re-educated on the provision of care and documentation required to support the care provided to include Charge Nurse notification with documentation to support the refusal is applicable. Resident #361 was discharged from the facility on 2/6/23. C N A staff member # 5 was re-educated by Staff Development Coordinator/Designee on the provision of care and documentation required to support the care provided to include Charge Nurse notification with documentation to support the refusal is applicable. Resident #358 was discharged from the facility on 8/30/23. Resident #127 was discharged from the facility on 8/17/23.	

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 08/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 103 medications to residents. On 8/14/23 at 2:20 p.m., LPN #10, a unit manager was interviewed. She stated if she were aware of three residents who needed incontinence care at the same time, she stated: "I would get to the most dire one first. The second and third one would have to wait." She added: "If possible, I would ask somebody to help me, if anyone was available." She stated the time of shift change does not alter the facility's responsibility to meet resident needs. She stated: "If it was me, I would not want to wait any more than 10 minutes to be changed." On 8/14/23 at 4:01 p.m., ASM (administrative staff member) #1, the administrator, ASM #4, the regional risk consultant, ASM #8, the regional consultant, and ASM #7, the director of nursing, were informed of these concerns. A review of the facility policy, "Activities of Daily Living (ADLs), Supporting," revealed, in part: "Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene...Appropriate care and services will be provided for residents who are unable to carry out ADLs independently...in accordance with the plan of care, including appropriate support and assistance with...hygiene (bathing, dressing, grooming, and oral care),...mobility (transfer and ambulation, including walking)...dining...and communication." No further information was provided prior to exit.	F 677	C N A staff members noted to have not documented Shower/Bath and oral care on the dates outlined in the citation were re-educated on the provision of care and documentation required to support the care provided to include Charge Nurse notification with documentation to support the refusal is applicable. Residents who receive ADL care have the potential to be affected by this practice. The Unit Manager/Designee will complete rounds and an audit of documentation to validate that residents who require ADL care including but not limited to incontinence care, mouth care, showers, repositioning, set up for meals are provided timely per care plan. Variances will be addressed. The Staff Development Coordinator/Designee will complete re-education for the Licensed Nursing and C N A staff members on ADL Care Provided for Dependent Residents, the completion of the care, the documentation of care provided and the Charge Nurse role in monitoring documentation and care provided.	

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 08/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 104 2. For Resident #48 (R48), the facility staff failed to provide incontinence care in a timely manner on 8/7/23. On the most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 6/9/23, R48 was coded as being cognitively intact for making daily decisions, having scored 13 out of 15 on the BIMS (brief interview for mental status). He was coded as requiring the extensive assistance of two staff members for toileting, as being frequently incontinent of bladder and always incontinent of bowel. R48 was admitted to the facility with a diagnosis of intellectual disability/autism. On 8/7/23 at 3:38 p.m., the surveyor entered R48's room. CNA (certified nursing assistant) #10 opened the door from the bathroom (shared with the two residents in the adjacent room), and stated: "I'm going to do this resident [pointing to a resident standing with her in the bathroom], then do him [pointing to R48]." CNA #10 then closed the bathroom door. R48 was sitting in his wheelchair, and the wheelchair was fully facing the door to the hallway. R48 was wearing only a shirt and incontinence briefs. There was a strong odor of feces surrounding R48. When asked how long he had been waiting to be changed, R48 stated: "It burns down there [pointing to his incontinence brief]." On 8/7/23 at 3:45 p.m., seven staff members were observed standing at the desk for R48's unit. Two of the seven were tapping and scrolling on their cell phones. On 8/7/23 at 4:00 p.m., CNA #10 began preparing R48 to have his incontinence brief changed.	F 677	The DON/Designee will audit 3 Dependent Residents via rounds and documentation to validate that residents who require ADL care including but not limited to incontinence care, mouth care, showers, repositioning, set up for meals are provided with services timely per care plan. Variances will be addressed. These audits will be conducted weekly x 4 weeks, then monthly x 2 months. The findings of the audits will be submitted by the Administrator/Designee to the QAPI Committee for review and recommendation monthly for 3 months or ongoing until compliance sustained.	

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 08/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 105	F 677		

A review of R48's care plan dated 6/12/23 revealed, in part: "I have urinary incontinence r/t (related to) physical limitations...Provide incontinence care...as needed...Check resident approximately every 2 hours and provide incontinence care as needed...I have bowel incontinence r/t (related to) physical incontinence...Provide incontinence care...as needed."

On 8/9/23 at 4:11 p.m., CNA #10 was interviewed. When asked about the observations on 8/7/23, and how she handled three residents who simultaneously needed incontinence brief changes, she stated: "I knew the suite mate would be quick in the bathroom, so I did him first. Then I did [R48]." She stated she was aware that R48 had been incontinent of bowel when and needed to be changed. She stated: "They had just changed him, and he messed his pants again. I needed to do somebody else first." She stated: "We usually have three CNAs for the whole unit. That day, we had five. I'm not sure why." She stated she does not usually ask for help from other CNAs because "it's just not there." She stated she does not usually think to ask a nurse for help because "they are usually busy passing meds [medications]."

On 8/10/23 at 3:26 p.m., CNA # 5 was interviewed. She stated: "We have teamwork. If too many residents need something at the same time, I will ask for help."

On 8/14/23 at 11:59 a.m., LPN (licensed practical nurse) # 7 was interviewed. She stated the maximum wait time for a resident who needs a brief change is "five to ten minutes, at the most."

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 08/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 106	F 677		

She stated she would help a CNA with incontinence care if she were asked, and if she were not in the middle of administering medications to residents.

On 8/14/23 at 2:20 p.m., LPN #10, a unit manager was interviewed. She stated if she were aware of three residents who needed incontinence care at the same time, she stated: "I would get to the most dire one first. The second and third one would have to wait." She added: "If possible, I would ask somebody to help me, if anyone was available." She stated the time of shift change does not alter the facility's responsibility to meet resident needs. She stated: "If it was me, I would not want to wait any more than 10 minutes to be changed."

On 8/14/23 at 4:01 p.m., ASM (administrative staff member) #1, the administrator, ASM #4, the regional risk consultant, ASM #8, the regional consultant, and ASM #7, the director of nursing, were informed of these concerns.

No further information was provided prior to exit.

3. For Resident #5 (R5), the facility staff failed to assess for and provide appropriate services for eating; and failed to get her out of bed on 8/7/23, 8/8/23, and 8/9/23.

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 7/22/23, R5 was coded as being moderately cognitively impaired for making daily decisions. She was coded as requiring the extensive assistance of two staff members for transfers from bed to chair, and as requiring the supervision of one person (physical assistance)

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 08/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 107	F 677		

for eating.

3. a. On 8/7/23 at 12:14 p.m., R5 was sitting in bed with the head of the bed elevated. R5 was attempting to feed herself food from her lunch tray, which was on the overbed table. The overbed table was positioned across R5's bed. R5 was positioned so that her nose was at the level of the plate on the lunch tray. R5's plate contained chopped meat and vegetables. She was attempting to feed herself using only her fingers. Some of the food was going into the resident's mouth; however, most of the food was landing on the resident's face, clothing, bed linens, and floor.

On 8/8/23 at 7:55 a.m., LPN (licensed practical nurse) #6, a unit manager, delivered R5's breakfast tray, and positioned the overbed table across R5's bed. R5 was in approximately the same position as she had been on 8/7/23 at the lunch observation. LPN #6 made no attempt to reposition the resident. LPN #6 set up the breakfast tray, including putting sugar on the oatmeal, jelly on the toast, and opening the milk. at 7:598 a.m., R5 attempted unsuccessfully to use her fork to feed herself eggs. She put the fork down, and began attempting to eat the eggs with her fingers. Some of the eggs went into her mouth; most of the eggs landed on her clothing, bed linens, and the floor.

A review of R5's care plan dated 12/15 20 revealed, in part: "Feeds herself after tray set up."

A review of R5's weights revealed no evidence of significant weight loss in the past six months.

On 8/14/23 at 9:16 a.m., CNA (certified nursing

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 08/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 108	F 677		

assistant) #11 was interviewed. She stated: "When I take care of [R5], I usually feed her. I work with her as part of the restorative program." She stated R5 is not able to feed herself.

On 8/14/23 at 10:38 a.m., OSM (other staff member) #14, an occupational therapy assistant, was interviewed. She stated she has observed R5 eating before. She stated: "She asked for an oatmeal cream pie. I got one for her and opened it for her. She tried to bring it to her mouth, but a lot of it feel on her gown." She stated: "I notice food all over her. I don't know how she's able to feed herself a complete meal." She stated OT (occupational therapy) addresses concerns "if there is the ability to carry over the skills that we teach. Sometimes there is a learned helplessness." She stated she did not believe R5 has the ability to carry over the skills that OT teaches. She stated the resident might benefit from adaptive eating equipment.

On 8/14/23 at 11:25 a.m., OSM #12, the director of rehab, an occupational therapist, was interviewed. She stated her staff does periodic OT screenings on all long term care residents. She stated: "These are only screenings, only what we can see on a quick observation." She stated if the therapist observes a concern of if staff interviews identify a concern, then a full OT evaluation would be performed. She stated R5 was last screened, evaluated, and treated from 1/8/23 through 7/21/23. She stated R5 was not evaluated or treated for eating/self-feeding. She stated the most recent eating/self-feeding evaluation had been on 6/16/22, and the resident was documented as being independent for feeding. She added: "That's our only baseline." She stated "independent" means that the resident

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 08/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANTERBURY REHABILITATION AND HEALTHCARE CENTER	**1776 CAMBRIDGE DRIVE RICHMOND, VA 23238**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 109	F 677		

is able to manipulate the utensils, bring hand to mouth with no physical assistance, and eat. She stated: "If the resident is missing the mouth, it warrants an evaluation. She stated: "If she is overshooting, we can evaluate for a possible adaptive eating device." She added: "That is not a dignified way for her to eat."

On 8/14/23 at 1:20 p.m., OSM #12 was interviewed. She stated she had observed R5's efforts to feed herself. "We definitely need to work on her positioning. She has tremors as well. We can try adaptive equipment. At the end of the day, it is a hand to mouth issue. She is going to need physical assistance hand to mouth."

On 8/14/23 at 4:01 p.m., ASM (administrative staff member) #1, the administrator, ASM #4, the regional risk consultant, ASM #8, the regional consultant, and ASM #7, the director of nursing, were informed of these concerns.

No further information was provided prior to exit.

3. b. On the following dates and times, R5 was observed either lying or sitting up in bed: 8/7/23 at 12:24 p.m. and 4:14 p.m.; 8/8/23 at 7:55 a.m. and 10:20 a.m.; 8/9/23 at 10:20 a.m. and 4:13 p.m. At each observation, a wheelchair was observed at the foot of the resident's bed.

Attempts were made to interview the resident about getting out of bed into a wheelchair, but she did not answer the question in a coherent manner.

A review of R5's clinical record revealed no evidence that she had refused attempts to get her out of bed.

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 08/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 110	F 677		

A review of R5's care plan dated 10/16/20 revealed, in part: "I have an ADL self care performance deficit r/t (related to) limited mobility...I require 2 person assist with transfers using mechanical lift."

On 8/10/23 at 2:19 p.m., LPN (licensed practical nurse) #7 was interviewed. She stated that residents should be gotten out of bed "every day, if possible." She stated this task is delegated to the CNA (certified nursing assistant). She stated if a resident refuses, the CNA should tell the nurse, and the nurse should document this in the clinical record.

On 8/14/23 at 9:16 a.m., CNA #11 was interviewed. She stated: "[R5] can't get out of bed by herself. She is a total assist times two." She added: "There is no reason she is not getting up." She stated when she takes care of her, she makes sure the resident gets out of bed. She stated sometimes the resident refuses, and if that is the case, she reports it to the nurse.

On 8/14/23 at 10:38 a.m., OSM (other staff member) #14, was interviewed. She stated R5 required a mechanical lift for transferring, but she did not know of any reason R5 could not get out of bed unless she refused.

On 8/14/23 at 4:01 p.m., ASM (administrative staff member) #1, the administrator, ASM #4, the regional risk consultant, ASM #8, the regional consultant, and ASM #7, the director of nursing, were informed of these concerns.

No further information was provided prior to exit.

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 08/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677		F 677		

Continued From page 111

4. For Resident #118 (R118), the facility staff failed to provide evidence that baths or showers were provided on multiple dates in June and July 2023.

On the most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 6/9/23, R118 was coded as being severely cognitively impaired for making daily decisions, having scored two out of 15 on the BIMS (brief interview for mental status). He was coded as being completely dependent on the assistance of two staff members for bathing.

A review of R118's point of care reports for June and July 2023 revealed blanks (no documentation) for day shift bathing (morning care) on the following dates: 6/1 through 6/16, 6/19 through 6/21, 6/23, 6/26 through 6/30; 7/2 through 7/7, 7/7 through 7/11, 7/13, 7/14, 7/16 through 7/21, 7/24, 7/25, 7/27. and 7/28. The review also revealed blanks for R5's scheduled bath/shower on the following dates: 6/2, 6/6, 6/9, 6/13, 6/16, 6/20, 6/23, 6/27, 7/4, 7/7, 7/11, 7/14, 7/18/ 7/21, 7/25, and 7/28.

A review of R118's care plan dated 4/7/22 failed to reveal any information related to being dependent on staff for bathing/showering.

On 8/10/23 at 3:26 p.m., CNA (certified nursing assistant) #5 was interviewed. When ask how she provides evidence that she has given a resident morning care or a bath/shower, she stated: "I chart in the ADLs [electronic medical record portion to which CNAs have access]." She stated this is true for all aspects of ADL care, including bathing.

F 677 Continued From page 112 F 677

On 8/14/23 at 2:20 p.m., LPN (licensed practical nurse) #10, a unit manager, was interviewed. When asked how a CNA evidences care they have provided, she stated: "They sign it off on [electronic medical record] kiosk."

On 8/14/23 at 4:01 p.m., ASM (administrative staff member) #1, the administrator, ASM #4, the regional risk consultant, ASM #8, the regional consultant, and ASM #7, the director of nursing, were informed of these concerns.

No further information was provided prior to exit.
5. For Resident #361 (R361), the facility staff failed to provide mouth care, and turning and positioning on multiple shifts in January 2023.

On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 1/31/23, R361 scored 0 out of 15 on the BIMS (brief interview for mental status), indicating the resident was severely cognitively impaired for making daily decisions. Section G coded the resident as being totally dependent on one staff with personal hygiene, including mouth care, and as being totally dependent on two or more staff with bed mobility.

A review of R361's ADL (activities of daily living) records and nurse's notes for January 2023 failed to reveal evidence that staff provided personal hygiene, including mouth care, and turning and positioning on 1/26/23 during the evening shift, 1/27/23 during the day shift, 1/30/23 during the day shift and 1/31/23 during the evening shift.

On 8/10/23 at 3:25 p.m., an interview was conducted with CNA (certified nursing assistant)

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 08/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 113	F 677		

#5 who was a CNA who worked evening shift. CNA #5 stated residents who need assistance should be turned and positioned every two hours, and mouth care should be provided every night before bedtime. CNA #5 stated that when staff turns and positions residents and provides mouth care, they should document this in the ADL records.

On 8/14/23 at 2:11 p.m., an interview was conducted with CNA #9. CNA #9 stated residents should be turned and positioned every two hours, and mouth care should be provided during each shift every day. CNA #9 stated this care is evidenced in the point of care computer system (ADL records).

On 8/14/23 at 4:06 p.m., ASM (administrative staff member) #1 (the administrator), ASM #4 (the regional risk consultant) and ASM #7 (the director of nursing) were made aware of the above concern.

6. For Resident #358 (R358), the facility staff failed to provide turning and positioning on multiple shifts in June 2023.

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 7/10/23, R358 scored 0 out of 15 on the BIMS (brief interview for mental status), indicating the resident was severely cognitively impaired for making daily decisions. Section G coded the resident as being totally dependent on one staff with personal hygiene, including mouth care, and bed mobility.

On 8/7/23 at 12:24 p.m., an interview was

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 08/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 114	F 677		

conducted with R358's family member. The family member voiced concern that the resident was not being turned and positioned.

A review of R358's ADL (activities of daily living) records and nurse's notes for June 2023 failed to reveal evidence that staff provided turning and positioning on 6/3/23 during the evening shift, 6/12/23 during the day shift, 6/17/23 during the evening shift, and 6/18/23 during the day shift.

On 8/10/23 at 3:25 p.m., an interview was conducted with CNA (certified nursing assistant) #5. CNA #5 stated residents who need assistance should be turned and positioned every two hours, and when staff turns and positions residents, they should document this in the ADL records.

On 8/14/23 at 2:11 p.m., an interview was conducted with CNA #9. CNA #9 stated residents should be turned and positioned every two hours and this care is evidenced in the point of care computer system (ADL records).

On 8/14/23 at 4:06 p.m., ASM (administrative staff member) #1 (the administrator), ASM #4 (the regional risk consultant) and ASM #7 (the director of nursing) were made aware of the above concern.
7. For Resident #127 (R127), the facility staff failed to provide showers/baths and oral care.

R127 was admitted with diagnoses that included but were not limited to Alzheimer's disease (1).

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 06/30/2023, the resident

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 08/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 115	F 677		

scored zero 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 R127 as requiring extensive assistance of one staff member for personal hygiene.

The facility's bathing POC (point of care) sheet for R127 dated February 2023 revealed blanks (no documentation) during the day shift on (7:00 a.m. to 3:00 p.m.) on 02/14/2023, 02/15/2023, 02/16/2023 and on 02/23/2023.

The facility's bathing POC sheet for R127 dated March 2023 revealed a blank during the day shift on (7:00 a.m. to 3:00 p.m.) on 03/10/2023 and documented "N/A (not applicable)" during the day shift on 03/10/2023, 03/11/2023, 03/19/2023 and on 03/26/2023.

The facility's "Personal hygiene including mouth/denture care" POC (point of care) sheet for R127 dated January 2023 revealed blanks during the day shift on (7:00 a.m. to 3:00 p.m.) on 01/07/2023, 01/08/2023, 01/21/2023 and on 01/22/2023 and documented "N/A (not applicable)" during the day shift on 01/11/2023.

The facility's "Personal hygiene including mouth/denture care" POC (point of care) sheet for R127 dated February 2023 revealed blanks during the day shift on (7:00 a.m. to 3:00 p.m.) on 02/14/2023, 02/15/2023, 02/16/2023 and on 02/23/2023 and documented "N/A (not applicable)" during the day shift on 02/01/2023, 02/02/2023, 02/03/2023, 02/04/2023, 02/05/2023, 02/06/2023, 02/07/2023, 02/08/2023, 02/09/2023, 02/10/2023, 02/11/2023, 02/12/2023 and on 02/13/2023. Further review of the eMAR

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 08/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677		F 677		

Continued From page 116
documented "N/A (not applicable)" during the evening shift on 02/14/2023, 02/15/2023, 02/19/2023, 02/20/2023 and on 02/27/2023.

The comprehensive care plan for R127 dated 06/17/2022 documented in part, "Focus. I have and ADL (activities of daily living) Self Care Performance Deficit. Date Initiated: 06/17/2022." Under "Interventions" it documented in part, "Provide me with short, simple instructions to promote independent bathing such as: Hold your washcloth in your hand. Put soap on your washcloth. Wash your face, etc. date Initiated: 06/22/2022."

The comprehensive care plan for R127 dated 03/24/2023 documented in part, "Focus. I have oral/dental health problems r/t (related to) Missing natural teeth. Date Initiated: 03/24/2023." Under "Interventions" it documented in part, "Provide mouth care (i.e.: brush teeth, denture care, gum care) as per ADL personal hygiene. Date Initiated: 03/24/2023."

On 8/10/23 at 3:25 p.m., an interview was conducted with CNA (certified nursing assistant) #5, a CNA who worked evening shift. CNA #5 stated residents who need assistance should be provided mouth care every night before bedtime. CNA #5 stated that when staff provides mouth care, they should document this in the ADL records.

On 8/14/23 at 2:11 p.m., an interview was conducted with CNA #9. CNA #9 stated residents should be provided mouth care during each shift every day. CNA #9 stated this care is evidenced in the point of care computer system (ADL records).

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 08/16/2023

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

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

F 677 Continued From page 117 F 677

On 08/15/2023 at approximately 2:26 p.m., an interview was conducted with LPN (licensed practical nurse) #1. After reviewing the POCs for R127's bathing and oral care for the dates listed above, LPN #1 stated that R127 did not receive bathing or oral care for the dates that were blank and coded as N/A.

On 08/14/2023 at approximately 5:00 a.m., ASM (administrative staff member) #1, administrator, ASM #4, regional risk consultant, ASM #5, regional director of case management, ASM #6, clinical consultant, ASM #7, director of nursing, and ASM #8, regional consultant, were made aware of the above findings.

No further information was provided prior to exit.

References:
(1) A brain disorder that seriously affects a person's ability to carry out daily activities) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/alzheimersdisease.html.

F 679 SS=D Activities Meet Interest/Needs Each Resident F 679 9/26/23
CFR(s): 483.24(c)(1)

§483.24(c) Activities.
§483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence

F 679

Continued From page 118

and interaction in the community.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to meet the assessed activities needs of one of 57 residents in the survey sample, Resident #5.

The findings include:

For Resident #5 (R5), the facility staff failed to provide evidence of providing individual activities to the resident.

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 7/22/23, R5 was coded as being moderately cognitively impaired for making daily decisions. She was coded as having impairment in range of motion for both left and right upper extremities. On the most recent annual MDS with an ARD of 3/9/23, R5 was coded as having expressed the following activities as "very important:" listening to music she likes, going outside when weather permits, and participating in religious services.

On the following dates and times, R5 was observed in her bed, with no music playing: 8/7/23 at 12:24 p.m. and 4:14 p.m.; 8/8/23 at 7:55 a.m. and 10:20 a.m.; and 8/9/23 at 4:13 p.m.

A review of R5's care plan dated 1/2/23 revealed, in part: "I am dependent on staff for activities, cognitive stimulation, social interaction r/t (related to) I require assistance with activities/participation...I need 1 to 1 bedside/in-room visits and activities if unable to

F 679

F679 Activities Meet Interest/Needs Each Resident

SS=D

Resident #5□s activities preference was reviewed by the Director of Life Enrichment.

Resident #5□s activity care plan is currently provided per individual activity preferences.

The Regional Director of Life Enrichment will provide Staff Member #13 with re-education on Activities and meeting the need of each resident.

Residents who currently reside at Canterbury Health and Rehabilitation have the potential to be affected by this practice. An audit will be conducted by the Life Enrichment Director/Designee on current residents to review individual activity needs/preferences and documentation will be implemented to support the provision of the individual needs as indicated. Variances were addressed.

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 08/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 679	Continued From page 119 attend events." On 8/10/23 at 12:34 p.m., OSM (other staff member) #13, the life enrichment director, was interviewed. He stated he had only recently taken over this position. When asked to provide evidence the facility was following R5's care plan for activities for 1:1 visits, he stated: "Once or twice a week, we go by and offer them something besides watching tv." He stated he spends much of his time on a different resident unit. He stated: "Once we get staff as it needs to be, we can round more often." He stated R5 can read and write, and he hopes they can offer her reading and writing materials. He added: "I think she will be a great candidate for our music therapy program." He stated he could not say the facility staff has been providing any 1:1 activities like cards or games for R5. On 8/14/23 at 4:01 p.m., ASM (administrative staff member) #1, the administrator, ASM #4, the regional risk consultant, ASM #8, the regional consultant, and ASM #7, the director of nursing, were informed of these concerns. A review of the facility policy, "Activity Evaluation," revealed, in part: "In order to promote the physical, mental and psychosocial well-being of residents, an activity evaluation is conducted and maintained for each resident...The resident's lifelong interests, spirituality, life roles, goals, strengths, needs, and activity pursuit patterns and preferences are included in the evaluation...The activity evaluation is used to develop an individual activities care plan...that will allow the resident to participate in activities of his/her choice and interest."	F 679	The Regional Director of Life Enrichment will re-educate the Activities staff on Activities and meeting the need of each resident, and the documentation to support the provision of the individual activities to the residents. The Director of Life Enrichment/Designee will conduct an audit of 3 residents to validate activities meeting the resident□s individual needs, and there is documentation to support the provision of the individual activity□s preferences. Variances will be addressed. These audits will be conducted weekly x 4 weeks, then monthly x 2 months. The findings of the audits will be submitted by the Administrator/Designee to the QAPI Committee for review and recommendation monthly for 3 months or ongoing until compliance sustained.	

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	495272	A. BUILDING ______ B. WING ______	C 08/16/2023

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F 679	Continued From page 120 No further information was provided prior to exit.	F 679		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to provide care and services to maintain the highest level of well-being for one of 57 residents in the survey sample, Residents #360. The findings include: For Resident #360 (R360), the resident was admitted to the facility on 7/31/23 with a diabetic ulcer and a surgical wound. The facility staff failed to initiate treatment for the diabetic ulcer until 8/2/23 and failed to initiate treatment for the surgical wound until 8/3/23. R360 was admitted to the facility on 7/31/23. A review of R360's clinical record revealed a wound progress report dated 8/2/23 that documented the resident presented with a diabetic neuropathic ulcer on the right plantar heel on 7/31/23. Further review of R360's clinical record revealed treatment was not initiated until 8/2/23. A physician's order dated 8/2/23 documented to	F 684	F684 Quality of Care SS=D Resident #360 was discharged from the facility on 8/19/23. Current residents who have a current diabetic or surgical or other wound care needs have the potential to be affected by this practice. An audit was accomplished on current residents with wounds to include but not limited to surgical wounds, diabetic ulcers, and pressure injury was completed to validate the initiation of timely treatment. Variances were addressed.	9/26/23

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 08/16/2023

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CANTERBURY REHABILITATION AND HEALTHCARE CENTER	1776 CAMBRIDGE DRIVE RICHMOND, VA 23238

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F 684	Continued From page 121 cleanse the right plantar heel with soap and water, pat dry and apply skin prep every shift. A wound progress report dated 8/2/23 documented R360 presented with a surgical wound on the left lower leg on 7/31/23. Further review of R360's clinical record revealed treatment was not initiated until 8/3/23. A physician's order dated 8/3/23 documented to cleanse the left lower leg with soap and water, pat dry and apply rolled gauze, and an ace wrap every day shift. On 8/10/23 at 2:57 p.m., an interview was conducted with RN (registered nurse) #1. RN #1 stated that when residents are admitted, the nurses complete a head-to-toe skin assessment and if a wound is present, the nurses should contact the physician and ask for an order for a wet to dry dressing until the wound care nurse practitioner can evaluate the wound. RN #1 stated treatment should be initiated on the day of admission. On 8/11/23 at 9:57 a.m., ASM (administrative staff member) #1 (the administrator) and ASM #4 (the regional risk consultant) were made aware of the above concern.	F 684	The Staff Development Coordinator/Designee will re-educate Licensed Nursing staff on Quality of Care, provision of care and services to maintain the highest level of Well-Being, to include but limited to notification of the provider to obtain orders to initiate treatment for diabetic, surgical, and other wound care in a timely manner. An audit will be completed by the unit manager/designee for 3 residents with new wounds to validate that physician orders were obtained timely and implemented. Variances will be addressed. These audits will be conducted weekly x 4 weeks, then monthly x 2 months. The findings of the audits will be submitted by the Administrator/Designee to the QAPI Committee for review and recommendation monthly for 3 months or ongoing until compliance sustained.	
F 686 SS=E	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and	F 686		9/26/23

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	495272	A. BUILDING ______ B. WING ______	C 08/16/2023

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CANTERBURY REHABILITATION AND HEALTHCARE CENTER	1776 CAMBRIDGE DRIVE RICHMOND, VA 23238

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F 686	Continued From page 122 (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to provide care and services to promote healing and treat a pressure injury for five of 57 residents in the survey sample, Residents #43, #118, #409, #360, and #510. The findings include: 1. For Resident #43 (R43), the facility failed to float her heels while she was in bed. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 5/2/23, R43 was coded as being at risk of developing pressure injuries, and as currently having a pressure injury. On the following dates and times, R43 was observed sitting up in her bed with both heels in direct contact with pillows which had been placed underneath her feet: 8/7/23 at 12:35 p.m. and 4:16 p.m.; 8/8/23 at 10:39 a.m.; 8/9/23 at 11:01 a.m. and 4:20 p.m. There was no evidence of heel suspension boots for R43. On 8/9/23 at 4:20 p.m., CNA (certified nursing assistant) #6 was observed standing at R43's bedside. When asked if R43's heels were currently being floated (elevated so they were not in contact with	F 686	F686 Treatment/Services to Prevent/Heal Pressure Ulcers SS=E Resident #43 orders were reviewed with care plan updated to reflect resident needs and preferences to include heels are floated with the use of pillows per preference, and HLSB ordered as resident tolerates. Resident #118 was turned, repositioned, and provided with incontinence care and barrier cream per the Care Plan. C N A and Licensed nursing staff assigned to the resident on the dates outlined in the 2567 were re-educated by the Staff Development Coordinator/Designee on Treatment/Services to Prevent/Heal Pressure Ulcers to include but not limited to turning and repositioning, application of barrier cream as ordered by the physician, and documentation of the care in the medical record.	

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	495272	A. BUILDING ______ B. WING ______	C 08/16/2023

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F 686 Continued From page 123

any surface), she stated: "No, her heels aren't floated." When asked why it is important to float this resident's heels, she stated the heels should be floated to prevent skin breakdown. When asked if she was aware of a heel lift device for the resident, she stated: "No. We just float them." She stated she usually roils a pillow or uses a wedge to prevent the resident's heels from coming into direct contact with the bed or a pillow.

A review of R43's clinical record revealed the following order written 10/21/22: "Bilateral heel lift suspensions when in bed every shift."

A review of R 43's care plan dated 10/21/22 revealed, in part: "Administer treatments as ordered...Heel lift boots to bilateral heels."

On 8/14/23 at 11:59 a.m., LPN (licensed practical nurse) #7 stated: "[R43]'s heels should be floated. End of sentence." She stated the resident currently has a pressure injury on her sacrum, and has previously had sink breakdown on her heels.

On 8/14/23 at 4:01 p.m., ASM (administrative staff member) #1, the administrator, ASM #4, the regional risk consultant, ASM #8, the regional consultant, and ASM #7, the director of nursing, were informed of these concerns.

No further information was provided prior to exit.

2. For Resident #118 (R118), the facility failed to evidence the application of barrier cream and turning/repositioning the resident on multiple dates in June and July 2023.

F 686

Resident #409 was discharged from the facility on 1/13/23.

Resident #360 was discharged from the facility on 8/19/23.

Resident #510 pressure ulcer care was provided in a sanitary manner. Resident #510 pressure injury was reviewed by clinical provider with no s/s of infection. Pressure injury site continues to heal no new orders.

Licensed Practical Nurse #2 was re-educated by the Staff Development Coordinator on Treatment/Services to Prevent/Heal Pressure wounds, providing pressure ulcer care in a sanitary manner, the standard of care related to pressure injury care, to include dating dressings and cleaning instruments before and after use.

Current residents who are at risk for pressure injury or receive wound care have the potential to be affected by this practice. An audit was completed by the unit manager/designee of residents at risk for pressure injury to validate that care plan interventions such as timely incontinence care, HLSB and/or offloading devices, turning, and repositioning and barriers creams as indicated were implemented and documented. Variances were addressed. An audit was completed by the unit manager/designee for residents that had new pressure injuries in the last 14 days to validate that physician orders were obtained timely and

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

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F 686	Continued From page 124 On the most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 6/9/23, R118 was coded as requiring the extensive assistance of two staff members for bed mobility (turning/repositioning). He was coded as being at risk for developing a pressure injury, and as currently have one unstageable pressure injury. A review of R118's clinical record revealed the following wound care note dated 5/10/23: "Date of Onset 5/10/23...Facility Acquired...Pressure Injury...R (right) hip." Further review of the clinical record revealed that at the time of the survey, R118 was still receiving treatment for this unstageable pressure injury. Further review of the clinical record revealed no evidence that R118 was turned and repositioned or had barrier cream applied on day shift on the following dates: 6/1 through 6/16, 6/19 through 6/21, 6/23, 6/26 through 6/30; 7/2 through 7/7, 7/7 through 7/11, 7/13, 7/14, 7/16 through 7/21, 7/24, 7/25, 7/27. and 7/28. The review revealed no progress notes related to the resident's refusal of care. A review of R118's care plan dated 4/7/22 revealed, in part: "I have potential for pressure ulcer development...I need to turn/reposition at least every 2 hours, more often as needed...apply barrier cream after each incontinence care." On 8/10/23 at 2:19 p.m., LPN (licensed practical nurse) #7 was interviewed. She stated: "The nurse is ultimately responsible for turning and repositioning of a resident. This is delegated to the CNAs (certified nursing assistants." She stated residents should be turned/repositioned	F 686	implemented. Audit also included random observations of wound care to validate that dressings are dated, and that wound care was provided in a sanitary manner to include instruments such as scissors are cleaned pre and post use. Variances were addressed. The Staff Development Coordinator will re-educate Licensed Nursing staff on wound/skin treatment to Prevent/Heal Pressure Ulcers, utilization of preventative/offloading devices, application of barrier creams, turning and repositioning, treatment initiation in a timely manner, provision of pressure ulcer care in a sanitary manner and dating dressings. The DON/Designee will complete an audit on of 3 residents at risk for pressure injury to validate that care plan interventions such as timely incontinence care, HLSB and/or offloading devices, turning, and repositioning and barriers creams as indicated were implemented and documented. Variances will be addressed. An audit will be completed by the unit manager/designee for 3 residents with new wounds to validate that physician orders were obtained timely and implemented. Audit will also include random observations of wound care to	

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 08/16/2023

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F 686 Continued From page 125
every two hours. She stated the CNAs document the care they give on the electronic medical record. She stated she writes a progress note if a CNA tells her that a resident has refused care.

On 8/10/23 at 3:26 p.m., CNA #5 was interviewed. She stated she turns residents every two hours, and signs off on what she has done in the electronic medical record. She stated if a resident refuses, she lets the nurse know, and the nurse also documents the refusal in a progress note. She stated the same is true for applying barrier cream when a resident is changed after incontinence.

On 8/14/23 at 4:01 p.m., ASM (administrative staff member) #1, the administrator, ASM #4, the regional risk consultant, ASM #8, the regional consultant, and ASM #7, the director of nursing, were informed of these concerns.

No further information was provided prior to exit.

3. For Resident #409 (R409), who was admitted with a sacral pressure injury on 1/6/23, the facility failed to implement treatment for this pressure injury until 1/9/23.

On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 1/13/23, R409 was coded as being in a persistent vegetative state. He was coded as having two unstageable pressure injuries. Resident #409 was discharged from the facility on 1/13/23.

A review of R409's admission nursing assessment dated 1/6/23 revealed the resident

F 686

validate that dressings are dated, and that wound care was provided in a sanitary manner to include instruments such as scissors are cleaned pre and post use. Variances will be addressed. These audits will be conducted weekly x 4 weeks, then monthly x 2 months. The findings of the audits will be submitted by the Administrator/Designee to the QAPI Committee for review and recommendation monthly for 3 months or ongoing until compliance sustained.

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	495272	A. BUILDING ______ B. WING ______	C 08/16/2023

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

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F 686	Continued From page 126 had one pressure injury on admission, a sacral wound measuring 5 cm x 6 cm (centimeters) , with a depth of 0.3 cm. Further review of R409's clinical record failed to reveal treatment orders for this sacral wound until 1/9/23. A review of R409's baseline care plan dated 1/6/23 revealed, in part: "The resident has a pressure ulcer and is at risk for further development r/t (related to) immobility, bowel incontinence, admitted with an unstageable pressure ulcer on his sacrum ...Administer treatments as ordered and monitor for effectiveness." A review of R409's point of care records for January 2023 revealed that both the turning and repositioning and the application of the barrier cream were signed off for every shift, indicated these interventions had been implemented. No CNAs (certified nursing assistant) who cared for R409 during his stay at the facility were available for interview during the survey. On 8/10/23 at 2:58 p.m., RN (registered nurse) #1 was interviewed. She stated that newly admitted residents should all be assessed head to toe by the admitting nurse. She stated if a resident is identified with a pressure injury, she checks the resident's record from the discharging facility to see if an order was in place there. If there is already an order, she initiates that treatment, with the approval of the facility's attending physician. She stated if there is no order for treatment prior to the resident's arrival at the facility, she calls the admitting physician at the	F 686		

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	495272	A. BUILDING ____ B. WING ____	C 08/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 686	Continued From page 127	F 686		

facility, and gets an order. She states ordinarily, this is an order for a wet to dry dressing until the wound specialist can assess the wound and write different orders. She stated the pressure injury should have a treatment initiated as soon as possible to prevent worsening.

On 8/14/23 at 2:20 p.m., LPN (licensed practical nurse) #10, a unit manager, was interviewed. This LPN had completed R409's admission nursing assessment referenced above. She stated: "Yes, he had a pressure spot on his sacrum. And I admit it. I didn't put the order in for treatment." She stated the facility's protocol is to initiate a basic treatment for pressure injuries, based on the admitting physician's orders, until the resident can be seen by the wound specialist.

On 8/14/23 at 4:01 p.m., ASM (administrative staff member) #1, the administrator, ASM #4, the regional risk consultant, ASM #8, the regional consultant, and ASM #7, the director of nursing, were informed of these concerns.

No further information was provided prior to exit.
4. For Resident #360 (R360), the resident was admitted to the facility on 7/31/23 with pressure injuries. The facility staff failed to initiate treatment for the pressure injuries until 8/2/23 and 8/3/23.

R360 was admitted to the facility on 7/31/23. A review of R360's clinical record revealed a wound progress report dated 8/2/23 that documented the resident presented with a stage two pressure injury (1) on the right heel on 7/31/23. Further review of R360's clinical record revealed treatment was not initiated until 8/2/23. A physician's order dated 8/2/23 documented to

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	495272	A. BUILDING ______ B. WING ______	C 08/16/2023

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

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F 686	Continued From page 128	F 686		

cleanse the right heel with normal saline and apply a hydrocolloid dressing once a day. A wound progress report dated 8/2/23 documented R360 presented with a stage four pressure injury (1) on the sacrum on 7/31/23. Further review of R360's clinical record revealed treatment was not initiated until 8/3/23. A physician's order dated 8/3/23 documented to cleanse the sacral wound with normal saline, apply green foam to the wound bed, cover with plastic drape and attach to a wound vac at a setting of 125 mm/Hg (millimeters of mercury), and to change every day shift on Tuesday, Thursday and Saturday.

On 8/10/23 at 2:57 p.m., an interview was conducted with RN (registered nurse) #1. RN #1 stated that when residents are admitted, the nurses complete a head-to-toe skin assessment and if a pressure injury is present, the nurses should contact the physician and ask for an order for a wet to dry dressing until the wound care nurse practitioner can evaluate the pressure injury. RN #1 stated treatment should be initiated on the day of admission.

On 8/11/23 at 9:57 a.m., ASM (administrative staff member) #1 (the administrator) and ASM #4 (the regional risk consultant) were made aware of the above concern.

Reference:
(1) "A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful.
Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis
Partial-thickness loss of skin with exposed

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 08/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 129 dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Stage 4 Pressure Injury: Full-thickness skin and tissue loss Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer..." This information was obtained from the website: https://cdn.ymaws.com/npiap.com/resource/resmgr/online_store/npiap_pressure_injury_stages.pdf . 5. For Resident #510, the facility failed to provide pressure injury care in a sanitary manner. On 8/08/23 at 12:41 PM, pressure injury care for Resident #510 was observed including heel care to right and left heel DTI, and sacral Stage 4 care. The top dressing was dated 8/5/23. The wound vac was removed and then replaced after wound care. The NP (nurse practitioner) wound care specialist, debrided some yellow tissue, wound was otherwise red with granulation. LPN (licensed practical nurse) #2, the wound care nurse, was observed completing sacral wound care: she removed bandage scissors from her right scrub top pocket and used them to cut the foam that would go inside of the sacral wound, without cleaning them. She applied the wound vac, obtained a seal. Dressing not dated and applied. Then put bandage scissors back into her scrub top pocket without cleaning them. When outside of the resident room at 12:30 PM, asked LPN #2, the wound care nurse, when the scissors would be cleaned, she stated, now, they will be. When asked if the scissors should have been cleaned prior to use, she stated, yes, they should have been cleaned prior to using. When	F 686		

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 130 asked about dating the dressing, LPN #2 stated, how would I date it? You cannot write on the resident's skin. When asked if she could date the dressing prior to applying it, LPN #2 stated, yes, that could be tried. On 8/10/23 at 7:45 AM, pressure injury care for Resident #510's sacral wound was observed. The dressing that was in place was not dated. The wound care nurse was observed completing sacral wound care: she removed bandage scissors from her right scrub top pocket and used them to cut the foam that would go inside of the sacral wound, without cleaning them. She applied the wound vac, obtained a seal. Dressing was dated and applied. Surveyor was washing hands at the resident's sink when LPN #2 tossed her bandage scissors into the sink. LPN #2 stated, "The little antibacterial wipes, I do not have any of them today to clean my scissors." When asked if she had followed the infection prevention measures for wound care regarding cleaning of the bandage scissors, LPN #3 stated, no, they were not cleaned prior to using them. A review of physician orders dated 8/2/23, revealed, "SACRUM- Cleanse with 0.25% Dakin's solution. Apply black foam vac dressing to wound vac dressing to wound vac at 123mm Hg (millimeters of mercury) of suction. If VAC lose suction may apply Dakin's wet to dry dressing daily. One time a day every Tuesday, Thursday, Saturday." On 8/8/23 at 12:41 PM and 8/10/23 at 7:45 AM, LPN #2, the wound care nurse was observed not following the standard of care related to pressure injury care, by cleaning instruments prior to using	F 686		

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 08/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 131 them and dating dressing. On 8/14/23 at 4:00 PM, ASM (administrative staff member) #1, the administrator, ASM #4, the regional risk consultant, ASM #7, the director of nursing and ASM #8, the regional consultant was made aware of the findings. No further information was provided prior to exit.	F 686		
F 687 SS=E	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to provide foot care for five of 57 residents in the survey sample, Residents #48, #34, #144, #63, and #121. The findings include: 1. For Resident #48 (R48), the facility staff failed to ensure the resident's toenails were cleaned and trimmed.	F 687	F687 Foot Care SS=E Resident #48, Resident #34, Resident #144, and Resident #121 were provided with toenail care by Health Care Podiatry Group on 8/12/23. Resident #63 was discharged from the	9/26/23

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 08/16/2023

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

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

F 687 Continued From page 132

On the most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 6/9/23, R48 was coded as requiring the extensive assistance of staff for ADLs (activities of daily living), including bathing and personal hygiene. R48 was admitted to the facility with diagnoses of intellectual disability/autism and diabetes.

On 8/7/23 at 3:38 p.m., R48 was observed sitting up in his wheelchair, and had no socks on his feet. All of R48's toenails extended beyond the length of the toes. Some of the nails had brownish yellow material underneath them.

On 8/8/23 at 10:22 a.m., R48's toenails were observed. All nails were beyond the length of the toes, and the left great toenail was between 1/2 and 3/4 inches beyond the end of the toe.

A review of the facility documentation for podiatry appointments revealed R48 had not been seen by the facility podiatrist within the past four weeks, and did not have a current appointment with the podiatrist.

A review of R48's care plan dated 4/20/23 revealed, in part: "I have an ADL Self Care Performance deficit...I require 1 staff assist with bathing...

On 8/10/23 at 2:19 p.m., LPN (licensed practical nurse) #7 was interviewed. She stated basic toenail care includes washing the foot with soap and water, including washing between the toes. It also involves applying lotion to dry feet. She stated the CNA(certified nursing assistant) is primarily responsible for the cleanliness of residents' feet. She states she has not provided

F 687

facility on 8/8/23.

C N A staff member #4 was re-educated by the Staff Development Coordinator/Designee on Foot Care and trimming of the resident nails.

Current Residents who require nailcare have the potential to be affected by this practice.

An audit was completed by the Unit Manager/Designee on resident Foot Care to review the need for nail care. Variances were addressed.

The Staff Development Coordinator/Designee re-educated the Licensed Nursing Staff and C N A staff on Foot Care, and nail care.

The DON/Designee will conduct an audit of 3 residents to validate foot care and nail care were provided. Variances will be addressed. These audits will be conducted weekly x 4 weeks, then monthly x 2 months. The findings of the audits will be submitted by the Administrator/Designee to the QAPI Committee for review and recommendation monthly for 3 months or

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 08/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANTERBURY REHABILITATION AND HEALTHCARE CENTER	**1776 CAMBRIDGE DRIVE RICHMOND, VA 23238**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 687	Continued From page 133 nail care to any residents. The CNAs are for trimming the nails of residents who are not diabetic. She stated CNAs are not allowed to provide nail care to diabetics. She stated the unit managers maintain a list of residents who need diabetic nail care. On 8/10/23 at 3:26 p.m., CNA #5 was interviewed. She stated every resident should have "good foot care." She stated this includes checking the feet for concerns, massaging heels, toes, and between the toes with lotion. She stated feet should be bathed every day as part of morning and evening care. She stated: "We cut fingernails and toenails if the resident is not diabetic." On 8/14/23 at 4:01 p.m., ASM (administrative staff member) #1, the administrator, ASM #4, the regional risk consultant, ASM #8, the regional consultant, and ASM #7, the director of nursing, were informed of these concerns. A review of the facility policy, "Foot Care," revealed, in part: "Residents receive appropriate care and treatment in order to maintain mobility and foot health...Overall foot care includes the care and treatment of medical conditions to prevent foot complications...Residents are assisted in making appointments with and transportation to and from specialists...Trained staff may provide routine foot care (e.g. [for example] toenail clipping within professional standards of practice for residents without complicating disease processes...Residents with foot disorders or medical conditions associated with foot complications are referred to qualified professionals."	F 687	ongoing until compliance sustained.	

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 08/16/2023

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

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

F 687 Continued From page 134 F 687

No further information was provided prior to exit.
2. For Resident #34, the facility staff failed to provide foot care/podiatry services.

Resident #34 had diagnoses that included "need for assistance with personal care." Resident #34 did not have a diagnosis of diabetes.

On 8/08/23 at 11:55 AM, an observation was made of Resident #34's feet. The left foot big toenail was 1/2 to 3/4 inch long. On the right foot, all toenails needed to be trimmed. The great toenail was 1/2 to 3/4 inch long.

A review of the clinical record revealed a physician's order dated 2/14/23 for "Podiatry consult and treatment as needed."

A review of the clinical record failed to reveal any evidence of when the toenails were last trimmed. On 8/9/23 at 3:05 PM and on 8/14/23 at 5:00 PM, a request for evidence of all incidents of podiatry care/toenail care for Resident #34 since admission (11/1/22) was requested. A list was provided of residents who received podiatry care in June 2023. Resident #34 was not on the list. No evidence was provided that Resident #34 had ever received any toenail care/podiatry services.

A review of the comprehensive care plan revealed one dated 11/1/22 for "I have an ADL (activities of daily living) Self Care Performance Deficit r/t (related to) Disease Process, External Devices/Medical Equipment." This care plan included an intervention dated 11/2/22 for "PERSONAL HYGIENE: I am dependent on staff for grooming/personal hygiene."

On 8/10/23 at 2:19 PM, an interview was

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 08/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 687	Continued From page 135	F 687		

conducted with LPN #7 (Licensed Practical Nurse). She stated that basic foot care included washing with soap and water, greasing / lotion. She stated that CNAs (Certified Nursing Assistant) will let her know any skin issues. She stated that bathing included in between the toes. She stated that CNAs were primarily responsible. She stated that she hasn't done the nail care, that the CNAs are supposed to be doing it on shower days if the resident is not diabetic. She stated that CNAs not allowed to diabetic foot care because the residents are more prone to wounds. She stated the unit managers has a list for podiatry care and that she asks for the resident to be placed on the list and the unit manager is responsible for making sure those residents get seen.

On 8/10/23 at 3:26 PM, an interview was conducted with CNA #5. She stated that for foot care, the CNAs check everyone's feet. She stated that you don't want dry feet, and that CNAs' put lotion on them and massage it on the heels, toes, and between the toes. She stated CNAs need to make sure they are nice and clean every day. She stated that if they are not clean, she bathes them. She stated the staff cut the fingernails and that the CNAs cut toenails if the resident is not diabetic, and that she asks the nurse if she can cut the toenails.

On 8/15/23 at 9:24 AM, an interview was conducted with LPN #1 (Licensed Practical Nurse). She stated that nail care is part of grooming, and if the resident is not diabetic, staff should attempt to trim the nails. She stated that if the nails are too thick, that they might be able to try and file them. She stated that they should have a podiatry consult and be seen by podiatry

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 08/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 687	Continued From page 136	F 687		

before they get too long.

On 8/14/23 at 4:00 PM at an end-of-day meeting, ASM #1 (Administrative Staff Member) the Administrator, ASM #4 the Regional Risk Consultant, ASM #7 the Director of Nursing and ASM #8 the Regional Consultant, were made aware of the findings. No further information was provided by the end of the survey.
3. For Resident #144, the facility failed to provide toenail care.

Observation on 8/8/23 at 11:23 AM, of Resident #144's toenails, revealed the following: right foot - all toenails needed to be trimmed being they were 1/4 - 1/2 inches long, the second toenail was pressing into the underneath of his big toe, and on the left foot all toenails needed to be trimmed.

Resident #144 was admitted to the facility on 3/27/23 with diagnoses that include but are not limited to: DM (diabetes mellitus).

Resident #144's most recent MDS (minimum data set) assessment, a quarterly annual assessment, with an assessment reference date of 7/4/23, coded the resident as scoring 03 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired. MDS Section G- Functional Status: coded the resident as total dependence with dressing, eating, hygiene and bathing.

Resident #144 was unable to communicate regarding nail care.

A review of the podiatry appointments for Resident #144 revealed, no appointment for April

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 08/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 687	Continued From page 137	F 687		

and May 2023. A review of the podiatry note for 6/26/23, revealed, "Toenails trim/care." There was no evidence of toenail care provided July 2023.

An interview was conducted on 8/8/12 at 12:30 PM, with LPN (licensed practical nurse) #2, when asked who provides nail care for the residents, LPN #2 stated, if the resident is diabetic or has thick toenails, podiatry cuts the toenails.

On 8/8/23 at 3:30 PM, an interview was conducted with CNA (certified nursing assistant) #2. When asked who provides toenail care, CNA #2 stated, "We look at them when they are getting bathed. If they are a diabetic or have thick toenails, we let the nurse know to put them on the podiatry list. If they are not diabetic or thick, we can trim them."

An interview was conducted on 8/10/23 at 9:41 AM, with OSM (other staff member) #5, the director of social services. When asked about podiatry appointments, OSM #5 stated, if there are too many residents, they roll them over to the next visit and those residents are the priority. Podiatry did not come in July, so they are coming 8/16/23 and there is a second date they are coming in August.

On 8/10/23 at 2:19 p.m., LPN (licensed practical nurse) #7 was interviewed. She stated basic toenail care includes washing the foot with soap and water, including washing between the toes. It also involves applying lotion to dry feet. She stated the CNA(certified nursing assistant) is primarily responsible for the cleanliness of residents' feet. She states she has not provided nail care to any residents. The CNAs are for

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 08/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 687		F 687		

Continued From page 138
trimming the nails of residents who are not diabetic. She stated CNAs are not allowed to provide nail care to diabetics. She stated the unit managers maintain a list of residents who need diabetic nail care.

An interview was conducted on 8/15/23 at 3:26 PM, with CNA #5. When asked to describe foot care, CNA #5 stated, we check everyone's feet. We do not want dry feet, so we put lotion on them. Massage heels, toes and in between the toes. We make sure they are nice and clean. We do this every day. We cut the fingernails and all the toenails unless they are diabetic.

On 8/14/23 at 4:00 PM, ASM (administrative staff member) #1, the administrator, ASM #4, the regional risk consultant, ASM #7, the director of nursing and ASM #8, the regional consultant was made aware of the findings.

No further information was provided prior to exit.

4. For Resident #63 (R63), the facility staff failed to provide podiatry care for toenail trimming.

R63 was admitted with diagnoses that included but were not limited to diabetes mellitus without complication (1).

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 05/21/2023, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact for making daily decisions.

On 08/08/2023 at approximately 8:30 p.m. an observation of R63's toenails were conducted

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 08/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 687	Continued From page 139	F 687		

with ASM (administrative staff member) #2, nurse practitioner wound specialist. When asked to describe the condition of R63's toenails she stated that there were to long, needed to be trimmed and should be seen by a podiatrist.

Review of R63's EHR (electronic health record) revealed a consult note from (Name of Podiatry Group) dated May 12, 2022. The note documented, "Patient was scheduled to be treated today, but was not treated. Reason: Patient refused: veteran hosp [hospital] will not pay for treatment." Further review of R63's EHR failed to evidence further attempts to provide services to trim R63's toenails.

On 8/10/23 at 2:19 p.m., LPN (licensed practical nurse) #7 was interviewed. She stated basic toenail care includes washing the foot with soap and water, including washing between the toes. It also involves applying lotion to dry feet. She stated the CNA(certified nursing assistant) is primarily responsible for the cleanliness of residents' feet. She states she has not provided nail care to any residents. The CNAs are for trimming the nails of residents who are not diabetic. She stated CNAs are not allowed to provide nail care to diabetics. She stated the unit managers maintain a list of residents who need diabetic nail care.

On 08/10/23 at approximately 3:26 p.m., an interview was conducted with CNA #5. When asked to describe foot care for residents she stated that the CNAs check the resident's feet and apply lotion to keep the feet from drying, making sure they are nice and clean. When asked how often the resident's toenails are checked she stated it is done everyday and cut

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 08/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANTERBURY REHABILITATION AND HEALTHCARE CENTER	**1776 CAMBRIDGE DRIVE RICHMOND, VA 23238**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 687		F 687		

Continued From page 140
the toenails if the resident is not diabetic.

On 08/15/2023 at approximately 10:24 a.m., OSM (other staff member) # 5, director of social services, provide a form entitled "Request for Services / Consultation" for (Name of Podiatry Group) for R63. The form documented in part, "Podiatry. Other (please specify): toenail trimming & (and) care" dated 06/26/2023. When asked if R63 received Podiatry care and toenail trimming in June 2023 she stated no.

On 08/14/2023 at approximately 9:50 a.m., ASM (administrative staff member) #1, administrator and ASM #4, regional risk consultant, were made aware of the above findings.

No further information was provided prior to exit.

References:
(1) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm.

5. For Resident #121 (R121), the facility staff failed to trim the toenails.

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 05/18/2023, the resident scored 8 (eight) out of 15 on the BIMS (brief interview for mental status), indicating the resident was moderately impaired of cognition for making daily decisions.

On 8/9/2023 at approximately 10:45 a.m. an observation of R121's toenails were conducted

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 08/16/2023

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

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F 687 Continued From page 141 F 687

with LPN (licensed practical nurse) #1. She stated number three and four toe (1) on the left foot were approximately a quarter inch too long and needed to be trimmed. Upon observation of R121's left foot LPN #1 stated number two, three and four toe (1) on the right foot were approximately a quarter inch too long and needed to be trimmed.

On 8/9/2023 at approximately 10:50 a.m. an interview was conducted with CNA (certified nursing assistant) #4. When asked about providing toenail care for the residents she stated that it was part of ADLs (activities of daily living). When asked if she trimmed R121's toenails as part of his ADL care that morning she stated R121 did not ask, and she did not initiate to offer to trim his toenails.

On 08/14/2023 at approximately 9:50 a.m., ASM (administrative staff member) #1, administrator and ASM #4, regional risk consultant, were made aware of the above findings.

No further information was provided prior to exit.

References:
(1) The toes are, from medial to lateral: The first toe, also known as the hallux ("big toe" or "great toe"), the innermost toe; The second toe, or "long toe"; The third toe, or "middle toe"; The fourth toe, or "ring toe"; The fifth toe, or "little toe", "pinky toe", or "baby toe"), the outermost toe. This information was obtained from the website: Digits of foot; Toes - e-Anatomy - IMAIOS.

F 688 SS=D Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) F 688 9/26/23

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 08/16/2023

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F 688	Continued From page 142 §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to provide treatment for contractures (1) for two of 57 residents in the survey sample, Residents #5 and #48. The findings include: 1. For Resident #5 (R5), the facility staff failed to provide a left hand palm guard for the resident's contacted left hand. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 7/22/23, R5 was coded as being moderately cognitively impaired for making daily decisions. She was coded as having impairment in range of motion for both left and right upper extremities.	F 688	F688 Increase/Prevent Decrease in ROM/Mobility SS=D Resident #5 was provided with a palm guard for her contracted left hand. Resident #48 is currently receiving therapy services as of 8/23/23. Current residents that have a contracture have the potential to be affected by this practice. An audit was accomplished of current residents who have contractures	

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	495272	A. BUILDING ______ B. WING ______	C 08/16/2023

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F 688	Continued From page 143 A review of R5's care plan dated 12/8/22 revealed, in part: "I require assistive/adaptive device...resident to wear Left palm protector at all times, as tolerated with removal for hand hygiene and skin checks." On the following dates and times, R5 was observed in her bed, with no palm guard/protector in her left hand: 8/7/23 at 12:24 p.m. and 4:14 p.m.; 8/8/23 at 7:55 a.m. and 10:20 a.m. On 8/9/23 at 4:13 p.m., R5 was observed in bed. She had a rolled washcloth in her left hand. At all observations, R5 had contractures in the fingers of her left hand. On 8/14/23 at 9:16 a.m., CNA (certified nursing assistant) #11 was interviewed. She stated R5 should have "splints on her hands" because of contractures. She stated: "We don't have splints so we roll up a washcloth." She stated she did not ever remember R5 having "real splints." On 8/14/23 at 11:25 a.m., OSM #12, the director of rehab and an occupational therapist, was interviewed. She stated her staff does periodic OT screenings on all long term care residents. She stated: "These are only screenings, only what we can see on a quick observation." She stated if the therapist observes a concern of if staff interviews identify a concern, then a full OT evaluation would be performed. She stated R5 was last screened, evaluated, and treated from 1/8/23 through 7/21/23. She stated R5 was not evaluated or treated for hand contractures. She stated the most recent evaluation for the use of her hands had been on 6/16/22, and the resident was documented as being independent for feeding. She added: "That's our only baseline."	F 688	to validate care plan interventions such as palm guards were implemented and to identify residents that need therapy screening/evaluation for contractures. Variances were addressed and therapy screens were completed with residents picked up for service as indicated. The Staff Development Coordinator/Designee re-educated the Licensed Nursing and C N A staff on the need to follow the residents care plan to include but not limited to using palm guards as indicated to Increase/Prevent Decrease in ROM/Mobility, and the process for notifying Therapy Services if a resident is noted with a need for screening/evaluation due to decrease in ROM due or contracture. Variances were addressed. An audit will be conducted by the DON/Designee of 3 residents with contractures to validate interventions such as palm guards are implemented per plan of care and that therapy referrals are made as indicated to increase/prevent decrease in ROM/Mobility. Variances will be addressed. These audits will be conducted weekly x 4 weeks, then monthly x 2 months. The findings of the audits will be submitted by the Administrator/Designee to the QAPI Committee for review and recommendation monthly for 3 months or	

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	495272	A. BUILDING ____ B. WING ____	C 08/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANTERBURY REHABILITATION AND HEALTHCARE CENTER	**1776 CAMBRIDGE DRIVE RICHMOND, VA 23238**

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F 688	Continued From page 144 She provided an 8/14/22 OT (occupational therapy) evaluation for R5. This evaluation included, in part: "Left palm guard." She stated: "A rolled up wash cloth is not sufficient." On 8/14/23 at 1:20 p.m., OSM #12 was interviewed. She stated: "[R5] definitely needs a palm guard as soon as possible." On 8/14/23 at 4:01 p.m., ASM (administrative staff member) #1, the administrator, ASM #4, the regional risk consultant, ASM #8, the regional consultant, and ASM #7, the director of nursing, were informed of these concerns. A review of the facility policy, "Functional Impairment," revealed, in part: As part of the physical examination, the physician will include items that relate to function as well as potential to benefit from rehabilitative services." A review of the facility policy, "Resident Mobility and Range of Motion," revealed, in part: "Residents with limited range of motion will receive treatment and services to increase and/or prevent a further decrease in ROM (range of motion)...The care plan will include specific interventions, exercises and therapies to maintain, prevent avoidable decline, and /or improve motility and range of motion...Interventions may include...the provision of necessary equipment." No further information was provided prior to exit. NOTES (1) "A contracture develops when the normally stretchy (elastic) tissues are replaced by nonstretchy (inelastic) fiber-like tissue. This tissue	F 688	ongoing until compliance sustained.	

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	495272	A. BUILDING ______ B. WING ______	C 08/16/2023

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F 688		F 688		

Continued From page 145
makes it hard to stretch the area and prevents normal movement." This information is taken from the website https://medlineplus.gov/ency/article/003185.htm.

2. For Resident #48 (R48), the facility staff failed to provide services for the resident's left and right hand contractures.

On the most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 6/9/23, R48 was coded as being cognitively intact for making daily decisions, having scored 13 out of 15 on the BIMS (brief interview for mental status). He was coded as being impaired for range of motion in both left and right upper extremities. R48 was admitted to the facility with a diagnosis of intellectual disability/autism.

On the following dates and times, R48 was observed in his room. In each observation, both R48's left and right hand were contracted, and there was no evidence of a device to treat the contracture in either hand: 8/7/23 at 3:38 p.m., 8/8/23 at 7:29 a.m. and 10:22 a.m.; and 8/9/23 at 3:45 p.m.

A review of R48's care plan dated 4/20/23 revealed no information related to the resident's hand contractures.

On 8/14/23 at 9:16 a.m., CNA (certified nursing assistant) #11 was interviewed. She stated she was not aware of any devices available for R48's hands. She stated: "His hands have always been that way."

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F 688	Continued From page 146 On 8/14/23 at 11:25 a.m., OSM #12, the director of rehab and an occupational therapist, was interviewed. She stated her staff does periodic OT (occupational therapy) screenings on all long term care residents. She stated: "These are only screenings, only what we can see on a quick observation." She stated if the therapist observes a concern of if staff interviews identify a concern, then a full OT evaluation would be performed. She stated she was not aware that R48 had contractures in his hand, but would go and look. On 8/14/23 at 1:20 p.m., OSM #12 was interviewed. She stated R48 was able to open and close his hands in a limited way, and that he can use his hands for gross motor skill tasks. She stated he can grasp and hold his phone, but, because of his contractures, he cannot perform fine motor skill tasks like punching the buttons on his phone. She stated: "Overall he is functional, but he needs assistance. I wouldn't put a splint on him all the time, but he would probably benefit from a resting hand splint at night to help prevent further contracture." On 8/14/23 at 4:01 p.m., ASM (administrative staff member) #1, the administrator, ASM #4, the regional risk consultant, ASM #8, the regional consultant, and ASM #7, the director of nursing, were informed of these concerns. No further information was provided prior to exit.	F 688		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains	F 689		9/26/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 689	Continued From page 147 as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, clinical record review and facility document review, it was determined the facility staff failed to keep residents free of accidents and hazards for one of 57 residents, Resident #144, and one of three wings on Grove Unit, the west wing. The findings include: 1. For Resident #144, the facility staff failed to ensure fall mats were in use to prevent injury from falls. Observations of Resident #144 revealed: on 08/07/23 at 11:40 AM, no floor mats on either side of bed; 8/10/23 at 2:45 PM, no floor mats on either side of bed; 8/08/23 at 7:45 AM, no floor mats on either side of bed; on 8/8/23 at 11:30 AM, no floor mats on either side of bed; and 8/10/23 9:15 AM, no floor mats on either side of bed. Resident #144's most recent MDS (minimum data set) assessment, a quarterly annual assessment, with an assessment reference date of 7/4/23, coded the resident as scoring 03 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired. A review of the comprehensive care plan dated 4/27/23 and revised 6/11/23, revealed, "FOCUS:	F 689	F689 Free of Accident Hazards/Supervision/Devices SS=E Resident #144 bilateral fall mats were obtained and placed while the resident is in bed. Resident #144 C N A #2, RN #1, and LPN#1 were re-educated by the Staff Development Coordinator/Designee on keeping residents Free of Accident Hazards/Supervision/Devices, to include maintaining the use of floor mats as ordered/Care Planned to minimize risk of injury. The chemical used for renovation on the Grove Unit Bondo was removed from the building and will not be utilized and an alternative product was purchased. Current Residents who reside at Canterbury Rehabilitation and Healthcare and utilize fall prevention devices have the	

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F 689	Continued From page 148 Resident is at risk for falls related to confusion, deconditioning/ weakness, history of falls, poor safety awareness...INTERVENTIONS: Bilateral fall mats. A review of the physician order dated 4/27/23, revealed, "Floor mats to both sides of bed every shift." An interview was conducted on 8/7/23 at 2:00 PM with CNA (certified nursing assistant) #2, when asked if Resident #144 had bilateral fall mats, CNA #2 stated, they are not there now. He used to have them. An interview was conducted on 8/9/23 at 2:20 PM, with RN (registered nurse) #1. When asked about the bilateral floor mats for Resident #144, RN #1 stated, "He used to have fall mats. I believe they took them to give to another resident who was more active." An interview was conducted on 8/14/23 at 2:15 PM, with LPN (licensed practical nurse) #1. When asked about the bilateral floor mats for Resident #144, LPN #1 stated, he had bilateral fall mats and when his room was changed, they must not have gone with him. A review of Resident #144's census sheet reveals Resident #144 was transferred to the current room on 6/11/23. On 8/14/23 at 4:00 PM, ASM (administrative staff member) #1, the administrator, ASM #4, the regional risk consultant, ASM #7, the director of nursing and ASM #8, the regional consultant was made aware of the findings. No further information was provided prior to exit.	F 689	potential to be affected by this process. Current Resident who resided at Canterbury Rehabilitation and Healthcare had the potential to be affected by this process. The chemical Bondo was removed from the facility and will not be utilized. An audit was conducted on current residents by the Unit Manager/Designee on fall prevention devices to include fall mats to validate implementation per Plan of Care. Variances were addressed. An audit by the Regional Maintenance Director to validate Bondo product was no longer utilized and removed from the building was conducted with no further variance noted. The Staff Development Coordinator/Designee completed re-education for the Licensed Nursing Staff, C N A staff, and Department Head staff on residents Free of Accident Hazards/Supervision/Devices, to include maintaining the use of floor mats as ordered/Care Planned to minimize risk of injury.	

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	495272	A. BUILDING ______ B. WING ______	C 08/16/2023

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CANTERBURY REHABILITATION AND HEALTHCARE CENTER	1776 CAMBRIDGE DRIVE RICHMOND, VA 23238

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F 689	Continued From page 149 2. The facility staff failed to ensure chemicals used for renovations on the Grove Unit were used in a well ventilated area which resulted in the evacuation of residents on the west wing. On 8/10/23 at approximately 9:30 AM, the surveyor rounded on west wing of Grove Unit, located on the second floor. The double doors from the central lobby area on Grove Unit were closed. There were no chemical odors in the central lobby. Upon entering the west wing on Grove through the double doors, a strong chemical odor that burned surveyor's nose was immediately noticed, and the chemical odor grew stronger as surveyor progressed down the hallway. A female resident was sitting in a wheelchair approximately one third way down the hall on the left side. A male resident was walking up the hall from the far end of the hall. Female resident and male resident were asked if they were okay, with no answer from the female resident and the male resident stating, he wanted to find his bed. LPN (licensed practical nurse) #1, the unit manager, had entered through the closed double doors onto the west wing. LPN #1 stated, what is that smell. Surveyor walked to far end of hall with LPN #1 who was coughing as we walked down the hall. Room 317 had a plastic zippered curtain over the doorway and there were two workers inside. When asked what was causing the chemical odor smell, there was no reply. This was asked a second time without a reply. Zippered curtain was opened and male construction worker was asked a third time what was causing the chemical odor smell, the female construction worker was sanding in the closet area. There was no reply. LPN #1 at that point	F 689	The Regional Maintenance Director/Designee will provide re-education to the construction crew regarding appropriate products for usage and what alternative products will be utilized. The DON/Designee will complete an audit of 5 residents at risk for falls to validate care plan interventions are implemented to include use of floor mats as indicated. Variances will be addressed. The Administrator/Designee will complete an audit to validate chemicals used for renovations on the Units are used according to manufacturer□s instructions, and do not pose a potential risk for the residents who reside within the facility. Variances will be addressed. Both audits will be conducted weekly x 4 weeks, then monthly x 2 months. The findings of the audits will be submitted by the Administrator/Designee to the QAPI Committee for review and recommendation monthly for 3 months or ongoing until compliance sustained.	

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 08/16/2023

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F 689	Continued From page 150	F 689		

went up the hall to move the female resident in the wheelchair out to the lobby. Surveyor began opening doors to count residents on unit. Thirteen residents were currently on the west wing, and a total of 20 residents were assigned on the west wing. Room 316 (room next to room 317 under construction) had strong chemical odor, which caused burning sensation in surveyor's nostrils. No residents were in room 316 at the time. The majority of resident room doors were closed. CNA (certified nursing assistant) #7 was in room 321 providing morning care, and when the door was opened there was no chemical odor in the room.

The construction supervisor and OSM (other staff member) #3, the maintenance director, arrived and was asked about the source of the chemical odor. The construction supervisor asked the male construction worker in room 317 to give him the can of "Bondo." Surveyor informed the construction supervisor that the workers had not replied to the questions regarding the source of the odor; he replied that the workers did not understand English. The construction supervisor was asked for the MSDS (material safety data sheets) for Bondo.

At approximately, 9:55 AM, LPN #1 brought staff back in through double doors and began moving residents off the unit into the central lobby area. ASM (administrative staff member) #1, the administrator, ASM #3, the vice president of operations and ASM #4, the regional risk consultant, arrived approximately 9:57 AM and the double doors to the west wing were opened to evacuate the residents to the lobby area. All residents were moved out of the west wing by 10:15 AM. OSM #3, the maintenance director,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 689	Continued From page 151	F 689		

unscrewed the windows on the west wing, opened the fire door next to room 317 and opened the fire door on the first floor to the outside. Exhaust fan was placed in the hall to pull air though the west wing. ASM #3, the vice president of operations, stated that Bondo is used in construction in building for metal doors. At 10:35 AM, residents were in the lobby or dining room area off of the west wing. ASM #3 stated, we are going to check on this in an hour. When asked what criteria would be used to open the west wing, ASM #3 stated, we are not going to open up then, just check on it. The chemical odor continued in room 316.

On 8/10/23 11:35 AM, CNA #12 was observed sitting in front of closed double doors to the west wing. CNA #12 stated, no residents have been allowed back. Observation revealed no residents in the hallway or rooms on the hallway. There was no chemical odor smell in common area around nurse station, other hallways or dining room. The medical provider had been contacted and was in process of performing physical assessments on Grove west wing residents. The medical practitioner conferring with CNAs about each resident's ability to express needs. No residents were identified by the medical provider as having adverse effects from the BONDO.

On 8/11/23, 8/14/23 and 8/15/23 no construction work was observed being done in room 317, there was no chemical odor in west wing of Grove Unit.

On 8/14/23 at 4:00 PM, ASM (administrative staff member) #1, the administrator, ASM #4, the regional risk consultant, ASM #7, the director of nursing and ASM #8, the regional consultant was

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 08/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 152 made aware of the findings. According to the facility's "Construction and Renovation-Role of the Administrator or Designee" policy, "Purpose: To reduce resident and employee exposure to potentially infectious agents released into the environment due to construction, renovation, remediation, repair and demolition or related activities. The administrator or designee(s) will establish and maintain surveillance for airborne and waterborne environmental disease (e.g., aspergillosis, Legionnaire's disease) as appropriate throughout the project to protect immunocompromised patients. The administrator or designee(s) will monitor construction and renovation projects until completion to ensure adherence to current CDC/HICPAC (center disease control/healthcare infection control practices advisory committee) guidelines and state or local requirements." A review of the Bondo can and the MSDS for BONDO dated 3/24/23, revealed, "Recommended use: automotive, body repair. Use with adequate ventilation. Hazard identification: Inhalation-respiratory tract irritation: signs/symptoms may include cough, sneezing, nasal discharge, headache, hoarseness and nose/throat pain." No further information was provided prior to exit.	F 689		
F 690 SS=E	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to	F 690		9/26/23

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 08/16/2023

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

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F 690	Continued From page 153 maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, clinical record review and facility document review, it was determined the facility staff failed to provide care and services for urinary catheter care for two of 15 residents with urinary catheters; Resident #144 and #86.	F 690	F690 Bowel/Bladder Incontinence Catheter, UTI SS=E Resident #144 was provided care for his indwelling catheter by Licensed Nurse and	

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F 690	Continued From page 154 The findings include: 1. For Resident #144, the facility staff failed to ensure care for an indwelling urinary catheter was provided. Observations of Resident #144 during the survey revealed the resident with a Foley (1) catheter and privacy covering on bag. Urinary catheter care was not observed. A review of the physician order dated 6/27/23, revealed, "Foley Output every shift for Foley Cath related to obstructive and reflux uropathy." A review of the July and August 2023 TAR (treatment administration record) revealed urine output documented each shift. There was no evidence of urinary catheter care documented for Resident #144 for July and August 2023. An interview was conducted on 8/9/23 at 2:25 PM, with RN (registered nurse) #1. When asked if a physician's order is required for urinary catheter care, RN #1 stated, no, that is not required. When asked where urinary catheter care is documented, RN #1 stated, it is on the TAR. When asked if there is no documentation of urinary catheter care for Resident #144, was the care plan implemented, RN #1 stated, no, it is not being implemented. An interview was conducted on 8/14/23 at 10:20 AM, with LPN (licensed practical nurse) #13. When asked where urinary catheter care is documented, LPN #13 stated, it is documented on the TAR. When asked if there is no documentation of urinary catheter care, was the care plan implemented, LPN #13 stated, no, it is	F 690	documentation to support provision of care was entered into the MAR. Resident #86 currently has a physician□s order for the use of an external urinary catheter and orders for catheter care per the manufacturer□s recommendations. LPN #6 and C N A #6 were re-educated on Bowel/Blader Incontinence Catheter care and the process for documentation of care provided, and for the utilization of external catheters the physician order requirement and care provision per the manufacturer□s recommendations by the Staff Development Coordinator/Designee. Current Residents who have an indwelling catheter or external urinary catheter have the potential to be affected by this practice. An audit was accomplished by the Unit Manager/Designee of current residents who utilize indwelling catheters for evidence to support that documentation of urinary catheter care was provided each shift. An audit was accomplished by the Unit Manager/Designee of current residents who utilize external catheters for current physician orders and orders for catheter care provision per the manufacturer□s recommendations.	

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	495272	A. BUILDING ______ B. WING ______	C 08/16/2023

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F 690

Continued From page 155
not being implemented.

On 8/14/23 at 4:00 PM, ASM (administrative staff member) #1, the administrator, ASM #4, the regional risk consultant, ASM #7, the director of nursing and ASM #8, the regional consultant was made aware of the findings.

No policy regarding urinary catheter care was provided. No further information was provided prior to exit.

Reference:
(1) A Foley catheter is a common type of indwelling catheter. It has soft, plastic or rubber tube that is inserted into the bladder to drain the urine.
https://medlineplus.gov/ency/article/003981.htm
2. For Resident #86 (R86), the facility staff failed to obtain physician's orders and provide care per manufacturer's instructions for the resident's external urinary catheter.

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 7/17/23, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact for making daily decisions. A review of R86's clinical record failed to reveal any physician's orders for R86's external urinary catheter. Further review of R86's clinical record failed to reveal any instructions for care of the external urinary catheter.

On 8/7/23 at 12:37 p.m., R86 was observed sitting upright in bed eating lunch. The resident's external urinary catheter canister was observed beside the bed, on the nightstand, and was

F 690

Variances were addressed.

The Staff Development Coordinator/Designee re-educated Licensed Nursing Staff and C N A staff on Bowel/Blader Incontinence Catheter care and the process for documentation of care provided, and the physician order requirement for the utilization of external catheters to include orders for catheter care per the manufacturer□s recommendations.

An audit will be accomplished by the DON/Designee of 3 residents who utilize an indwelling urinary catheter to validate catheter care was provided and documented documentation to support that documentation of urinary catheter care was provided each shift. In addition, an audit will be accomplished by the DON/Designee of 3 residents who utilize an external urinary catheter to validate a physician order is in place and that orders are present and implemented for catheter care per the manufacturer□s recommendations. Variances will be addressed. These audits will be conducted weekly x 4 weeks, then monthly x 2 months. The findings of the audits will be submitted by the DON/Designee to the QAPI Committee for review and recommendation monthly for 3 months or ongoing until compliance sustained.

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 08/16/2023

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CANTERBURY REHABILITATION AND HEALTHCARE CENTER	1776 CAMBRIDGE DRIVE RICHMOND, VA 23238

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F 690	Continued From page 156 approximately three fourths full of urine. On 8/8/23 at 7:27 a.m., R86 was observed lying in bed. The resident's external urinary catheter canister was observed beside the bed, on the nightstand, and was approximately one tenth full of urine. On 8/9/23 at 4:18 p.m., R86 was observed lying in bed. The resident's external urinary catheter canister was observed beside the bed, on the nightstand, and was approximately one third full of urine. At that time, an interview was conducted with R86. R86 stated her daughter bought the catheter system because the facility staff were not changing the resident in a timely manner. R86 stated she did not personally care for the catheter but provided the supplies for care. R86 stated since she has resided on the current hall, some of the staff do not clean the catheter system like they should but she tells them to rinse the wick, tubing and canister once a day and change the wick once a day, or more if she has a bowel movement. On 8/10/23 at 7:50 a.m., R86 was observed lying in bed. The resident's external urinary catheter canister was observed beside the bed, on the nightstand, and was approximately one half full. On 8/10/23 at 4:07 p.m., an interview was conducted with CNA (certified nursing assistant) #6 (a CNA who cared for R86). CNA #6 stated the external urinary catheter was new to her. CNA #6 stated she replaces the wick and washes the tubing and canister per R86's request and if the resident has a bowel movement. On 8/11/23 at 8:14 a.m., an interview was conducted with LPN (licensed practical nurse) #6. LPN #6 stated R86 has had the external urinary catheter for at least a few months, is the first resident at the facility to have that external urinary	F 690		

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	495272	A. BUILDING ______ B. WING ______	C 08/16/2023

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F 690	Continued From page 157	F 690		

catheter, and it's been a learning experience. LPN #6 stated he looked up the device and knew that staff had to empty it and clean it out, but he did not obtain any physician's orders because it was a device the resident brought from home. LPN #6 stated staff knows how to care for the device because R86 tells them and it's important to empty it and make sure the tubing is clean for infection control because there is a risk for urinary tract infections. (Note- on 6/6/23, R86 was treated with antibiotic therapy for a urinary tract infection).

The external urinary catheter manufacturer's instructions documented the following, "The PureWick System (Trademark) is an innovative option to managing urinary incontinence. It includes the PureWick (Trademark) Female External Catheter and the PureWick (Trademark) Urine Collection System. The System works outside the body to draw urine away, helping keep skin dry.
The PureWick (Trademark) Urine Collection System 2000cc (mL) canister should be emptied before volume reaches 1800cc (mL), or as needed.
Is the PureWick (Trademark) Female External Catheter reusable? No. The wick should be replaced at least every 8 to 12 hours or sooner if soiled with feces or blood. Skin should be assessed to see if it's been compromised, and perineal care should be performed prior to placement of a new wick.
The canister and tubing should be replaced every 60 days, or sooner if you see signs of degradation." This information was obtained from the website:
https://www.purewickathome.com/faq.html.

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

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F 690	Continued From page 158 On 8/11/23 at 9:57 a.m., ASM (administrative staff member) #1 (the administrator) and ASM #4 (the regional risk consultant) were made aware of the above concern. The facility policy titled, "PureWick Female External Catheter" Documented, "2. The female external catheter should be changed when soiled with feces or blood and at least once a shift, no more than every 12 hours. 3. Urine collection canister and tubing should be replaced once a week or as needed if the tubing and canister are visibly soiled or damaged."	F 690		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.	F 693		9/26/23

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 08/16/2023

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F 693	Continued From page 159 This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, resident interview, clinical record review and facility document review, it was determined the facility staff failed to provide tube feeding per physician orders, for one of 16 residents; Resident #144. The findings include: For Resident #144, the facility staff failed to follow physician orders for tube feeding. On 8/7/23 at 2:30 PM, Resident #144 was observed with Glucerna 1.5 calorie, 700 ml (milliliters) still hanging at the bedside and not infusing. The feeding was labeled with a start date of 8/6/23 6:00 AM. The Glucerna container held 1500 milliliters. Resident #144 was admitted to the facility on 3/27/23 with diagnoses that include but are not limited to: dysphagia. Resident #144's most recent MDS (minimum data set) assessment, a quarterly annual assessment, with an assessment reference date of 7/4/23, coded the resident as scoring 03 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired. MDS Section G- Functional Status: coded the resident as total dependence with eating. A review of MDS Section K-Swallowing and Nutritional Status: coded the resident as signs and symptoms of possible swallowing disorder as: PEG (percutaneous endoscopic gastrostomy) tube: yes. A review of the comprehensive care plan dated	F 693	F693 Tube Feeding Mgmt/Restore Eating Skills SS=D Resident #144 tube feeding orders were reviewed by the clinical provider with no new recommendations or orders. Resident #144 is currently receiving tube feeding at rate and time per order. The bag and tubing are dated for current date. RN #1 was provided with re-education on following current orders for tube feedings and dating tubing with correct date by the Staff Development Coordinator/Designee. Current residents who receive tube feedings have the potential to be affected by this practice. An audit was completed by Unit Manager/Designee for current residents who receive tube feeding to validate administration rate and times are per physician orders and that the tubing is dated correctly. No further variances were noted.	

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	495272	A. BUILDING ______ B. WING ______	C 08/16/2023

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F 693	Continued From page 160 4/27/23 and revised 6/11/23, revealed, "FOCUS:...Resident has a nutritional problem related to NPO (nothing by mouth) and dependence on enteral infusion, diagnosis of encephalopathy, CKD, dysphagia, respiratory failure, altered mental status, DM, anemia, and PEG (percutaneous endoscopic gastrostomy) in place. Resident requires require enteral tube feeding related to dysphagia...INTERVENTIONS:...Provide enteral nutrition as ordered. Provide flushes of free water as ordered for hydration and tube patency. Administer tube feeding as ordered..." A review of the physician's order dated 6/1/23, revealed, "Enteral: Glucerna 1.5 Calorie liquid via feeding tube every shift, feeding pump set at 75 ml/hr (milliliters per hour) for 20 hours, total volume 1500 ml. Provides 2250 kcal, 124 protein, 1139 ml free water. UP AT 1300 (1:00 PM), DOWN AT 0900 (9:00 AM), or until total volume infused. AND two times a day begin and end each infusion period with flush of 200 mL free water for hydration and tube patency AND every 3 hours flush PEG tube with 200 mL free water for hydration and tube patency." An interview was conducted on 8/7/23 at 3:30 PM, with RN (registered nurse) #1. When shown the hanging enteral feeding for Resident #144, RN #1 stated, it was left hanging, it should have been taken down. When asked about the date, RN #1 stated, it is the wrong date and time. They will be hanging the new feeding soon. When asked if enteral orders were followed, RN #1 stated, no, it should have been hanging. On 8/14/23 at 4:00 PM, ASM (administrative staff member) #1, the administrator, ASM #4, the	F 693	Licensed Nursing staff members were re-educated by the staff development coordinator on following current orders for tube feedings and dating the tube with the correct date. An audit was completed by Unit Manager/Designee for current residents who receive tube feeding to validate administration rate and times are per physician orders and that the tubing is dated correctly Variances will be addressed. These audits will be conducted weekly x 4 weeks, then monthly x 2 months. The findings of the audits will be submitted by the DON/Designee to the QAPI Committee for review and recommendation monthly for 3 months or ongoing until compliance sustained.	

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	495272	A. BUILDING ______ B. WING ______	C 08/16/2023

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

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F 693	Continued From page 161	F 693		

regional risk consultant, ASM #7, the director of nursing and ASM #8, the regional consultant was made aware of the findings.

According to the facility's "Enteral Nutrition" policy, "The nursing staff and provider monitor the resident for signs and symptoms of inadequate nutrition, altered hydration, hypo- or hyperglycemia, and altered electrolytes. The nursing staff and provider also monitor the resident for worsening of conditions that place the resident at risk for the above. Enteral feedings are scheduled to try to optimize resident independence whenever possible (e.g., at night or during hours that do not interfere with the resident's ability to participate in facility activities). The nurse confirms that orders for enteral nutrition are complete. Complete orders include: a. the enteral nutrition product; b. delivery site (tip placement); c. the specific enteral access device (nasogastric, gastric, jejunostomy tube, etc.); d. administration method (continuous, bolus, intermittent); e. volume and rate of administration; f. the volume/rate goals and recommendations for advancement toward these; and g. instructions for flushing (solution, volume, frequency, timing and 24-hour volume)."

No further information was provided prior to exit.

Reference:
(1) Tube feeding is a way to provide nutrition when you cannot eat or drink safely by mouth. This can happen if you are unconscious or have trouble swallowing. Besides nutrition, tube feeding can provide fluids and medicines. It can also be used to remove stomach contents. The types of tubes used include the nasogastric tube (NG tube), the gastrostomy tube (G-tube or

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 08/16/2023

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

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F 693	Continued From page 162 PEG-tube), and the jejunostomy tube (J-tube or PEJ-tube). The NG tube is inserted through the nose and is used for a short time. The G-tube and J-tube are inserted through a small incision in the skin on the abdomen and are for longer-term use. https://medlineplus.gov/ency/imagepages/19965.htm	F 693		
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review and clinical record review, the facility staff failed to provide respiratory care and services consistent with professional standards for four of 57 residents in the survey sample, Residents #360, #358, #106 and #54. The findings include: 1. For Resident #360 (R360), the facility staff failed to obtain a physician's order for the use of an incentive spirometer and failed to store the incentive spirometer in a sanitary manner. R360 was admitted to the facility on 7/31/23.	F 695	F695: Respiratory/Tracheostomy Care and Suctioning SS=E Resident #360 was discharged from the facility on 8/19/23. Resident #358 was discharged from the facility on 8/30/23. Resident #106 was discharged from the	9/26/23

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 163 R360's admission minimum data set (MDS) assessment was in progress. An admission assessment dated 7/31/23 documented R360 was alert and oriented to person, place, time and situation. Further review of R360's clinical record failed to reveal a physician's order for an incentive spirometer. On 8/7/23 at 12:11 p.m., 8/7/23 at 3:54 p.m., and 8/8/23 at 9:53 a.m., R360 was observed lying in bed. An incentive spirometer was observed on the heating/air conditioning unit and the mouthpiece was in contact with the unit. On 8/8/23 at 9:53 a.m., an interview was conducted with R360. R360 stated they use the incentive spirometer a couple of times a day and has never been offered something to cover the device. On 8/10/23 at 2:19 p.m., an interview was conducted with LPN (licensed practical nurse) #7. LPN #7 stated a resident should have a physician's order for an incentive spirometer to make sure it is used in a timely fashion, and an incentive spirometer should be covered for infection control purposes. On 8/11/23 at 9:57 a.m., ASM (administrative staff member) #1 (the administrator) and ASM #4 (the regional risk consultant) were made aware of the above concern. 2. For Resident #358 (R358), the facility staff failed to administer oxygen at the physician prescribed rate of two liters per minute. A review of R358's clinical record revealed a physician' order dated 8/7/23 for oxygen at two liters per minute via nasal cannula every shift.	F 695	facility on 8/21/23. Resident #54 oxygen orders were reviewed, and oxygen was adjusted by the licensed nurse to the prescribed rate. LPN #7, #13, and RN #1 were provided with re-education on receiving and following orders for incentive spirometer use and how to properly store when not in use, review of oxygen administration per order, and monitoring of pulse oximeters as ordered. Current residents who utilize respiratory services have potential to be affected by this practice. An audit of residents who utilize oxygen was conducted to validate oxygen is administered at a rate and method as ordered and pulse oximetry monitoring is conducted as ordered. In addition, an audit of residents that have incentive spirometers to validate an order is in place and storge in a sanitary manner is maintained when not in use. No further variances were noted. Licensed Nursing staff members were re-educated on following physician orders	

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 08/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANTERBURY REHABILITATION AND HEALTHCARE CENTER	**1776 CAMBRIDGE DRIVE RICHMOND, VA 23238**

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F 695	Continued From page 164 On 8/7/23 at 12:21 p.m. and 7:35 a.m., R358 was observed lying in bed receiving oxygen via nasal cannula at one and a half liters per minute, as evidenced by the middle of the ball in the oxygen concentrator flowmeter positioned on the one-and-a-half-liter line. On 8/10/23 at 2:19 p.m., an interview was conducted with LPN (licensed practical nurse) #7. LPN #7 stated nurses should know the prescribed oxygen rate by looking at the order in the computer. LPN #7 stated it's important for the rate to be correct because if the rate is over or under, the nurse is, "Kinda practicing out of the scheduled orders." LPN #7 stated that when the physician's order is for two liters per minute, then it's best to be at eye level of the flowmeter in the oxygen concentrator, and the ball in the flowmeter should be center on the two-liter line. On 8/14/23 at 4:06 p.m., ASM (administrative staff member) #1 (the administrator), ASM #4 (the regional risk consultant) and ASM #7 (the director of nursing) were made aware of the above concern. The oxygen concentrator manufacturer's instructions documented, "5. Adjust the flow to the prescribed setting by turning the knob on the top of the flow meter until the ball is centered on the line marking the specific flow rate." The facility policy titled, "Oxygen Administration" documented, "1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration." 3. For Resident #106, the facility staff failed to provide respiratory therapy as ordered. Resident	F 695	for oxygen administration, completing pulse oximetry as ordered, obtaining orders prior to the use of incentive spirometers, and sanitary storage of incentive spirometers when not in use. An audit of 3 residents who utilize oxygen will be conducted by Respiratory Director/Designee to validate oxygen is administered at a rate and method as ordered and pulse oximetry monitoring is conducted as ordered. In addition, an audit of 3 residents that have incentive spirometers will be completed to validate an order is in place for use and storge in a sanitary manner is maintained when not in use. Variances will be addressed. These audits will be conducted weekly x 4 weeks, then monthly x 2 months. The findings of the audits will be submitted by the DON/Designee to the QAPI Committee for review and recommendation monthly for 3 months or ongoing until compliance sustained.	

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 08/16/2023

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

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F 695	Continued From page 165	F 695		

#106 was observed to be receiving oxygen via nasal cannula at two liters per minute without consistent documented oxygen saturation levels via pulse oximetry (1).

Resident #106 was admitted to the facility on 10/10/22 with diagnoses that include but are not limited to: ASCVD (atherosclerotic cardiovascular disease), COPD (chronic obstructive pulmonary disease), OSA (obstructive sleep apnea), and CHF (congestive heart failure).

Resident #106's most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 7/12/23, coded the resident as scoring 04 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired. A review of MDS Section O-Special Procedures: coded the resident as oxygen-yes.

A review of the comprehensive care plan dated 7/2/23, revealed, "FOCUS: Resident requires supplemental oxygen. INTERVENTIONS: Change tubing as per facility protocol. 02 per MD order. Monitor vital signs, including pulse oximeter, as ordered and clinically indicated..."

A review of the physician orders dated 7/1/23, revealed, "Oxygen at 2-4 liters/minute via nasal cannula to attain SPO2 [oxygen saturation] above 88% every 24 hours as needed for Shortness of Breath maintain SPO2 sat above 88%."

A review of Resident #106's oxygen saturation summary, revealed oxygen saturations were obtained at least every 24 hours from 7/1/23 to 7/17/23, however there were oxygen saturation

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 08/16/2023

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

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F 695	Continued From page 166 levels documented from 7/18/23 through 8/10/23 under the vital signs tab, TAR (treatment administration record) or progress notes. An interview was conducted on 8/14/23 at 10:20 AM with LPN (licensed practical nurse) #13. When asked if there was no documentation of SPO2 levels to determine oxygen administration levels of 2-4 liters, was the oxygen therapy services being provided per orders, LPN #13 stated, no, it is not. On 8/14/23 at 2:15 PM, an interview was conducted with RN (registered nurse) #1. When asked where SPO2 levels would be documented, RN #1 stated on the MAR-TAR (medication administration record-treatment administration record). When asked if oxygen saturation/pulse oximeter as ordered are not evidenced in Resident #106's medical record, is oxygen therapy services being provided as ordered, RN #1 stated, no, it is not being done as ordered. On 8/14/23 at 4:00 PM, ASM (administrative staff member) #1, the administrator, ASM #4, the regional risk consultant, ASM #7, the director of nursing and ASM #8, the regional consultant was made aware of the findings. According to the facility's "Oxygen Administration" policy, "Assessment: Before administering oxygen, and while the resident is receiving oxygen therapy, assess for the following: 1. Signs or symptoms of cyanosis (i.e., blue tone to the skin and mucous membranes); 2. Signs or symptoms of hypoxia (i.e., rapid breathing, rapid pulse rate, restlessness, confusion); 3. Signs or symptoms of oxygen toxicity (i.e., tracheal irritation, difficulty breathing, or slow, shallow rate	F 695		

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 08/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 167	F 695		

of breathing); 4. Vital signs; 5. Lung sounds; 6. Arterial blood gases and oxygen saturation, if applicable; and 7. Other laboratory results (hemoglobin, hematocrit, and complete blood count), if applicable. Documentation: After completing the oxygen setup or adjustment, the following information should be recorded in the resident's medical record: 1. The date and time that the procedure was performed. 2. The name and title of the individual who performed the procedure. 3. The rate of oxygen flow, route, and rationale."

No further information was provided prior to exit.

(1) A pulse oximeter can also measure blood oxygen saturation levels through a small clip that ' s usually placed on your finger or toe. An oximeter reading only indicates what percentage of your blood is saturated with oxygen, known as the SpO2 level, as well as your heart rate. It ' s a quick and harmless way to check if someone ' s blood oxygen level is too low.
https://my.clevelandclinic.org/health/diagnostics/22447-blood-oxygen-level
4. For Resident #54 (R54), the facility staff failed to administer oxygen at the rate ordered by the physician.

On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 5/30/23, the resident was coded as receiving oxygen in the facility.

On the following dates and times, R54 was observed in bed receiving oxygen through a nasal cannula via a concentrator at a rate of three liters per minute (3 lpm): 8/7/23 at 12:10 p.m. and 4:18 p.m.' 8/8/23 at 10:38 a.m.; and 8/9/23 at 11:14

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 08/16/2023

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

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F 695		F 695		

Continued From page 168
a.m. and 12:27 a.m.

A review of R54's orders revealed the following order dated 5/23/23: "O2 (oxygen) at 2 lpm for O2 sat [saturation] <90% (less than 90%)."

A review of R54's August 2023 MAR (medication administration record) failed to reveal evidence that the resident's oxygen saturation was less than 90% without the supplemental oxygen therapy.

A review of R54's care plan dated 5/31/23 revealed, in part: "I have altered respirator status...Administer oxygen as ordered."

On 8/9/23 at 12:27 p.m., LPN (licensed practical nurse) #3 observed the rate of oxygen administration on the concentrator for R54. She stated: "It's set on three liters."

On 8/9/23 at 4:11 p.m., CNA (certified nursing assistant) #10 was asked if she was aware of R54 adjusting his own oxygen rate. She stated she was not. She stated she was not sure the resident was mobile enough to be able to get to the concentrator and change the rate.

On 8/10/23 at 2:19 p.m., LPN (licensed practical nurse) #7 was interviewed, she stated if a resident had orders for oxygen to be administered at two liters per minute, the center of the ball on the concentrator should be on the two liter line. She stated the physician orders the rate. She stated if the oxygen is flowing at any other rate other than the one ordered by the physician, the nurse is practicing outside of her scope of practice.

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 08/16/2023

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

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F 695	Continued From page 169 On 8/14/23 at 4:01 p.m., ASM (administrative staff member) #1, the administrator, ASM #4, the regional risk consultant, ASM #8, the regional consultant, and ASM #7, the director of nursing, were informed of these concerns. No further information was provided prior to exit.	F 695		
F 697 SS=E	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, it was determined that the facility staff failed to implement a complete pain management program for two of 57 residents in the survey sample, Residents #63 and #133. The findings include: 1. For Resident #63 (R63), the facility staff failed to attempt non-pharmacological interventions prior to the administration of a prn (as needed) pain medications, Acetaminophen (1) and failed to document the location of the pain. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 05/21/2023, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident was	F 697	F697: Pain Management SS=E Resident # 63 was discharged from the facility on 8/8/23. Resident # 133 pain management orders were reviewed with the clinical provider with orders updated to include location and/or pain characteristics, and nonpharmacological interventions prior to administration of unscheduled analgesics. LPN # 16 was re-educated by Staff Development Coordinator/Designee	9/26/23

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 08/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANTERBURY REHABILITATION AND HEALTHCARE CENTER	**1776 CAMBRIDGE DRIVE RICHMOND, VA 23238**

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

F 697

Continued From page 170

cognitively intact for making daily decisions.

The physician order for R63 documented in part, "Acetaminophen Tablet. Give 325 mg (milligrams) by mouth every 6 (six) hours as needed for pain not to exceed 3000mg per day. Order Date: 05/06/2022."

The eMAR (electronic medication administration record) for R63 dated July 2023 documented the physician's orders as stated above. The eMAR revealed that R63 received 325 mgs of Acetaminophen with no evidence of non-pharmacological interventions being attempted nor documentation of the location of R63's pain on 07/03/2023, 07/06/2023, 07/08/2023, 07/13/2023, 07/17/2023, 07/18/2023, 07/19/2023, 07/22/2023, 07/24/2023 and on 07/25/2023.

The eMAR (electronic medication administration record) for R63 dated August 2023 documented the physician's orders as stated above. The eMAR revealed that R63 received 325 mgs of Acetaminophen with no evidence of non-pharmacological interventions being attempted nor documentation of the location of R63's pain on 08/01/2023 and 08/04/2023.

The nursing progress notes for R63 for the dates list above failed to evidence documentation of non-pharmacological interventions prior to the administration of Acetaminophen and the location of R63's pain.

Review R63's comprehensive care plan dated 01/21/2023 failed to evidence documentation to address R63's pain and pain interventions.

F 697

regarding offering and documenting nonpharmacological interventions prior to administering unscheduled analgesics.

LPN # 10 was re-educated by Staff Development Coordinator/Designee on documentation of pain management program to include location and/or pain characteristics, and/or attempts at nonpharmacological interventions.

Current residents on pain management therapy have the potential to be affected by this practice.

An audit was completed by Unit Manager/Designee of residents who utilize pain medication to validate pain management services is provided in a manner that is consistent with professional standards of practice to include but not limited to including location of pain and/or pain characteristics and attempting nonpharmacological interventions prior to administration of unscheduled pain medications. Variances were addressed.

Licensed Nursing staff members were re-educated on pain management program to include location and/or pain characteristics, and/or attempts at nonpharmacological interventions.

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 08/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANTERBURY REHABILITATION AND HEALTHCARE CENTER	**1776 CAMBRIDGE DRIVE RICHMOND, VA 23238**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 171 On 08/10/2023 at approximately 2:15 p.m., an interview was conducted with LPN (licensed practical nurse) #16. When asked to describe the procedure for administering as needed (prn) pain medications LPN #16 stated they would assess the resident's pain level on a scale of zero to ten with ten being their worse pain and ask the resident where the pain was, try to alleviate the pain without the medication and if that was not successful then administer the pain medication. When asked about documenting the non-pharmacological interventions attempted and the location of the resident's pain, she stated that it would be documented on the MAR and in the progress notes. After reviewing R63's eMAR and nursing progress notes for the dates listed above LPN # 16 stated that a full pain assessment was not completed, and non-pharmacological interventions were not attempted. On 08/14/2023 at approximately 9:50 a.m., ASM (administrative staff member) #1, administrator and ASM #4, regional risk consultant, were made aware of the above findings. No further information was provided prior to exit. References: (1) Used to relieve mild to moderate pain from headaches, muscle aches, menstrual periods, colds and sore throats, toothaches, backaches, and reactions to vaccinations (shots), and to reduce fever. This information was obtained from the website: https: https://medlineplus.gov/druginfo/meds/a681004.html. 2. For Resident #133, the facility staff failed to implement a complete pain management program to include pain location and/or pain	F 697	An audit will be completed by Unit Manager/Designee of 3 residents on pain management therapy to validate pain management services is provided in a manner that is consistent with professional standards of practice to include but is not limited to documentation of location of pain and/or pain characteristics and attempts at nonpharmacological interventions prior to administration of unscheduled pain medications were made. Variances will be addressed. These audits will be conducted weekly x 4 weeks, then monthly x 2 months. The findings of the audits will be submitted by the DON/Designee to the QAPI Committee for review and recommendation monthly for 3 months or ongoing until compliance sustained.	

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 08/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697		F 697		

Continued From page 172
characteristics, and/or attempts at non-pharmacological interventions.

A review of the clinical record revealed a physician's order dated 8/1/23 for Oxycodone (1) 5 mg (milligrams) one capsule every six hours as needed for moderate to severe pain.

A review of the August 2023 MAR (Medication Administration Record) revealed the Oxycodone was administered as follows:

8/1/23 at 8:19 PM
8/2/23 at 1:22 AM and 12:59 PM
8/3/23 at 5:29 AM
8/4/23 at 2:32 AM and 12:10 PM
8/5/23 at 12:00 AM and 9:00 PM
8/7/23 at 4:09 AM and 12:10 PM
8/8/23 at 10:41 PM
8/10/23 at 9:01 PM
8/11/23 at 2:03 AM
8/13/23 at 3:29 AM
8/14/23 at 4:35 AM

Further review of the clinical record failed to reveal evidence of pain location and/or pain characteristics, and/or attempts at non-pharmacological interventions.

A review of the clinical record revealed the comprehensive care plan which included one dated 7/6/23 for "I have pain and/or potential for pain." This care plan included the intervention dated 5/1/23 for "Encourage me to try non-pharmacological interventions for pain relief as applicable e.g. positioning, relaxation therapy, bathing, heat and cold application, muscle stimulation, ultrasound."

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 08/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 173 On 8/14/23 at 12:18 PM, LPN #10 (Licensed Practical Nurse) was interviewed. She stated that given this resident's condition, the only non-pharmacological interventions that could really be offered is a change in position, which she stated the resident did not like to do. She stated that the resident did not like to get up for anything else. She stated that pain location and characteristics and non-pharmacological interventions should be documented. On 8/14/23 at 4:00 PM at an end-of-day meeting, ASM #1 (Administrative Staff Member) the Administrator, ASM #4 the Regional Risk Consultant, ASM #7 the Director of Nursing and ASM #8 the Regional Consultant, were made aware of the findings. No further information was provided by the end of the survey. References: (1) Oxycodone is used to treat moderate to severe pain. Information obtained from https://medlineplus.gov/druginfo/meds/a682132.html	F 697		
F 698 SS=E	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determined that facility staff failed	F 698	F698: Dialysis	9/26/23

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 08/16/2023

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

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

F 698 Continued From page 174
to ensure ongoing communication and collaboration with the dialysis facility regarding dialysis care and services, for one of seven residents receiving dialysis services; Resident #149.

The findings include:

For Resident #149, the facility staff failed to utilize and maintain consistent communication with the dialysis center by way of the dialysis communication book in June, July, and August of 2023

A review of the clinical record revealed a physician's order dated 6/16/23 for dialysis on Tuesdays, Thursdays and Saturdays.

A review of the dialysis communication book was conducted. The following dates for which the resident was scheduled for dialysis were not represented in the communication book to evidence that any communication occurred between the facility and the dialysis center: June 17, 20, 24, 27, and 29 of 2023. July 6, 8, 11, 15, 18, 22, 25, 27, and 29 of 2023. August 1, 3, 5, and 10 of 2023.

On 8/15/23 at 9:24 AM, an interview was conducted with LPN #1 (Licensed Practical Nurse). She stated that there should be communication documented every time they send a resident to dialysis, and bring the book back after dialysis and that the dialysis center should be documenting on every visit. She stated that the type of information that should be documented in the communication book included pre and post dialysis weight, blood pressure, medications given, etc. She stated that there

F 698

SS=E

The licensed nurse obtained provided and obtained an update from Resident #149 dialysis center on 9/8/23. The dialysis center coordinator was also made aware of the need to provide updates utilizing the communication form. Resident #149 is provided dialysis communication book for each dialysis appointment.

Current residents on dialysis have potential to be affected by this practice. An audit was completed by Unit Manager/Designee on residents receiving dialysis to validate dialysis communication is sent and received for dialysis appointment. Variances were addressed.

Licensed Nursing staff members were re-educated on the need for residents who require dialysis to have ongoing communication and collaboration between the facility and the dialysis facility regarding dialysis care and services this includes but is not limited to completion and maintaining the dialysis communication form sent and to be returned with the resident on each visit.

The Unit Manager/designee will complete an audit of 3 residents on dialysis to validate communication regarding care

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 08/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698	Continued From page 175 should be something documented for every visit. A review of a "Dialysis Communication Log" revealed the following information contained on the form to be filled in by the facility and the dialysis center: Vital signs, weight - including pre and post dialysis weight, labs drawn, dietician comments, shunt site care, medications administered, tolerance of dialysis treatment, time of last food intake, additional comments, resident name, date. A policy for dialysis was requested. The policy provided, "Hemodialysis Catheters - Access and Care Of" did not address the requirement for communication with, to and from, the facility and dialysis center at each dialysis treatment / visit. On 8/14/23 at 4:00 PM at an end-of-day meeting, ASM #1 (Administrative Staff Member) the Administrator, ASM #4 the Regional Risk Consultant, ASM #7 the Director of Nursing and ASM #8 the Regional Consultant, were made aware of the findings. No further information was provided by the end of the survey.	F 698	and services that are being sent to and received from the dialysis center for each dialysis appointment. Variances will be addressed. These audits will be conducted weekly x 4 weeks, then monthly x 2 months. The findings of the audits will be submitted by the DON/Designee to the QAPI Committee for review and recommendation monthly for 3 months or ongoing until compliance sustained.	
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation.	F 700		9/26/23

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F 700	Continued From page 176 §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to implement bed rail requirements for three of 57 residents in the survey sample, Residents #359, #95 and #358. The findings include: 1. For Resident #359 (R359), the facility staff implemented bed rails without a documented recommended clinical need, failed to review the risks and benefits of bed rails, and failed to obtain informed consent for the use of bed rails. On 8/7/23 at 12:17 p.m. and 8/8/23 at 11:38 a.m., R359 was observed lying in bed with a left grab bar (bed rail) in the upright position. A review of R359's clinical record failed to reveal a physician's order for bed rails, failed to reveal evidence that the risks and benefits of bed rails were explained to the resident (or resident representative), and failed to reveal evidence that informed consent for the use of bed rails was obtained. The bed rail evaluation section of an	F 700	F700: Bedrails SS=D Resident #359, and #95, were reviewed for bed rails by the IDT to include documentation of clinical need, review of the risks and benefits of bed rails, physician order and informed consent for the use of bed rails. Resident #358 was discharged from the facility on 8/30/23. Current residents who utilize bedrails have the potential to be affected by this practice. An audit of current residents that utilize bed rails was conducted to validate documentation of assessment to include	

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	495272	A. BUILDING ______ B. WING ______	C 08/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANTERBURY REHABILITATION AND HEALTHCARE CENTER	**1776 CAMBRIDGE DRIVE RICHMOND, VA 23238**

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F 700 Continued From page 177

admission/readmission evaluation packet form dated 8/4/23 documented, "1. Is the resident ambulatory? No. 3. Does the resident use the bed rail to assist with bed mobility? No. 4. Does the resident use the bed rail to assist with transfers? No. Recommendations and Care Planning: c. Bed Rail is not indicated at this time..."

On 8/10/23 at 3:36 p.m., an interview was conducted with LPN (licensed practical nurse) #1, regarding the use of bed rails. LPN #1 stated residents must be educated about the risks and benefits and a consent form has to be filled out. LPN #1 stated the facility frowns on bed rails because someone could get caught in them, but they can be helpful if someone uses them for turning. LPN #1 stated if an evaluation documents bed rails are not indicated then they should not be on the bed.

On 8/14/23 at 4:06 p.m., ASM (administrative staff member) #1 (the administrator), ASM #4 (the regional risk consultant) and ASM #7 (the director of nursing) were made aware of the above concern.

The facility policy titled, "Bed Safety and Bed Rails" documented, "3. The use of bed rails or side rails (including temporarily raising the side rails for episodic use during care) is prohibited unless the criteria for use of bed rails have been met, including attempts to use alternatives, interdisciplinary evaluation, resident assessment, and informed consent."

2. For Resident #95 (R95), the facility staff implemented bed rails without a current, documented, recommended clinical need.

F 700

therapy evaluation as indicated, review of risks and benefits, physician orders and informed consent is in place. Variances were addressed.

Licensed Nursing staff members were re-educated on the process for the use of bed rails which includes documentation of clinical need, review of the risks and benefits of bed rails, physician order and informed consent for the use of bed rails.

A review of 3 residents that utilize bedrails will be conducted by the DON/Designee to validate documentation of assessment to include therapy evaluation as indicated, review of risks and benefits, physician orders and informed consents are in place. Variances will be addressed. These audits will be conducted weekly x 4 weeks, then monthly x 2 months. The findings of the audits will be submitted by the DON/Designee to the QAPI Committee for review and recommendation monthly for 3 months or ongoing until compliance sustained.

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 08/16/2023

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

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F 700	Continued From page 178 On 8/7/23 at 4:09 p.m., and 8/8/23 at 7:34 a.m., R95 was observed lying in bed with bilateral grab bars in the upright position. A review of R95's clinical record revealed a physician's order dated 10/6/20 for two grab bars to aide in positioning and mobility. The bed rail evaluation section of an admission/readmission evaluation packet form dated 6/24/23 documented, "1. Is the resident ambulatory? No. 3. Does the resident use the bed rail to assist with bed mobility? No. 4. Does the resident use the bed rail to assist with transfers? No. Recommendations and Care Planning: c. Bed Rail is not indicated at this time..." On 8/10/23 at 3:36 p.m., an interview was conducted with LPN (licensed practical nurse) #1, regarding the use of bed rails. LPN #1 stated the facility frowns on bed rails because someone could get caught in them, but they can be helpful if someone uses them for turning. LPN #1 stated if an evaluation documents bed rails are not indicated then they should not be on the bed. On 8/14/23 at 4:06 p.m., ASM (administrative staff member) #1 (the administrator), ASM #4 (the regional risk consultant) and ASM #7 (the director of nursing) were made aware of the above concern. On 8/15/23 at 1:24 p.m., an interview was conducted with LPN#14. LPN #14 stated that if a resident has an older physician's order for bed rails, but then has a nursing assessment that documents bed rails are not indicated then the order should probably be discontinued, and the continuation of bed rails should be addressed.	F 700		

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	495272	A. BUILDING ____ B. WING ____	C 08/16/2023

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F 700	Continued From page 179	F 700		

3. For Resident #358 (R358), the facility staff failed to obtain a therapy evaluation to determine there was a clinical need for bed rails.

On 8/7/23 at 12:21 p.m. and 8/8/23 at 7:30 a.m., R358 was observed lying in bed with bilateral grab bars (bed rails) in the upright position.

A review of R358's clinical record failed to reveal a physician's order for bed rails. The bed rail evaluation section of an admission/readmission evaluation packet form dated 8/5/23 documented, ""1. Is the resident ambulatory? No. 3. Does the resident use the bed rail to assist with bed mobility? No. 4. Does the resident use the bed rail to assist with transfers? No. Recommendations and Care Planning: Further Therapy Evaluation is recommended..." A review of a physical therapy evaluation dated 8/7/23 and an occupational therapy evaluation dated 8/7/23 failed to document any information regarding bed rails.

On 8/10/23 at 3:36 p.m., an interview was conducted with LPN (licensed practical nurse) #1, regarding the use of bed rails. LPN #1 stated the facility frowns on bed rails because someone could get caught in them, but they can be helpful if someone uses them for turning. LPN #1 stated that if a nursing assessment documents further therapy evaluation is recommended then therapy should be involved.

On 8/14/23 at 3:20 p.m., an interview was conducted with OSM (other staff member) #12 (the director of rehab). OSM #12 stated she does not review the nursing admission/readmission evaluation packet forms so if the nursing staff

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 08/16/2023

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

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F 700	Continued From page 180 feels that a therapy evaluation for the use of bed rails is needed, then she should be told during the daily clinical meeting. OSM #12 stated she was not made aware that nursing staff recommended a therapy evaluation for R358's bed rails. On 8/14/23 at 4:06 p.m., ASM (administrative staff member) #1 (the administrator), ASM #4 (the regional risk consultant) and ASM #7 (the director of nursing) were made aware of the above concern.	F 700		
F 742 SS=D	Treatment/Srvcs Mental/Psychoscial Concerns CFR(s): 483.40(b)(1) §483.40(b) Based on the comprehensive assessment of a resident, the facility must ensure that- §483.40(b)(1) A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being; This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, the facility staff failed to provide services related to trauma-informed care for one of 57 residents in the survey sample, Resident #37. The findings include: For Resident #37 (R37), who had a diagnosis of PTSD (post-traumatic stress disorder) (1), the facility staff failed to follow up on a	F 742	F742:Treatment/Srvcs Mental/Psychosocial Concerns SS=D Resident #37 was reviewed by the social worker on 8/31/23 and offered counseling services for mental/psychosocial concerns.	9/26/23

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 08/16/2023

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

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F 742	Continued From page 181 recommendation for counseling services. On the most recent MDS (minimum data set). an annual assessment with an ARD (assessment reference date) of 5/21/23, R37 was coded as being moderately impaired for making daily decisions, having scored 11 out of 15 on the BIMS (brief interview for mental status). He was scored a zero on the mood severity evaluation, indicating he had no symptoms of mood dysfunction during the look back period. He was coded as having demonstrated no behaviors during the look back period. R37 was admitted to the facility with diagnoses including depression, chronic PTSD, and visual hallucinations. A review of R37's clinical record revealed a progress note from a licensed clinical social worker who was no longer employed at the facility, OSM (other staff member) #17. The note was dated 7/19/22. A review of the note revealed, in part: "The patient was doing well today...He did state that he had some depression from his familial issues, but otherwise has been in a good mood...The psychotherapist and patient discussed focusing on positive thinking, especially when it concerns family. They resolved that the patient will be mindful when talking to family...The psychotherapist will monitor over the following weeks, continuing to build rapport...Treatment Plan Progress/Goals...This psychotherapist will work with the patient on establishing coping mechanisms to feel less depressed...This psychotherapist will work to engage patient in combating emotional distress and adjusting to the unit well. This psychotherapist will encourage use of mindfulness to reduce anxiety through deep breathing exercises...Prescribed Frequency:	F 742	Current residents who reside at Canterbury Rehabilitation and Healthcare have potential to be affected by this practice. An audit was completed and residents with mental/psychosocial concerns were identified to validate counseling services are offered and provided as indicated. Variances were addressed. Social Work staff members re-educated by the Regional Social Services Consultant on trauma informed care to include but not limited to offering and referring utilization of counseling services for residents with mental/psychosocial concerns. A review of 3 residents will be conducted by the Administrator/Designee of residents with mental/psychosocial concerns to validate counseling services are offered and provided as indicated. Variances will be addressed. These audits will be conducted weekly x 4 weeks, then monthly x 2 months. The findings of the audits will be submitted by the Administrator/Designee to the QAPI Committee for review and recommendation monthly for 3 months or ongoing until compliance sustained.	

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	495272	A. BUILDING ______ B. WING ______	C 08/16/2023

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F 742		F 742		

Continued From page 182
Weekly."

Further review of R37's clinical record revealed no evidence that R37 had received any counseling services since he was seen on 7/19/22.

A review of R37's care plan dated 11/27/22 revealed no information related to trauma informed services for R37.

On 8/11/23 at 8:31 a.m., OSM #5, the director of social services, was interviewed. She stated her role in trauma informed care is limited to completing the assessments that are required for the MDSs. She stated: "We ask the questions about the resident's mood and if they have experienced any trauma." She stated she does not have a role in developing a care plan for trauma informed care, and was not sure who is responsible for that. She stated she was aware that R37 has a diagnosis of PTSD, but did not think the resident was receiving counseling at this time. She stated she was not sure how R37 and OSM #17 were "connected." She stated no staff had raised concerns about R37's mood or behavior recently, and she had not observed any concerns. She stated she did not see any follow up to OSM #17's recommendation, and that she was not aware of the recommendation.

On 8/15/23 at 10:16 a.m., ASM (administrative staff member) #7, the director of nursing, was interviewed. She stated OSM #17 had been with the facility for a while, but no longer was employed by the facility. She stated none of the facility staff was aware of the recommendation for further counseling on OSM #17's progress note. OSM #17 uploaded progress notes directly into

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	495272	A. BUILDING ______ B. WING ______	C 08/16/2023

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

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F 742	Continued From page 183 the facility's electronic medical record, and "that poses a problem. This one got lost." She stated trauma informed care should definitely be included in a resident's care plan, and residents with a history of PTSD should be seen at least annually by psychological services. On 8/14/23 at 4:01 p.m., ASM (administrative staff member) #1, the administrator, ASM #4, the regional risk consultant, ASM #8, the regional consultant, and ASM #7, the director of nursing, were informed of these concerns. A review of the facility policy, "Trauma Informed and Culturally Competent Care...Purpose...to address the needs of trauma survivors by minimizing triggers and/or re-traumatization...perform universal screening of residents...incorporate the following principles...safety...trust and transparency...peer support...collaboration...empowerment, voice and choice." No further information was provided prior to exit. NOTES (1) "Post-traumatic stress disorder (PTSD) is a disorder that develops in some people who have experienced a shocking, scary, or dangerous event...Those who continue to experience problems may be diagnosed with PTSD. People who have PTSD may feel stressed or frightened, even when they are not in danger." This information is taken from the website https://www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd.	F 742		
F 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d)	F 745		9/26/23

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 08/16/2023

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

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F 745	Continued From page 184 §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, the facility staff failed to provide medically related social services for one of 57 residents in the survey sample, Resident #37. The findings include: For Resident #37 (R37), who had a diagnosis of PTSD (post-traumatic stress disorder) (1), the facility social worker failed to follow up on a recommendation for counseling services. On the most recent MDS (minimum data set). an annual assessment with an ARD (assessment reference date) of 5/21/23, R37 was coded as being moderately impaired for making daily decisions, having scored 11 out of 15 on the BIMS (brief interview for mental status). He was scored a zero on the mood severity evaluation, indicating he had no symptoms of mood dysfunction during the look back period. He was coded as having demonstrated no behaviors during the look back period. R37 was admitted to the facility with diagnoses including depression, chronic PTSD, and visual hallucinations. A review of R37's clinical record revealed a progress note from a licensed clinical social worker who was no longer employed at the facility, OSM (other staff member) #17. The note was dated 7/19/22. A review of the note revealed,	F 745	F745: Provision of Medically Related Social Service SS=D Resident #37 was reviewed by the social worker on 8/31/23 and offered counseling services for mental/psychosocial concerns. Current residents who reside at Canterbury Rehabilitation and Healthcare have potential to be affected by this practice. An audit was completed and residents with mental/psychosocial concerns were identified to validate counseling services are offered and provided as indicated. Variances were addressed. Social Work staff members re-educated by the Regional Social Service Consultant on trauma informed care to include but not limited to offering and referring utilization of counseling services for residents with mental/psychosocial concerns.	

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CANTERBURY REHABILITATION AND HEALTHCARE CENTER	1776 CAMBRIDGE DRIVE RICHMOND, VA 23238

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F 745	Continued From page 185 in part: "The patient was doing well today...He did state that he had some depression from his familial issues, but otherwise has been in a good mood...The psychotherapist and patient discussed focusing on positive thinking, especially when it concerns family. They resolved that the patient will be mindful when talking to family...The psychotherapist will monitor over the following weeks, continuing to build rapport...Treatment Plan Progress/Goals...This psychotherapist will work with the patient on establishing coping mechanisms to feel less depressed...This psychotherapist will work to engage patient in combating emotional distress and adjusting to the unit well. This psychotherapist will encourage use of mindfulness to reduce anxiety through deep breathing exercises...Prescribed Frequency: Weekly." Further review of R37's clinical record revealed no evidence that R37 had received any counseling services since he was seen on 7/19/22. A review of R37's care plan dated 11/27/22 revealed no information related to trauma informed services for R37. On 8/11/23 at 8:31 a.m., OSM #5, the director of social services, was interviewed. She stated her role in trauma informed care is limited to completing the assessments that are required for the MDSs. She stated: "We ask the questions about the resident's mood and if they have experienced any trauma." She stated she does not have a role in developing a care plan for trauma informed care, and was not sure who is responsible for that. She stated she was aware	F 745	A review of 3 residents will be conducted by the Administrator/Designee of residents with mental/psychosocial concerns to validate counseling services are offered and provided as indicated. Variances will be addressed. These audits will be conducted weekly x 4 weeks, then monthly x 2 months. The findings of the audits will be submitted by the Administrator/Designee to the QAPI Committee for review and recommendation monthly for 3 months or ongoing until compliance sustained.	

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CANTERBURY REHABILITATION AND HEALTHCARE CENTER	**1776 CAMBRIDGE DRIVE RICHMOND, VA 23238**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 745	Continued From page 186	F 745		

that R37 has a diagnosis of PTSD, but did not think the resident was receiving counseling at this time. She stated she was not sure how R37 and OSM #17 were "connected." She stated no staff had raised concerns about R37's mood or behavior recently, and she had not observed any concerns. She stated she did not see any follow up to OSM #17's recommendation, and that she was not aware of the recommendation.

On 8/14/23 at 4:01 p.m., ASM (administrative staff member) #1, the administrator, ASM #4, the regional risk consultant, ASM #8, the regional consultant, and ASM #7, the director of nursing, were informed of these concerns.

On 8/15/23 at 10:16 a.m., ASM (administrative staff member) #7, the director of nursing, was interviewed. She stated OSM #17 had been with the facility for a while, but no longer is employed by the facility. She stated none of the facility staff was aware of the recommendation for further counseling on OSM #17's progress note. OSM #17 uploaded progress notes directly into the facility's electronic medical record, and "that poses a problem. This one got lost." She stated trauma informed care should definitely be included in a resident's care plan, and residents with a history of PTSD should be seen at least annually by psychological services. She stated trauma informed care is a team effort, and the social worker is responsible for making sure residents are receiving the services as recommended by members of the team.

A review of the facility's job description for the social services director revealed, in part: "Develop and implement policies and procedures for the identification of medically related social

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 08/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANTERBURY REHABILITATION AND HEALTHCARE CENTER	**1776 CAMBRIDGE DRIVE** **RICHMOND, VA 23238**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 745	Continued From page 187 and emotional needs of the resident...Refer resident/families to appropriate social service agencies when the Center does not provide the services or needs of the resident in a private setting...Develop a written plan of care for each resident that identifies social problems/needs No further information was provided prior to exit. NOTES (1) "Post-traumatic stress disorder (PTSD) is a disorder that develops in some people who have experienced a shocking, scary, or dangerous event...Those who continue to experience problems may be diagnosed with PTSD. People who have PTSD may feel stressed or frightened, even when they are not in danger." This information is taken from the website https://www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd.	F 745		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	F 755		9/26/23

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 08/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANTERBURY REHABILITATION AND HEALTHCARE CENTER	**1776 CAMBRIDGE DRIVE RICHMOND, VA 23238**

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F 755	Continued From page 188 §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review and clinical record review, the facility staff failed to provide pharmacy services for five of 57 residents in the survey sample, Residents #86, #115, #360, #95 and #358. The findings include: 1. For Resident #86 (R86), the facility staff failed to ensure the physician ordered medication levothyroxine sodium (1), was available and administered on 8/5/23 and 8/6/23. A review of 86's clinical record revealed a physician's order dated 4/1/23 for levothyroxine sodium 175 mcg (micrograms)- one tablet once a day for hypothyroidism. A review of R86's August 2023 MAR (medication administration record) revealed the same physician's order for levothyroxine sodium. On 8/5/23 and 8/6/23, the	F 755	F755: Pharmacy SS:E Residents #86, #115, and #95s ordered medications were reviewed by Unit Manager/Designee to validate ordered medications were on hand and available for administration. No further variances were noted, and medications administered as prescribed by the physician at this time. Resident # 360 was discharged from the facility on 8/19/23. Resident #358 was discharged from the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495272	A. BUILDING ______ B. WING ______	C 08/16/2023

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

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F 755	Continued From page 189 MAR documented the code, "5=Hold." Nurses' notes dated 8/5/23 and 8/6/23 documented, "Med on order." Further review of nurses' notes and the August 2023 MAR failed to reveal documentation that levothyroxine sodium was administered to R86 on 8/5/23 and 8/6/23. A review of the facility backup medication supply list revealed levothyroxine sodium was not stocked in the supply. On 8/10/23 at 2:19 p.m., an interview was conducted with LPN (licensed practical nurse) #7. LPN #7 stated non-narcotic medications should be ordered from the pharmacy when there are ten pills remaining. LPN #7 stated if a medication is not available for administration, then she checks the backup medication supply, and if the medication is not available there, she notifies the pharmacy and doctor. On 8/11/23 at 9:57 a.m., ASM (administrative staff member) #1 (the administrator) and ASM #4 (the regional risk consultant) were made aware of the above concern. The facility policy titled, "Medication and Treatment Orders" documented, "11. Drugs and biologicals that are required to be refilled must be reordered from the issuing pharmacy not less than three (3) days prior to the last dosage being administered to ensure that refills are readily available." Reference: (1) "Levothyroxine is used to treat hypothyroidism (condition where the thyroid gland does not produce enough thyroid hormone)." This information was obtained from the website:	F 755	facility on 8/30/23. Residents who have ordered for medication administration have the potential to be affected by this practice. A review of residents receiving medications was completed by Unit Manager/Designee to validate medications are on hand and available for administration per physician orders. Variances were addressed. Licensed Nursing staff members were re-educated by the Staff Development Coordinator/Designee on the process for ordering medication, utilizing back up drug box and ordering stat medications from the pharmacy. This education included the need to notify the physician if a medication is not available on hand for further instruction. The Unit Manager/designee will audit x 3 residents weekly for medication availability per physician orders. Variances will be addressed. These audits will be conducted weekly x 4 weeks, then monthly x 2 months. The findings of the audits will be submitted by the DON/Designee to the QAPI Committee for review and recommendation monthly for 3 months or ongoing until compliance	

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 08/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 190 https://medlineplus.gov/druginfo/meds/a682461.html. 2. For Resident #115 (R115), the facility staff failed to ensure the physician ordered medications lisinopril (1), allopurinol (2) and diltiazem (3) were available and administered on 7/9/23. A review of R115's clinical record revealed the following physician's orders: 4/1/23-lisinopril 40 mg (milligrams) once a day for high blood pressure 4/1/23-allopurinol 300 mg once a day for gout 4/4/23-diltiazem 30 mg (milligrams) every eight hours for high blood pressure A review of R115's MAR (medication administration record) for July 2023 revealed the same physician's orders for lisinopril, allopurinol and diltiazem. On 7/9/23 for the morning doses, the MAR documented the code, "5=Hold." Nurses' notes dated 7/9/23 documented the medications were on order. Further review of nurses' notes and the July 2023 MAR failed to reveal documentation that the morning doses of lisinopril, allopurinol and diltiazem were administered to R115 on 7/9/23. A review of the facility backup medication supply list revealed lisinopril, allopurinol, and diltiazem were not stocked in the supply. On 8/10/23 at 2:19 p.m., an interview was conducted with LPN (licensed practical nurse) #7. LPN #7 stated non-narcotic medications should be ordered from the pharmacy when there are ten pills remaining. LPN #7 stated if a medication is not available for administration, then she checks	F 755	sustained.	

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 08/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755		F 755		

Continued From page 191
the backup medication supply, and if the medication is not available there, she notifies the pharmacy and doctor.

On 8/11/23 at 9:57 a.m., ASM (administrative staff member) #1 (the administrator) and ASM #4 (the regional risk consultant) were made aware of the above concern.

References:
(1) Lisinopril is used to treat high blood pressure. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a692051.html.
(2) Allopurinol is used to treat gout. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682673.html.
(3) Diltiazem is used to treat high blood pressure. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a684027.html.

3. For Resident #360 (R360), the facility staff failed to ensure the as needed pain medication Percocet (1) was available for administration.

R360 was admitted to the facility on 7/31/23. R360's admission minimum data set assessment was in progress. An admission assessment dated 7/31/23 documented R360 was alert and oriented to person, place, time and situation.

A review of R360's clinical record revealed a physician's order dated 7/31/23 for Percocet 5-325 mg (milligrams)- one tablet every four hours as needed for pain.

On 8/10/23 at 9:50 a.m., an interview was

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 08/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 192	F 755		

conducted with R360. The resident voiced concern that he ran out of his prescribed pain medication on 8/9/23. R360 further stated he did not receive his prescribed pain medication from about 2:00 p.m. on 8/9/23 until 6:00 a.m. on 8/10/23 but the nurse gave him Tylenol.

A review of narcotic reconciliation sheets revealed R360 received the last dose of Percocet on 8/9/23 at 9:45 a.m. and did not receive another dose until 8/10/23 at 6:00 a.m.

On 8/10/23 at 10:35 a.m., an interview was conducted with LPN (licensed practical nurse) #11. LPN #11 stated R360 typically asks for Percocet every four hours. LPN #11 stated that on 8/9/23, she gave R360 the last dose of Percocet in the morning, so she had to obtain a new prescription and fax it to the pharmacy. LPN #11 stated Percocet is not in the facility backup medication supply and the pharmacy is not close.

A review of the facility backup medication supply list revealed Percocet was not stocked in the supply.

On 8/10/23 at 2:19 p.m., an interview was conducted with LPN (licensed practical nurse) #7. LPN #7 stated a new prescription for controlled medications should be obtained, and the medication should be ordered from the pharmacy when there are seven or eight pills remaining. LPN #7 stated if a medication is not available for administration, then she checks the backup medication supply, and if the medication is not available there, she notifies the pharmacy and doctor.

On 8/11/23 at 9:57 a.m., ASM (administrative

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 08/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANTERBURY REHABILITATION AND HEALTHCARE CENTER	**1776 CAMBRIDGE DRIVE RICHMOND, VA 23238**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 193	F 755		

staff member) #1 (the administrator) and ASM #4 (the regional risk consultant) were made aware of the above concern.

Reference:
(1) Percocet is used to treat pain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682132.html.

4. For Resident #95 (R95), the facility staff failed to ensure the physician ordered medication Xtampza (1) was available and administered on 6/1/23 through 6/5/23.

A review of R95's clinical record revealed a physician's order dated 6/24/22 for Xtampza 18 mg (milligrams) twice a day for pain.

A review of R95's MAR (medication administration record) for June 2023 revealed the same physician's order for Xtampza. For the evening dose on 6/1/23, both doses on 6/2/23 through 6/4/23, and the evening dose on 6/5/23, the MAR documented the code, "5=Hold." A nurse's note dated 6/1/23 documented the nurse would administer the medication upon arrival from the pharmacy. A nurse's note dated 6/2/23 documented the medication was on order. Nurses' notes dated 6/3/23 and 6/4/23 documented the nurse would administer the medication upon arrival from the pharmacy.

A review of the facility backup medication supply list revealed Xtampza was not stocked in the supply.

On 8/10/23 at 2:19 p.m., an interview was conducted with LPN (licensed practical nurse) #7.

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 08/16/2023

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

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

F 755 Continued From page 194 F 755

LPN #7 stated a new prescription for controlled medications should be obtained, and the medication should be ordered from the pharmacy when there are seven or eight pills remaining. LPN #7 stated if a medication is not available for administration, then she checks the backup medication supply, and if the medication is not available there, she notifies the pharmacy and doctor.

On 8/14/23 at 4:06 p.m., ASM (administrative staff member) #1 (the administrator), ASM #4 (the regional risk consultant) and ASM #7 (the director of nursing) were made aware of the above concern.

Reference:
(1) Xtampza is used to treat pain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682132.html.

5. For Resident #358 (R358), the facility staff failed to ensure the physician ordered medication oxycodone (1) was available and administered on 6/24/23.

A review of R358's clinical record revealed a physician's order dated 3/21/23 for oxycodone oral solution five mg (milligrams)/ five ml (milliliters)- five ml once a day for pain.

A review of R358's MAR (medication administration record) for June 2023 revealed the same physician's order for oxycodone oral solution. On 6/24/23, the MAR documented the code, "5=Hold." A nurse's note dated 6/24/23 documented, "medication on order, waiting for arrival."

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 08/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 195	F 755		

A review of the facility backup medication supply list revealed oxycodone oral solution was not stocked in the supply.

On 8/10/23 at 2:19 p.m., an interview was conducted with LPN (licensed practical nurse) #7. LPN #7 stated a new prescription for controlled medications should be obtained and the medication should be ordered from the pharmacy when there are seven or eight doses remaining. LPN #7 stated if a medication is not available for administration, then she checks the backup medication supply and if the medication is not available there, she notifies the pharmacy and doctor.

On 8/14/23 at 4:06 p.m., ASM (administrative staff member) #1 (the administrator), ASM #4 (the regional risk consultant) and ASM #7 (the director of nursing) were made aware of the above concern.

Reference:
(1) Oxycodone is used to treat pain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682132.html.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION	(X5) COMPLETION DATE
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5)	F 756		9/26/23

§483.45(c) Drug Regimen Review.
§483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.

§483.45(c)(2) This review must include a review of the resident's medical chart.

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 08/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 196 §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to take action on a recommendation from the pharmacist for one of 57 residents in the survey sample, Resident #90. The findings include:	F 756	F756: Drug Regimen Review, Report Irregular, Act on SS:D Resident #90 orders were reviewed by the clinical provider with no new	

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 08/16/2023

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

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

F 756

Continued From page 197

For Resident #90, the facility staff failed to have the physician/nurse practitioner, respond timely to a pharmacy recommendation made on 5/25/2023.

The Medication Regimen Review dated, 5/25/2023, documented, "This resident continues to utilize sliding scale insulin to manager glucose control. CMS [Centers for Medicare & Medicaid Services] guidelines state that continued or long-term need for sliding scale insulin for non-emergency coverage may indicate inadequate blood sugar control. Also, high rates of finger sticks and insulin injections may add to patient discomfort and nursing time expenditures without significant long-term benefit in patient outcomes. Please consider modifications to this resident's medication therapy to minimize or eliminate the use of Sliding Scale Insulin Therapy."

Review of the physician orders for sliding scale insulin were dated 3/24/2023. Further review of the clinical record failed to evidence any documentation/response related to the pharmacy recommendation dated 5/25/2023.

An interview was conducted, via phone, on 8/9/2023 at 5:37 p.m. with ASM (administrative staff member) #7, the director of nursing. When asked the process for responding to the monthly pharmacy recommendations, ASM #7 stated the pharmacist sends her the report. She prints it out and sends it to each floor for the doctor or nurse practitioner to review and say, yes or no, to the recommendations. ASM #7 stated the doctor/nurse practitioner has 30 days to act on them. Once the nurse takes of any orders from

F 756

recommendations or orders at that time.

Current residents who are on medication have potential to be affected by this practice.

An audit of residents who had pharmacy consultant reviews were completed in the last 30 days were completed to validate pharmacy recommendations were addressed by the clinical provider. Variances were addressed.

Licensed Nursing staff members were re-educated on the facility medication regimen review process to include reviewing pharmacy consultant recommendations with clinical provider timely and validate that recommendation are addressed and documentation of review is maintained.

An audit of 10 pharmacy consultant medication reviews will be conducted by the Director of Nurses/designee to validate documentation is in place that supports pharmacy consultant recommendations are reviewed and addressed by the clinical provider timely. Variances will be addressed. These audits will be conducted monthly x 3 months. The findings of the audits will be submitted by the DON/Designee to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495272	A. BUILDING ______ B. WING ______	C 08/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 198	F 756		

the recommendation, the forms are scanned into the clinical record.

On 8/10/2023 at approximately 10:00 a.m. the facility provided a copy of the 5/25/2023 pharmacy recommendation with the nurse practitioner's review dated 8/10/2023. The nurse practitioner disagreed and documented "On long term SSI (sliding scale insulin), A1C (hemoglobin A1C) (1) 6.8, will continue to reassess."

The facility policy, "Medication Regimen Review (MRR) and Reporting" documented in part, "6. Resident - specific MRR recommendations and findings are documented and acted upon by the nursing care center and/or physician. 7. A record of the consultant pharmacist's observations and recommendations is made available in an easily retrievable format to nurses, physicians and the care planning team within 48 hours of MRR completion. 8. The nursing care center follow up on the recommendations to verify that appropriate action had been taken. Recommendations shall be acted upon within 30 days."

ASM (administrative staff member) #1, the administrator, ASM # 4, the regional risk consultant, and ASM #5, the regional director of case management, were made aware of the above findings on 8/8/2023 at 4:59 p.m.

No further information was provided prior to exit.

(1) Hemoglobin A1C measures your average blood glucose, or blood sugar, level over the past 3 months. This information was obtained from the following website:
https://medlineplus.gov/a1c.html

QAPI Committee for review and recommendation monthly for 3 months or ongoing until compliance sustained.

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 08/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 199	F 757		
F 757 SS=E	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, it was determined the facility staff failed to ensure five of 57 residents in the survey sample were free of unnecessary medications, Resident #90, #11, #160, #149 and #133. The findings include: 1. For Resident #90 (R90), the facility staff failed to monitor the resident for side effects (bleeding) from the anticoagulant medications, Eliquis (1).	F 757	F757: Drug Regimen is Free from Unnecessary Drugs SS=E Resident #90s medications were reviewed with the clinical provider with orders updated to include monitoring for side effects of anticoagulant medication therapy.	9/26/23

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 08/16/2023

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

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

F 757 Continued From page 200

Resident #90 had diagnoses that included but were not limited to: atrial fibrillation, history of a stroke, diabetes and status post left below the knee amputation.

The physician order dated, 3/3/2023, documented, "Apixaban Oral tablet 5 mg (milligram); Give 1 tablet by mouth two times a day for blood thinner."

The July and August 2023 MAR (medication administration record) documented the above order. The medication was documented as having been administered per the physician order. There was no documentation of monitoring of side effects for the use of an anticoagulant.

The July and August 2023 TAR (treatment administration record) failed to evidence documentation of monitoring of side effects for the use of an anticoagulant.

The comprehensive care plan dated, 3/13/2023, documented in part, "Focus: I am on anticoagulant therapy." The "Interventions" documented in part, "Monitor/record/report PRN (as needed) s/sx (signs and symptoms) of anticoagulant complications: blood tinges or frank blood in urine, black tarry stools, dark or bright red blood in stools, bruising, sudden severe headaches, nausea, vomiting, muscle joint pain, lethargy, blurred vision, SOB (shortness of breath), loss of appetite, sudden changes in mental status, significant or sudden changes in vital signs. Report to nurse PRN signs/symptoms of side effects including bruising, bleeding, blood in urine, blood in stool, black tarry stools, nausea, vomiting, blurred vision, pain, shortness of breath,

F 757

Resident #11s clinical provider was made aware of cited occurrence, orders were reviewed and clarified with medication on hand to reflect ordered dose.

Resident #160s orders were reviewed with clinical provider and updated to include nonpharmacological interventions prior to administering unscheduled pain medication and to monitor for side effects of anticoagulant medication therapy.

Resident #149s medication was reviewed with the clinical provider and orders were updated to include monitoring for side effects and toxicity related to antipsychotic/antimanic medication therapy.

Resident #133s medication was reviewed with the clinical provider with orders updated to include monitoring for side effects of anticoagulant medication therapy.

RN #2 was provided with re-education regarding reviewing medications for correct dosage prior to administration.

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 08/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 201 sudden changes in mental status, weakness, lethargy." An interview was conducted with LPN (licensed practical nurse) #9 on 8/8/2023 at 3:09 p.m. When asked if the nurses should be monitoring anything for a resident receiving anticoagulants, LPN #9 stated, yes, for bleeding and bruising. LPN #9 was asked where it is documented that she monitored the resident, LPN #9 stated, there is a place on the TAR or progress notes for that. LPN #9 looked at R90's TAR and MAR and stated it was not there for this resident and it is on some of her other residents. When asked if she documents in the nurse's notes every shift she works that she monitored the resident for side effects of the use of anticoagulants, LPN #9 stated, no. The facility policy, "Anticoagulation Management" documented in part, "1. As part of the initial assessment, the physician and staff will identify individuals who are currently anticoagulated; for example, those with a recent history of deep vein thrombosis (DVT), or heart valve replacement, atrial fibrillation or those who have had recent joint replacement surgery. a. Assess for any signs or symptoms related to adverse drug reactions due to the medication alone or in combination with other medications...5. The staff and physician will monitor for possible complications in individuals who are being anticoagulated and will manage related problems. a. If an individual on anticoagulation therapy shows signs of excessive bruising, hematuria, hemoptysis, or other evidence of bleeding, the nurse will discuss the situation with the physician before giving the next scheduled dose of anticoagulant. b. The physician will order measures to address any	F 757	Residents who receive medication administration by facility staff, are on single dosing pack of Lokelma, on anticoagulant therapy, unscheduled pain medication or antimanic medications have potential to be affected by this practice. The Unit Manager/designee completed an audit of current residents receiving anticoagulant medication therapy, and antipsychotic/antimanic medication therapy to validate monitoring for side effects is in place. An audit was also completed for residents with orders for non-scheduled pain medication to validate nonpharmacological measures are attempted prior to use. In addition, an audit was completed for residents on Lokelma single dose packs to validate order clarification obtained as needed and that the correct dosage is on hand and administered. Variances were addressed. Licensed Nursing staff members were re-educated by the staff development coordinator on monitoring and documenting side effects for residents receiving anticoagulant medication, and antipsychotic/antimanic medications. The need to attempt nonpharmacological measures prior to administering unscheduled pain medications and the need to validate correct dose prior to administration of medication. The unit managers/designee will complete	

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 08/16/2023

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

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

F 757

Continued From page 202

complications, including holding or discontinuing the anticoagulant as indicated. c. In individuals receiving anticoagulation who are bleeding or who have a markedly elevated PT/INR, it may suffice to stop the anticoagulant and recheck the PT/INR if the individual is stable, there is no more than minor bleeding, and the INR is not more than 9. Once Vitamin K is given to try to reverse the effects of warfarin, it can hamper subsequent resumption of anticoagulation for a week or more."

ASM (administrative staff member) #1, the administrator, ASM #4, the regional risk consultant, and ASM #6, the clinical care consultant, were made aware of the above finding on 8/9/2023 at 5:30 p.m.

No further information was provided prior to exit.

(1) Eliquis (Apixaban) Apixaban is used help prevent strokes or blood clots in people who have atrial fibrillation (a condition in which the heart beats irregularly, increasing the chance of clots forming in the body and possibly causing strokes) that is not caused by heart valve disease. Apixaban is also used to prevent deep vein thrombosis (DVT; a blood clot, usually in the leg) and pulmonary embolism (PE; a blood clot in the lung) in people who are having hip replacement or knee replacement surgery. Apixaban is also used to treat DVT and PE and may be continued to prevent DVT and PE from happening again after the initial treatment is completed. Apixaban is in a class of medications called factor Xa inhibitors. It works by blocking the action of a certain natural substance that helps blood clots to form. This information was obtained from the following website:

F 757

an audit of 3 residents who are prescribed anticoagulant therapy, or antimanic medications to validate monitoring for side effects is in place. An audit of 3 residents with orders for non-scheduled pain medication will also be completed to validate nonpharmacological measures are attempted prior to use. In addition, two residents will be reviewed during medication administration to validate that the correct dosage is on hand and administered as ordered. Variances will be addressed. These audits will be conducted weekly x 4 weeks, then monthly x 2 months. The findings of the audits will be submitted by the DON/Designee to the QAPI Committee for review and recommendation monthly for 3 months or ongoing until compliance sustained.

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 08/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 203 https://medlineplus.gov/druginfo/meds/a613032.html 2. For Resident #11 (R11), the facility staff failed to verify the dosage of Lokelma (Sodium Zirconium Cyclosilicate) (1) prior to the administration on 8/8/2023 resulting in them receiving 10 grams rather than the 5 grams that was ordered by the physician. On 8/8/2023 at 8:35 a.m., an observation was made of RN (registered nurse) #2 administering medications at the facility. RN #2 was observed preparing medications for R11. RN #2 prepared scheduled medications to administer to R11 including a single dosing pack labeled "Lokelma 10 gm (gram)" which she was observed dissolving the entire packet contents into a cup of water and administered to the resident. Review of the physician orders for R11 documented in part, "Sodium Zirconium Cyclosilicate Oral Packet 5 GM (Sodium Zirconium Cyclosilicate) Give 1 packet by mouth one time a day for hyperkalemia. Order Date: 05/01/2023." The eMAR (electronic medication administration record) for R11 dated 8/1/2023-8/31/2023 documented in part, "Sodium Zirconium Cyclosilicate Oral Packet 5 GM (Sodium Zirconium Cyclosilicate) Give 1 packet by mouth one time a day for hyperkalemia -Start Date- 05/02/2023 0900 (9:00 a.m.)." The eMAR documented RN #2 administering the medication scheduled for 9:00 a.m. on 8/8/2023. On 8/8/2023 at 10:55 a.m., an interview was conducted with RN #2. RN #2 stated that prior to	F 757		

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 08/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757		F 757		

Continued From page 204
medication administration they checked to make sure they had the correct person, correct medication, correct dosage, correct time, correct route and correct documentation. RN #2 reviewed the physician order for the 5 GM of Sodium Zirconium Cyclosilicate Oral Packet and the 10 GM packets of the medications on the medication cart and stated that they should have checked the dosage closer because the resident was supposed to get 5 GM and they had received 10 GM.

The facility policy "Administering Medications" revised April 2019, documented in part, "...The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication..."

On 8/8/2023 at approximately 5:00 p.m., ASM (administrative staff member) #1, the administrator, ASM #4, the regional risk consultant and ASM #5, the regional director of case management were made aware of the findings.

No further information was presented prior to exit.

Reference:
(1) Sodium zirconium cyclosilicate is used to treat hyperkalemia (high levels of potassium in the blood). Sodium zirconium cyclosilicate is not used for emergency treatment of life-threatening hyperkalemia because it takes some time to work. Sodium zirconium cyclosilicate is in a class of medications called potassium removing agents. It works by removing excess potassium from the body. This information was obtained

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 08/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757		F 757		

Continued From page 205
from the website:
https://medlineplus.gov/druginfo/meds/a618035.html

3. For Resident #160 (R160), the facility staff failed to A) implement non-pharmacological interventions prior to administration of as needed pain medications and B) evidence monitoring for anticoagulant adverse effects.

On the admission assessment for R160 dated 7/27/2023 the resident was assessed as being alert and oriented to person, place and time. The assessment documented R160 being cognitively able to report pain, having pain less than weekly with preferred pain relief measures of narcotic pain relievers.

The physician orders for R160 documented in part,
- "Hydrocodone-Acetaminophen Oral Tablet 10-325 MG (milligram) (Hydrocodone-Acetaminophen) Give 1 tablet by mouth every 4 hours as needed for Pain related to Pain, Unspecified (). Order Date: 07/27/2023."
- "Percocet Oral Tablet 5-325 MG (Oxycodone w/Acetaminophen) Give 1 tablet by mouth every 6 hours as needed for pain. Order Date: 07/28/2023."
- "Apixaban Oral Tablet 5 MG (Apixaban) Give 1 tablet by mouth two times a day for atrial fib (fibrillation). Order Date: 07/27/2023."

The eMAR (electronic medication administration record) for R160 dated 7/1/2023-7/31/2023 documented the Hydrocodone-Acetaminophen was administered on 7/29/2023: at 1:36 a.m. for a pain level of 8, at 5:24 p.m. for a pain level of 7, at 9:24 p.m. for a pain level of 7, on 7/30/2023: at

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 08/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 206	F 757		

3:27 a.m. for a pain level of 8, at 9:45 a.m. for a pain level of 8, at 4:58 p.m. for a pain level of 7 and on 7/31/2023: at 9:41 a.m. for a pain level of 9. The eMAR further documented the Percocet administered on 7/30/2023 at 9:09 p.m. for a pain level of 6 and on 7/31/2023 at 5:17 p.m. for a pain level of 0. The eMAR failed to evidence documentation of non-pharmacologic interventions attempted prior to administration of the as needed pain medication.

The eMAR documented Apixaban administered to R160 each day as ordered beginning on 7/27/2023 at 5:00 p.m. The eMAR failed to evidence documentation of monitoring for anticoagulant adverse effects.

The eMAR for R160 dated 8/1/2023-8/31/2023 documented the Hydrocodone-Acetaminophen administered on 8/1/2023 at 11:37 a.m. for a pain level of 3, on 8/4/2023 at 7:07 p.m. for a pain level of 4, on 8/5/2023: at 5:20 a.m. for a pain level of 6, at 5:42 p.m. for a pain level of 7, on 8/6/2023 at 11:43 a.m. for a pain level 0, at 5:48 a.m. for a pain level 7 and 8/8/2023 at 11:36 a.m. for a pain level of 3. The eMAR further documented the Percocet administered on 8/1/2023 at 4:36 p.m. for a pain level of 4, on 8/2/2023: at 9:15 a.m. for a pain level of 8, at 4:48 p.m. for a pain level of 4, on 8/3/2023: at 8:00 a.m. for a pain level of 5, at 2:30 p.m. for a pain level of 5, on 8/5/2023 at 11:00 a.m. for a pain level of 5, on 8/7/2023 at 11:00 a.m. for a pain level of 5, and on 8/8/2023 at 7:07 p.m. for a pain level of 5. The eMAR failed to evidence documentation of non-pharmacologic interventions attempted prior to administration of the as needed pain medication.

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 08/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 207	F 757		

The eMAR documented Apixaban was administered to R160 as ordered at 9:00 a.m. and 5:00 p.m. The eMAR failed to evidence documentation of monitoring for anticoagulant adverse effects.

The progress notes including medication administration notes failed to evidence documentation of non-pharmacologic interventions attempted prior to administration of the as needed pain medication for the dates listed above with the exception of 7/30/2023 at 9:09 p.m. where repositioning was attempted prior to administration. The progress notes failed to evidence monitoring for anticoagulant adverse effects.

The baseline care plan for R160 documented in part;
- "I have pain and/or potential for pain r/t (related to) being a dialysis patient. Date Initiated: 07/27/2023." Under "Interventions" it documented in part, "...Encourage me to try non-pharmacological interventions for pain relief as applicable e.g. positioning, relaxation therapy, bathing, heat and cold application, muscle stimulation, ultrasound. Date Initiated: 07/27/2023..."
- "I am on anticoagulant therapy. Date Initiated: 07/28/2023." Under "Interventions" it documented in part, "... Monitor/record/report PRN (as needed) s/sx (signs/symptoms) of anticoagulant complications: blood tinged or frank blood in urine, black tarry stools, dark or bright red blood in stools, bruising, sudden severe headaches, nausea, vomiting, muscle joint pain, lethargy, blurred vision, SOB (shortness of breath), loss of appetite, sudden changes in mental status, significant or sudden changes in

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 08/16/2023

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

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

F 757

Continued From page 208

vital signs. Date Initiated: 07/28/2023... Report to nurse PRN signs/symptoms of side effects including: bruising, bleeding, blood in urine, blood in stool, black tarry stools, nausea, vomiting, blurred vision, pain, shortness of breath, sudden changes in mental status, weakness, lethargy. Date Initiated: 07/28/2023."

On 8/8/2023 at 3:50 p.m., an interview was conducted with LPN (licensed practical nurse) #7. LPN #7 stated that R160 was alert and oriented to person, place and time and requested pain medication when they needed it. LPN #7 stated that they attempted non-pharmacological interventions like repositioning prior to the medications. She stated that they did this to see if the non-pharmacological interventions would help and to avoid the resident having to get pain medications. She stated that these were attempted each time prior to administration of the medication and should be documented in the medication administration notes. She stated that anticoagulant monitoring was done every shift and was not sure where it was documented. LPN #7 reviewed R160's eMAR and stated that she was taking an anticoagulant but she did not see where there was documentation of monitoring for adverse effects on there. She stated that normally there was an area on the eMAR to document the monitoring.

On 8/9/2023 at 12:47 p.m., an interview was conducted with LPN #6, unit manager. LPN #6 stated that the staff monitored residents on anticoagulants for bleeding and it was documented on the eMAR with the medication. He stated that R160 was on the medication for atrial fibrillation and not ordered for monitoring of bleeding although they were still monitoring them

F 757

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 08/16/2023

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

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

F 757 Continued From page 209
for it.

The facility policy "Administering Medications" failed to evidence guidance on non-pharmacological interventions prior to as needed pain medication administration.

The facility policy "Anticoagulation- Clinical Protocol" revised November 2018 documented in part, "... 5. The staff and physician will monitor for possible complications in individuals who are being anticoagulated, and will manage related problems.
a. If an individual on anticoagulation therapy shows signs of excessive bruising, hematuria, hemoptysis, or other evidence of bleeding, the nurse will discuss the situation with the physician before giving the next scheduled dose of anticoagulant.
b. The physician will order measures to address any complications, including holding or discontinuing the anticoagulant as indicated..."

On 8/9/2023 at 5:17 p.m., ASM (administrative staff member) #1, the administrator stated that they did not have any evidence of non-pharmacologic interventions prior to administration of the as needed pain medications in July and August of 2023 for R160 to provide.

On 8/9/2023 at 5:40 p.m., ASM #1, the administrator, ASM #4, the risk consultant and ASM #6, the clinical care consultant were made aware of the concern.

No further information was provided prior to exit.
4. For Resident #149, the facility staff failed to ensure daily monitoring for the use of an antimanic medication, Lithium Carbonate.

F 757

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495272	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING ______	(X3) DATE SURVEY COMPLETED C 08/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANTERBURY REHABILITATION AND HEALTHCARE CENTER	**1776 CAMBRIDGE DRIVE RICHMOND, VA 23238**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 210	F 757		

A review of the clinical record revealed an order dated 6/16/23 for Lithium Carbonate 150 mg (milligrams) twice daily for schizoaffective disorder bipolar type.

Further review of the clinical record revealed an order dated 6/30/23 for Lithium Orotate 5 mg tabs and to administer 20 mg in the morning and 30 mg in the evening for bipolar disorder.

Further review of the clinical record failed to reveal monitoring for the use of Lithium side effects and toxicity.

A review of the comprehensive care plan failed to reveal any evidence that the use, side effects, and monitoring for toxicity of Lithium was care planned.

On 8/14/23 at 12:18 PM, LPN #10 (Licensed Practical Nurse) was interviewed. She stated that there should be monitoring for the side effects and toxicity of Lithium.

On 8/15/23 at 9:24 AM, an interview was conducted with LPN #1. She stated that there should be monitoring for the side effects and toxicity of Lithium.

On 8/14/23 at 4:00 PM at an end-of-day meeting, ASM #1 (Administrative Staff Member) the Administrator, ASM #4 the Regional Risk Consultant, ASM #7 the Director of Nursing and ASM #8 the Regional Consultant, were made aware of the findings. No further information was provided by the end of the survey.

References:

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 08/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 211	F 757		

(1) Lithium is used treat mania in people with bipolar disorder and for schizophrenia. Information obtained from https://medlineplus.gov/druginfo/meds/a681039.html

5. For Resident #133, the facility staff failed to monitor for the use of an anticoagulant medication.

A review of the clinical record revealed an order dated 7/7/23 for Apixaban (1) 5 mg (milligrams) twice daily for the prevention of blood clots.

Further review of the clinical record failed to reveal consistent monitoring for the use and side effects of an anticoagulant medication.

On 8/14/23 at 12:18 PM, LPN #10 (Licensed Practical Nurse) was interviewed. She stated that the weekly skin checks would qualify as monitoring for signs of bruising related to the use of anticoagulant medication.

A review of the clinical record revealed that a weekly skin check was completed on 6/22/23 and then not again until 8/10/23. There were no weekly skin checks between these two dates to indicate monitoring for the use of an anticoagulant medication from 6/2/23 to 8/10/23.

A review of the comprehensive care plan revealed one dated 5/9/23 for "Monitor/record/report PRN (as needed) s/sx (signs and symptoms) of anticoagulant complications: blood tinged or frank blood in urine, black tarry stools, dark or bright red blood

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 08/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 212 in stools, bruising, sudden severe headaches, nausea, vomiting, muscle joint pain, lethargy, blurred vision, SOB (shortness of breath), loss of appetite, sudden changes in mental status, significant or sudden changes in vital signs." On 8/14/23 at 4:00 PM at an end-of-day meeting, ASM #1 (Administrative Staff Member) the Administrator, ASM #4 the Regional Risk Consultant, ASM #7 the Director of Nursing and ASM #8 the Regional Consultant, were made aware of the findings. No further information was provided by the end of the survey. References: (1) Apixaban is used to prevent blood clots. Information obtained from https://medlineplus.gov/druginfo/meds/a613032.html	F 757		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs	F 758		9/26/23

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 08/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 213 unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview and facility document review it was determined that the facility staff failed to evidence monitoring of antipsychotic medication for one of 57 residents in the survey sample, Resident #160. The findings include:	F 758	F758: free from Unnec. Psychotropic Meds/PRN Use SS=D Resident #160 orders were reviewed with the clinical provider with orders revised to	

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 08/16/2023

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

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

F 758

Continued From page 214

For Resident #160 (R160), the facility staff failed to monitor behaviors and adverse effects of the antipsychotic medication Quetiapine Fumarate (1).

R160 was admitted to the facility with diagnoses that included but were not limited to major depressive disorder and pain, unspecified.

On the admission assessment for R160 dated 7/27/2023 the resident was assessed as being alert and oriented to person, place and time. The resident was assessed as having a psychiatric or cognitive condition, taking an antidepressant, and having a pertinent diagnosis of Dementia, OBS (organic brain syndrome), Alzheimer's, Delusions, Hallucinations, Anxiety disorder, Depression, Manic Depression or Schizophrenia.

The physician orders for R160 documented in part,
- "Quetiapine Fumarate Tablet 50 MG (milligram) Give 1 tablet by mouth two times a day for Bipolar Disorder. Order Date: 08/03/2023."

The eMAR (electronic medication administration record) for R160 dated 8/1/2023-8/31/2023 documented the Quetiapine 50 mg administered each day as ordered beginning at 9:00 p.m. on 8/3/2023. The eMAR failed to evidence monitoring for behaviors or adverse effects of the anti-psychotic medication.

The progress notes documented in part,
- "8/3/2023 15:43 (3:43 p.m.) Psychosocial note. Note Text : Psychiatric New Evaluation. Chief Complaint: Patient seen to evaluate mental status and adjust medication. History of Present Illness.

F 758

include behavior and side effects monitoring related to antipsychotic medication use.

Residents who are prescribed antipsychotic medication have potential to be affected by this practice. An audit of current residents receiving antipsychotic medications was completed by the Unit Manager/designee to validate monitoring of behaviors and side effects had been completed and documented. Variances were addressed.

Licensed Nursing staff members were re-educated by the staff development coordinator/designee on the facility policy regarding psychotropic medication use to include monitoring and documenting side effects of antipsychotic therapy.

An audit will be conducted by the Unit Manager/Designee of 3 residents receiving antipsychotic medications to validate monitoring of behaviors and documentation of side effects had been completed. Variance will be addressed. These audits will be conducted weekly x 4 weeks,then monthly x 2 months. The findings of the audits will be submitted by the DON/Designee to the QAPI Committee for review and recommendation monthly for 3 months or ongoing until compliance sustained.

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 08/16/2023

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

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F 758	Continued From page 215	F 758		

Initial evaluation requested for a new admission to assess for anxiety and episodes of crying... She stated she has a history of past psychiatric hospitalization for bipolar depression. She also mentioned that she had both auditory and visual hallucinations while she was admitted in the hospital recently... We agreed to add Seroquel [Quetiapine] 50mg BID [twice a day] for bipolar depression... Primary Diagnosis: Bipolar Disorder 'Depressed' Moderate - F31.32. Treatment Plan / Recommendations. Plan: Supportive care, Reviewed SE and Risk/Benefits analysis, Supportive therapy provided. Antipsychotic Medication: After careful consideration ' the benefits of anti-psychotic medications in this patient outweigh the potential risks of tardive dyskinesia ' hyperglycemia and stroke. They help in modifying the behavior such that normal care is possible while the patient is in the nursing facility."

The baseline care plan for R160 documented in part, "I use anti-depressant medication r/t [related to] depression. Date Initiated: 07/27/2023."

On 8/8/2023 at 3:50 p.m., an interview was conducted with LPN (licensed practical nurse) #7. LPN #7 stated that there were specific behaviors they monitored residents taking antipsychotic medications for that were documented on the eMAR every shift. She stated that anything out of the ordinary was reported to the physician. She reviewed R160's eMAR and stated that she did not see anything monitoring behaviors or adverse effects of the antipsychotic medication.

On 8/9/2023 at 12:47 p.m., an interview was conducted with LPN #6, unit manager. LPN #6 stated that staff documented behavior monitoring under the behavior tracking section on the eMAR

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 08/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 216 every shift. On 8/8/2023 at 3:50 p.m., an interview was conducted with LPN #5. LPN #5 stated that they monitored residents taking antipsychotic medications for behaviors and vital signs. She stated that they monitored for behavior changes and documented them in the medical record. She stated that they monitored for adverse effects from antipsychotic medications every shift and some staff documented in their medication administration notes that no adverse effects were observed but she was not sure if it was documented routinely. The facility policy "Antipsychotic Medication Use" revised July 2022, documented in part, "...17. The staff will observe, document, and report to the attending physician information regarding the effectiveness of any interventions, including antipsychotic medications. 18. Nursing staff shall monitor for and report any of the following side effects and adverse consequences of antipsychotic medications to the attending physician: a. General/anticholinergic: constipation, blurred vision, dry mouth, urinary retention, sedation; b. Cardiovascular: orthostatic hypotension, arrhythmias; c. Metabolic: increase in total cholesterol/triglycerides, unstable or poorly controlled blood sugar, weight gain; or d. Neurologic: akathisia, dystonia, extrapyramidal effects, akinesia; or tardive dyskinesia, stroke or TIA..." On 8/9/2023 at 5:40 p.m., ASM (administrative staff member) #1, the administrator, ASM #4, the risk consultant and ASM #6, the clinical care	F 758		

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 08/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 217 consultant were made aware of the concern. No further information was provided prior to exit. Reference: (1) Quetiapine tablets and extended-release (long-acting) tablets are used to treat the symptoms of schizophrenia (a mental illness that causes disturbed or unusual thinking, loss of interest in life, and strong or inappropriate emotions). Quetiapine tablets and extended-release tablets are also used alone or with other medications to treat episodes of mania (frenzied, abnormally excited or irritated mood) or depression in patients with bipolar disorder (manic depressive disorder; a disease that causes episodes of depression, episodes of mania, and other abnormal moods). In addition, quetiapine tablets and extended-release tablets are used with other medications to prevent episodes of mania or depression in patients with bipolar disorder. Quetiapine extended-release tablets are also used along with other medications to treat depression. Quetiapine tablets may be used as part of a treatment program to treat bipolar disorder and schizophrenia in children and teenagers. Quetiapine is in a class of medications called atypical antipsychotics. It works by changing the activity of certain natural substances in the brain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a698019.html	F 758		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be	F 761		9/26/23

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 08/16/2023

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

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F 761	Continued From page 218 labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, the facility staff failed to ensure medications were stored properly on one of four medication carts on the Tuckahoe unit. The findings include: Observation was made on 8/8/2023 at 12:23 p.m. of the Tuckahoe unit. RN (registered nurse) #2 had left her medication cart which was outside of room 115 and entered the room on the opposite side of the hallway. Her medication cart was not within her sight. On top of the medication cart was a plastic medication cup which contained a	F 761	F761: Label/Store Drugs and Biologicals SS=D No specific residents were identified. RN #2 was provided with re-education by Staff Development Coordinator/Designee on keeping the medication cart closed and locked when not in use and line of sight. Current residents have potential to be	

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 08/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 219 bright orange substance with a white plastic spoon sticking out of it. When RN #2 returned to her medication cart, she was asked what was in the plastic cup that was orange, RN #2 stated it was a resident's medication that she's been trying to get into her all morning. RN #2 stated the orange color is coming from the multivitamin that was mixed in it. When asked if medications are to be left on the top of a medication cart when she is not at her cart, RN #2 stated she had forgotten to lock it up. RN #2 was asked if medications can be left on the medication cart unattended, RN #2 replied, no. The "Administering Medications" policy revised April 2019 documented in part, " ...19. During administration of medications, the medication cart is kept closed and locked when out of sight of medication nurse or aide. It may be kept in the doorway of the resident's room, with open drawers facing inward and all other sides closed. No medications are kept on top of the cart. The cart must be clearly visible to the personnel administering medications, and all outward sides must be inaccessible to residents or others passing by ..." ASM (administrative staff member) #1, the administrator, ASM # 4, the regional risk consultant, and ASM #5, the regional director of case management, were made aware of the above findings on 8/8/2023 at 4:59 p.m. No further information was provided prior to exit.	F 761	affected by this practice. Walking rounds were completed by the Unit Manager/Designee on each nursing unit at different times of the day to validate that the medication cart was closed and locked when out of sight of the medication nurse. No further variances were noted. Licensed Nursing staff members were re-educated on keeping the medication cart closed and locked when not in use and out of sight of the medication nurse by the staff development coordinator. An audit to include 3 rounds will be conducted by the DON/Designee on nursing units at different times of the day to validate that the medication carts are closed and locked when not in use and out of the sight of the medication nurse will be completed. Variance will be addressed. These audits will be conducted weekly x 4 weeks, then monthly x 2 months. The findings of the audits will be submitted by the DON/Designee to the QAPI Committee for review and recommendation monthly for 3 months or ongoing until compliance sustained.	
F 773 SS=D	Lab Srvcs Physician Order/Notify of Results CFR(s): 483.50(a)(2)(i)(ii) §483.50(a)(2) The facility must-	F 773		9/26/23

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 08/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 773	Continued From page 220 (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to provide laboratory services in a timely manner for one of 57 residents in the survey sample, Resident #360. The findings include: For Resident #360 (R360), the facility staff failed to obtain STAT (immediate) BMP (basic metabolic panel) (1) and CBC (complete blood count) (2) laboratory tests, per a physician's order, on 8/3/23. A review of R360's clinical record revealed a nurse practitioner's note dated 8/3/23 at 8:47 a.m. that documented, "Assessment and Plan: 1. Nausea and vomiting without abdominal pain or diarrhea. Regular bowel movements. No chills or fever. Vital signs are stable, abdominal exam is benign. Ordered Zofran (medication used to treat nausea and vomiting) 4 milligrams POQ (by mouth every) 6 hours PRN (as needed) nausea vomiting x3d (times three days), ordered stat BMP to assess for dehydration given patients report of decreased fluid intake, we can do IV	F 773	F773 (D) Lab Services Physician Order/Notify of Results Resident # 360 was discharged from the facility on 8/19/23. LPN #1 and LPN # 11 were re-educated by the DON/Designee on the laboratory service process for STAT test requisitions and arranging for tests in a timely manner. Current residents requiring STAT labs have the potential to be affected. An audit of residents ordered to have STAT labs in the last 7 days was conducted validating timeliness of lab draw per MD order. No further variances were noted. Licensed Nursing Staff were re-educated by the Staff Development Coordinator/Designee on the laboratory service process for STAT test requisitions and arranging for tests in a timely manner. The DON/Designee will conduct an audit	

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 08/16/2023

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

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

F 773 Continued From page 221

(intravenous) fluids if necessary, ordered clear liquid diet times 24 hours. Discussed with nurse."

Further review of R360's clinical record revealed a physician's order dated 8/3/23 for a STAT BMP and CBC for nausea and vomiting. A nurse's note dated 8/3/23 documented, "Lab out to draw stat CBC and BMP, but unable to obtain specimen, stated 'He's a hard stick', Lab notified, will send someone else to attempt to draw ordered labs today." Another nurse's note dated 8/3/23 documented, "Lab called back to facility stated they do not have anyone to come back out today to attempt the blood draw, lab to be drawn in AM with routine lab orders." A review of the BMP and CBC lab results revealed the lab specimens were collected on 8/4/23 at 2:00 p.m.

On 8/10/23 at 10:51 a.m., an interview was conducted with LPN (licensed practical nurse) #11. LPN #11 stated phlebotomists from an outside company come to the facility to obtain labs. LPN #11 stated she believed someone comes from the company daily every day except for Sundays. LPN #11 stated nurses at the facility do not routinely draw blood but she guessed they could if someone who knew how to do it was available and present in the facility. LPN #11 stated that on 8/3/23, stat labs were ordered for R360 so she called the outside company, someone came out, said she couldn't obtain the labs and asked LPN #11 to call the company and let them know. LPN #11 stated she called the company then they called back to someone else at the facility and said no one could come out that day.

On 8/11/23 at 8:23 a.m., an interview was conducted with LPN #1. LPN #1 stated STAT

F 773

of 3 residents with stat lab orders to validate labs were completed in a timely manner and that the clinical provider was made aware if order was not completed. Variances will be addressed. These audits will be conducted weekly x 4 weeks, then monthly x 2 months. The findings of the audits will be submitted by the DON/Designee to the QAPI Committee for review and recommendation monthly for 3 months or ongoing until compliance sustained.

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 08/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANTERBURY REHABILITATION AND HEALTHCARE CENTER	**1776 CAMBRIDGE DRIVE RICHMOND, VA 23238**

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F 773	Continued From page 222 labs should be obtained within an hour of being ordered. On 8/11/23 at 9:57 a.m., ASM (administrative staff member) #1 (the administrator) and ASM #4 (the regional risk consultant) were made aware of the above concern. References: (1) "A basic metabolic panel (BMP) is a test that measures eight different substances in your blood. It provides important information about your body's chemical balance and metabolism. Metabolism is the process of how the body uses food and energy. A BMP includes tests for the following: Glucose, a type of sugar and your body's main source of energy. Calcium, one of the body's most important minerals. Calcium is essential for proper functioning of your nerves, muscles, and heart. Sodium, potassium, carbon dioxide, and chloride. These are electrolytes, electrically charged minerals that help control the amount of fluids and the balance of acids and bases in your body. BUN (blood urea nitrogen) and creatinine, waste products removed from your blood by your kidneys." This information was obtained from the website: https://medlineplus.gov/lab-tests/basic-metabolic-panel-bmp/ (2) "Your blood contains red blood cells (RBC), white blood cells (WBC), and platelets. Blood count tests (CBC) measure the number and types of cells in your blood." This information was obtained from the website: https://medlineplus.gov/bloodcounttests.html	F 773		
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2)	F 804		9/26/23

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 08/16/2023

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CANTERBURY REHABILITATION AND HEALTHCARE CENTER	1776 CAMBRIDGE DRIVE RICHMOND, VA 23238

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F 804	Continued From page 223 §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to provide food at a palatable temperature. The findings include: The facility staff failed to provide food at a palatable temperature during lunch on 8/8/2023. On Resident #48's (R48) most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 6/9/2023, the resident scored 13 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was cognitively intact. On 8/07/2023 at 3:38 p.m., R48 was interviewed. When asked about the food he was served, he stated, "It is cold and inedible." On Resident #160's (R160) admission assessment dated 7/27/2023, the resident was assessed as being alert and oriented to person, place and time. On 8/8/2023 at 10:14 a.m., R160 was sitting up in her bed eating breakfast. She stated the food was "terrible." When asked if the	F 804	F804 (D) Nutritive Value/Appear, Palatable/Prefer Temp Resident # 48 was reviewed with no adverse effects related to cited occurrence with palatable temperature during the lunch meal. Resident # 160 was reviewed with no adverse effects related to cited occurrence with palatable temperature during the lunch meal. OSM #2 and OSM #7 were re-educated by the facility administrator on validating meals are served at a palatable temperature per the facility policy. Current residents have the potential to be affected. A resident council meeting will be held by 9/25/23 with review of dining services to include palatability to be reviewed. Findings will be addressed. The Dining Service Manager and Dietary staff were re-educated by the facility administrator on the proper	

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F 804	Continued From page 224 food she was served was warm, she stated, "No, it's usually kind of cold." Review of the resident council minutes dated 6/29/2023 documented concerns for cold food served on the units. The resident council minutes dated 7/19/2023 documented concerns regarding undercooked meats and vegetables. On 8/8/2023 at 11:00 a.m., the holding temperatures of lunch were obtained from the service line in the kitchen and were as follows: Pureed ham- 176 degrees Fahrenheit Pureed sweet potatoes- 149 degrees Fahrenheit Pureed peas- 163 degrees Fahrenheit Mechanical soft ham- 138 degrees Fahrenheit Regular sweet potatoes- 155 degrees Fahrenheit Regular peas- 177 degrees Fahrenheit Regular ham- 165 degrees Fahrenheit After the holding temperatures were obtained, resident meals were plated, covered with a lid, placed in food carts and taken to the units. On 8/8/2023 at 12:49 p.m., a test tray was plated and sent to the west hallway of the Tuckahoe unit with the resident trays. On 8/8/2023 at 1:04 p.m., when the final meal was served on the west hallway of the Tuckahoe unit, the temperatures of the food on the test tray were obtained by OSM (other staff member) #2, the dietary manager. The temperatures were: Pureed ham- 94.5 degrees Fahrenheit Pureed sweet potatoes- 119.5 degrees Fahrenheit Pureed peas- 117.1 degrees Fahrenheit Mechanical soft ham- 123.3 degrees Fahrenheit Regular sweet potatoes- 133.8 degrees Fahrenheit Regular peas- 121.6 degrees Fahrenheit	F 804	process/procedure to maintain palatable food temperatures per policy and procedure. The Dining Service Manager/Designee will audit 3 test trays to validate food temps are maintained per policy and procedures. Variances will be addressed. These audits will be conducted weekly x 4 weeks, then monthly x 2 months. The findings of the audits will be submitted by the Administrator/Designee to the QAPI Committee for review and recommendation monthly for 3 months or ongoing until compliance sustained.	

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	495272	A. BUILDING ______ B. WING ______	C 08/16/2023

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CANTERBURY REHABILITATION AND HEALTHCARE CENTER	1776 CAMBRIDGE DRIVE RICHMOND, VA 23238

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F 804	Continued From page 225 Regular ham- 127.9 degrees Fahrenheit The food on the test tray was sampled by two surveyors who determined the pureed ham and pureed peas were not warm enough to be an appetizing temperature. OSM #7, the district manager confirmed this and stated these food items could be warmer. The facility policy, "Food and Nutrition Services" dated October 2017, documented in part, "Policy Statement. Each resident is provided with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident..." On 8/8/2023 at approximately 5:00 p.m., ASM (administrative staff member) #1, the administrator, ASM #4, the risk consultant and ASM #5, the regional director of case management were made aware of the concern. No further information was presented prior to exit.	F 804		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility	F 812		9/26/23

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F 812	Continued From page 226 gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, and facility document review, it was determined that the facility staff failed to store food in a sanitary manner in one of one kitchen, in one of three nourishment rooms in the facility and during meal service. The findings include: 1. On 8/7/2023 at 11:20 a.m., an observation was conducted of the kitchen with OSM (other staff member) #2, dietary manager. Observation of the dry goods storage area revealed a two pound bag of brown sugar approximately three-quarters full closed by plastic wrap. The package was observed to not have an opened date. OSM #2 stated that the staff should date the product when opened so that they knew when it needed to be discarded. She stated that she was going to discard it because she was unable to identify when the bag had been opened. Further observation of the dry goods storage area revealed an 18 quart plastic storage bin with approximately four quarts of a ground course yellow substance that OSM #2 identified as cornmeal. The plastic storage bin was observed to not be labeled or dated. OSM #2 stated that the bin contained cornmeal and it should have been labeled and dated when the cornmeal was	F 812	F812 (D) Food Procurement, Store/Prepare/Serve-Sanitary The two-pound bag of brown sugar observed in the dry goods storage area was removed from the inventory and discarded without adverse effects to the cited occurrence. The ground coarse yellow substance, identified as cornmeal, observed in the dry goods storage area was removed from the inventory without adverse effects related to the cited occurrence. OSM # 2 was re-educated by facility administrator on validating that items kept in the dry goods storage room are dated and labeled per facility policy. The fans observed in the kitchen were removed with no adverse effects related to the cited occurrence. Facility policy updated to reflect guidance for maintaining dust free fans. OSM #2 was re-educated by the facility administrator to ensure that when utilizing fans in the kitchen area the fan is free of	

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

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F 812

Continued From page 227

poured into the bin for storage and a use by date.

Observation of the kitchen area revealed two portable fans in use. One fan was observed sitting on top of a rolling cart facing a four shelf metal rack containing clean serving utensils including serving scoops, knives and steam table containers. The metal cage on the fan was observed with visible dust all around the edges. When asked about the fans, OSM #2 stated that they had been having issues with the air conditioning in the kitchen and maintenance had been working on it but it had been very hot in the kitchen so they had been using the fans to keep cooler. She stated that the fans should be blowing up towards the ceiling and not blowing towards the clean utensils. OSM #2 viewed the visible dust on the metal cage of the fan and stated that she was not sure who was responsible for cleaning of the fans but the fan should not have dust on it. She stated that the dietary staff did not clean the fans.

Further observation of the kitchen area revealed a large dry goods storage bin labeled sugar, dated 7/8, use by 9/8. Inside of the bin, a single paper cup was observed inside of the bin on top of the sugar. When asked about the cup, OSM #2 stated that the cup should not be in the bin and nothing should be inside the bin touching the product.

On 8/7/2023 at 2:45 p.m., an observation of the nourishment room on the facility Grove unit was conducted with LPN (licensed practical nurse) #8. A stand up refrigerator/freezer for resident food items was observed to contain a white paper bag with a receipt dated 7/29 on it, there was no resident name observed on the receipt or bag.

F 812

dust and not blowing on the dish ware.

The paper cup observed inside of the sugar bin was removed with no adverse effects related to the cited occurrence.

Unlabeled food items observed in paper bags and boxes in the refrigerator in the Grove unit pantry were removed with no adverse effects related to cited occurrence.

The five pieces of cake observed uncovered were removed from resident□s trays and replaced with covered cake with no adverse effects related to cited occurrence.

LPN # 6, OSM # 2 and OSM # 7 were re-educated on how to serve and distribute food in accordance with professional standards for food service safety.

Current residents have the potential to be affected. An audit of dry storage room, kitchen and Grove unit pantry was conducted by Dietary Manager/Designee to ensure variances were addressed.

Dietary staff were re-educated by the Dietary Manager/Designee on storing food in a sanitary manner in the kitchen, nourishment rooms and during meal service.

Dietary staff were re-educated by the Dietary Manager/Designee on the use of fans in the kitchen.

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

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F 812	Continued From page 228 Further review by LPN #8 revealed a container with food contents that were not labeled, dated or identified with a resident name. A fast food box with no identifying resident name or date was observed in the refrigerator. At this time an interview was conducted with LPN #8. LPN #8 stated that the night shift staff checked the refrigerator each night for temperatures and expired/unlabeled/undated items and should discard anything that was past three days. She stated that the refrigerator was for resident use only and the items in the refrigerator should have been dated and labeled with the residents name and room number because they could not identify who they belonged to or when they came in. On 8/8/2023 at 3:45 p.m., an interview was conducted with ASM (administrative staff member) #3, the vice president of operations. ASM #3 stated that fans would be avoided in the kitchen normally and they were not sure of the process for cleaning of the fans but thought that dietary staff would put a request in for maintenance to have them cleaned. ASM #3 stated that they would not want the fans blowing directly on the dishware in the kitchen. The facility policy "Foods Brought by Family/Visitors" undated, documented in part, "...Perishable foods are stored in re-sealable containers with tightly fitting lids in a refrigerator. Containers are labeled with the resident's name, the item and the "use by" date. The nursing staff will discard perishable foods on or before the "use by" date..." The facility policy "Safety Guidelines" dated September 2021, failed to evidence guidance for maintaining dust free fans or use of fans in the	F 812	Licensed Nursing staff and CNAs were re-educated by the DON/Designee on the proper labeling and storage of residents items in the nourishment rooms. An audit of the nourishment rooms will be conducted 4x a week for 4 weeks, then 2 times a week x 4 weeks by Dietary manager/Designee validating the proper storage of residents food items. An audit of the Dry food storage area will be conducted 4 x week for 4 weeks, then 2 times a week for 4 weeks by the Dietary Manager/Designee validating proper storing of food. A random audit of 10 meal trays will be conducted weekly x 8 weeks by DON/Designee validating that items on meal trays are served in accordance with professional standards. The findings of the audit will be submitted by the DON/Designee to QAPI monthly for 3 months or ongoing until compliance is sustained.	

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 08/16/2023

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F 812	Continued From page 229	F 812		

kitchen area.

The facility policy "Food Storage: Dry Goods" revised 9/2017, documented in part, "Policy Statement. All dry goods will be appropriately stored will be appropriately stored [sic] in accordance with the FDA (food and drug administration) Food Code... Storage areas will be neat, arranged for easy identification, and date marked as appropriate..."

On 8/8/2023 at approximately 5:00 p.m., ASM #1, the administrator, ASM #4, the regional risk consultant and ASM #5, the regional director of case management were made aware of the findings.

No further information was provided prior to exit.
2. The facility staff served individual cake squares on plates with no covers at lunch on 8/7/23.

On 8/7/23 at 11:57 a.m., lunch tray distribution was observed on the middle hallway on the Westham unit. Five of the eight trays contained individual pieces of devil's food cake on small saucers. Each of the five pieces of cake was uncovered.

On 8/7/23 at 12:02 p.m., LPN (licensed practical nurse) #6, the unit manager, was assisting in passing out the lunch trays containing the uncovered cake. When asked about this, LPN #6 stated: "Yes, they actually should be covered. I didn't think of it until you brought it up." LPN #6 stated the cake pieces should have been covered to prevent them from coming into contact with any type of germs.

On 8/14/23 at 9:09 a.m., OSM (other staff

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 08/16/2023

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CANTERBURY REHABILITATION AND HEALTHCARE CENTER	1776 CAMBRIDGE DRIVE RICHMOND, VA 23238

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F 812	Continued From page 230 member) #2, the dietary manager, and OSM #7, the district manager for dietary, were interviewed. Both OSM #2 and OSM #7 stated the individual cake servings should have been wrapped in plastic or have some type of lid. OSM #7 said: "It's a sanitation issue." On 8/14/23 at 4:01 p.m., ASM (administrative staff member) #1, the administrator, ASM #4, the regional risk consultant, ASM #8, the regional consultant, and ASM #7, the director of nursing, were informed of these concerns. No further information was provided prior to exit.	F 812		
F 842 SS=E	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 that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential	F 842		9/26/23

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 08/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANTERBURY REHABILITATION AND HEALTHCARE CENTER	**1776 CAMBRIDGE DRIVE RICHMOND, VA 23238**

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F 842	Continued From page 231	F 842		

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-
(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;

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

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F 842

Continued From page 232

(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 resident interview, staff interview, facility document review and clinical record review, the facility staff failed to maintain an accurate clinical record for four of 57 residents in the survey sample, Residents #86, #361, #144 and #63.

The findings include:

1. For Resident #86 (R86), the facility staff failed to accurately document the resident's ADLs (activities of daily living). On 8/8/23 and 8/9/23, the facility staff documented R86 was assisted with transferring but the resident was not out of bed.

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 7/17/23, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact for making daily decisions.

On 8/8/23 at 7:27 a.m., 8/8/23 at 10:43 a.m., 8/8/23 at 3:42 p.m., 8/9/23 4:12 p.m., 8/10/23 at 7:51 a.m. and 8/10/23 at 2:02 p.m., R86 was observed lying in bed. On 8/10/23 at 2:02 p.m., an interview was conducted with R86. R86 stated the they had not been out of bed all week. A review of R86's ADL records for August 2023 revealed documentation that the resident was totally dependent with physical assistance of two or more staff with transferring during the evening

F 842

F842 (E) Resident Records- Identifiable Information

Resident # 86 continues to reside in the facility with no adverse effects related to cited occurrence.

CNA 6 was re-educated by the DON/Designee on POC documentation and the importance of documenting the correct information in the patient□s chart.

Resident #361 no longer resides in the facility.

LPN 10 was re-educated by DON/Designee on nursing documentation and the importance of documenting the correct information in the patient□s chart.

Resident # 144 continues to reside in the facility with no adverse effects related to cited occurrence.

RN # 1 was re-educated by the DON/Designee on nursing documentation and the importance of documenting the correct information in the patient□s chart.

Resident # 63 no longer resides in the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495272	A. BUILDING ______ B. WING ______	C 08/16/2023

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

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F 842	Continued From page 233 shift on 8/8/23 and 8/9/23, and during the day shift on 8/8/23 and 8/10/23. On 8/10/23 at 4:07 p.m., an interview was conducted with CNA (certified nursing assistant) #6 (a CNA who documented assisting R86 with transferring on 8/8/23 and 8/9/23). CNA #6 stated R86 rarely gets out of bed. CNA #6 stated she mistakenly documented she assisted R86 with transferring and stated she should have documented the code NA [not applicable]. On 8/11/23 at 9:57 a.m., ASM (administrative staff member) #1 (the administrator) and ASM #4 (the regional risk consultant) were made aware of the above concern. The facility policy titled, Charting and Documentation" documented, "All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care." 2. For Resident #361 (R361), the facility staff failed to accurately document the location of an ischial pressure injury. A skin assessment dated 1/26/23 documented a pressure injury on the right ischium, but the pressure injury was located on the left ischium. A review of R361's skin assessment dated 1/26/23 documented multiple pressure injuries including a pressure injury on the right ischium. Review of wound care nurse practitioner	F 842	Current residents have the potential to be affected. A seven-day review of POC charting, of residents□ charts/nursing notes was conducted by the DON/Designee. Follow up was completed as indicated. CNAs were re-educated by the Staff Development Coordinator/Designee to accurately document the resident□s ADLs. Licensed nurses were re-educated on the documentation process per the facility□s policy and procedures in accordance with nursing standards. An audit of 3 residents will be completed related to POC charting to validate completion and accuracy. Variances will be addressed. These audits will be conducted weekly x 4 weeks, then monthly x 2 months. The findings of the audits will be submitted by the DON/Designee to the QAPI Committee for review and recommendation monthly for 3 months or ongoing until compliance sustained.	

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F 842	Continued From page 234	F 842		

assessments dated 1/31/23 and weekly wound progress reports dated 2/1/23 revealed documentation for a pressure injury on the left ischium but no documentation regarding a pressure injury on the right ischium.

On 8/14/23 at 1:56 p.m., am interview was conducted with LPN (licensed practical nurse) #10. LPN #10 stated she completed R361's skin assessment on 1/26/23. LPN #10 stated she mistakenly documented a pressure injury on R361's right ischium but the wound was on the left ischium.

On 8/14/23 at 4:06 p.m., ASM (administrative staff member) #1 (the administrator), ASM #4 (the regional risk consultant) and ASM #7 (the director of nursing) were made aware of the above concern.
3. For Resident #144, the facility staff failed to evidence complete and accurate documentation for bilateral fall mats.

Observations of Resident #144 on 08/07/23 at 11:40 AM, no floor mats on either side of bed, 8/10/23 at 2:45 PM, no floor mats on either side of bed, 8/08/23 at 7:45 AM, no floor mats on either side of bed, on 8/8/23 at 11:30 AM, no floor mats on either side of bed and 8/10/23 9:15 AM, no floor mats on either side of bed.

A review of the physician order dated 4/27/23, revealed, "Floor mats to both sides of bed every shift."

A review of the August 2023 TAR (treatment administration record) revealed, "Floor mats to both sides of bed every shift" and documented as fall mats present 8/7/23 day shift through 8/10/23

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F 842	Continued From page 235	F 842		

day shift- total of 10 shifts.

An interview was conducted on 8/9/23 at 2:20 PM, with RN (registered nurse) #1. When asked about the bilateral floor mats for Resident #144, RN #1 stated, he used to have fall mats. I believe they took them to give to another resident who was more active. When asked about the documentation on the TAR (treatment administration record) which revealed, "floor mats to both sides of bed every shift" and documented that they were present, what did that indicate, RN #1 stated, it was an error in documentation. When asked if there are errors in documentation is the medical record, complete and accurate, RN #1 stated, no, it is not.

On 8/14/23 at 4:00 PM, ASM (administrative staff member) #1, the administrator, ASM #4, the regional risk consultant, ASM #7, the director of nursing and ASM #8, the regional consultant was made aware of the findings.

No further information was provided prior to exit.
4. For Resident #63, the facility staff failed to document in the clinical record, the resident's refusal to use offloading boots.

Review of R63's electronic health record documented a podiatry consult dated 02/24/2022. Under recommendations it documented in part, " ...Spoke to nurse about making sure his feet are not resting on the end of the bed and I told her to have pcp (primary care physician) order offloading boots and wound care dressing ..."

Review of the physician's orders for R63 dated February 2022 through January 2023 failed to evidence an order for offloading boots.

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F 842	Continued From page 236	F 842		

Review of R63's progress notes dated 02/24/2022 through 01/31/2023 failed to evidence R63 was provided with and/or refused the use of offloading boots.

Review of the R63's comprehensive care plan dated of 10/15/2020 failed to evidence the use of offloading boots.

On 08/08/2023 at approximately 2:57 p.m., ASM (administrative staff member) #4, regional risk consultant, stated R63 did not have a physician's order for offloading boots.

On 08/10/2023 at approximately 1:00 p.m., RN (registered nurse) #3, MDS director, was asked if R63's comprehensive care plan addressed the use and/or refusal for the use of offloading boots. At approximately 1:30 p.m., RN #3 informed the surveyor that there was no evidence R63's comprehensive care plan addressed the use and/or refusal for the use of offloading boots.

On 08/16/2023 at approximately 9:18 a.m., ASM #1, administrator, informed the surveyor that there was documentation of R63 refusing the use of offloading boots.

On 08/16/2023 at approximately 9.30 a.m., an interview was conducted with ASM #7, director of nursing. She provided the surveyor with a document entitled "Clinical Stand Down" dated 03/02/2022. Under the heading "Resident" it documented in part, "(Name of R63) - ® HLSB." When asked about the document she stated it was part of her risk management documents. When asked to interpret "® HLSB" she stated it stood for "Refused Heel Lift Suppression Boots"

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	495272	A. BUILDING ______ B. WING ______	C 08/16/2023

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F 842	Continued From page 237 and it was her notation that R63 refused to wear the offloading boots. When asked if the "Clinical Stand Down" document was part of R63's clinical record she stated no. No further information was provided prior to exit.	F 842		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other	F 880		9/26/23

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F 880	Continued From page 238 persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined the facility staff failed to maintain effective infection control	F 880	F880 (D) Infection Prevention & Control No specific residents were identified.	

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F 880 Continued From page 239
practices in one of two dining rooms.

The findings include:

Observation was made of the staff serving the residents in the Tuckahoe dining room on 8/7/2023 at 11:32 a.m. OSM (other staff member) #10, the activity assistant, was helping getting resident's orders for their lunch and passing out drinks to the residents. OSM #10 had gloves on. OSM #10 was observed using hand sanitizer with the gloves on between serving residents. OSM #10 continued to pass plates to residents. At 11:53 a.m. OSM #10 was observed using hand sanitizer with his gloves on, again. He never changed gloves.

An interview was conducted with OSM #10 on 8/7/2023 at 12:00 p.m. When asked why he used hand sanitizer with his gloves on, OSM #10 stated, "To make sure my hands are disinfected well."

An interview was conducted with RN (registered nurse) #4, the infection preventionist, on 8/8/2023 at 1:49 p.m. When asked if a staff member should use hand sanitizer on the gloves when you have gloves on, RN #4 stated, "No, I don't teach that either." RN #4 was asked what the staff should who are serving food to the residents in the dining room have on, should they be wearing gloves, RN #4 stated, no. When asked if the staff is going from resident to resident, what hand hygiene practice should they follow, RN #4 stated if they are going table to table, resident to resident, then they should be using hand sanitizer every third resident and then wash their hands.

The facility policy, "Preventing Foodborne Illness -

F 880

OSM # 10 was re-educated on the hand hygiene process per facility protocol when passing out food trays.

Current residents have the potential to be affected. The DON/Designee conducted a review of meals to validate hand hygiene was being used appropriately. No further variances were noted.

The facility staff will be re-educated on the correct hand hygiene protocol for passing out meal trays to residents by the DON/Designee.

A random audit of 5 staff members per week x 4 weeks, then 3 staff members a week x 4 weeks will be conducted by the DON/Designee validating the correct hand hygiene protocol is being utilized. The findings of the audit will be submitted by the DON/Designee to QAPI monthly for 3 months or ongoing until compliance is sustained.

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F 880	Continued From page 240 Employee Hygiene and Sanitary Practices," documented in part, "13. Gloves are not required when distributing foods to residents at the dining tables or when assisting residents to eat, unless touching ready-to-eat food." ASM (administrative staff member) #1, the administrator, ASM # 4, the regional risk consultant, and ASM #5, the regional director of case management, were made aware of the above findings on 8/8/2023 at 4:59 p.m. No further information was provided prior to exit.	F 880		
F 921 SS=D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide a safe and functional environment for one of 12 resident rooms (for Resident #129). The findings include: The facility staff failed to provide a safe and functional environment for one of 12 resident rooms, for Resident #129. During the initial resident screening on 8/7/23 at 2:59 PM, resident room 316 revealed a wall mounted hand sanitizer dispenser partially torn off the wall above and to the left of the resident's sink, a section of damaged dry wall containing a hole	F 921	F921 Safe/Functional/Sanitary/Comfortable Environment 1. Resident #129 Hand sanitizer wall mount, dry wall, missing flooring, peeled wallpaper, and cove base was repaired in resident room. 2. Residents who reside at Canterbury Rehabilitation and Healthcare Center have the potential to be affected by this practice. An audit was conducted by the	9/26/23

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F 921

Continued From page 241

approximately six inches below and to the left of the resident's sink, missing flooring in the doorway between the resident room and bathroom, approximately 12 inches of cove base torn off the wall with additional tearing of the dry wall between the head of the residents beds and an approximate 12 inch piece of cove base falling off the wall to the left side the heating/air conditioning unit at the far side of the room.

On 8/8/23 at 3:30 PM, an interview was conducted with CNA (certified nursing assistant) #2. When shown Resident #129's room with the broken dry wall, peeled wallpaper and no tiles in doorway between resident room/ bathroom, and asked if this was a safe, sanitary environment, CNA #2 stated, no, this is not sanitary. When asked if this is a safe environment, CNA #2 stated, no it is not.

On 8/9/23 at 10:15 AM, an interview was conducted with OSM (other staff member) #3, the maintenance director. When shown Resident #129's room with broken dry wall, peeled wallpaper and no tiles in doorway between resident room/bathroom and asked if this was a safe, sanitary environment, OSM #3 stated, no, it is not.

On 8/14/23 at 4:00 PM, ASM (administrative staff member) #1, the administrator, ASM #4, the regional risk consultant, ASM #7, the director of nursing and ASM #8, the regional consultant was made aware of the findings.

According to the facility's "Construction and Renovation-Role of the Administrator or Designee" policy, "Purpose: To reduce resident and employee exposure to potentially infectious

F 921

Administrator/Designee of resident rooms to ensure a safe, functional, sanitary, and comfortable environment for residents, staff, and the public. Variances were addressed.

3. Weekly audit of 5% of resident rooms and common areas will be conducted by the Administrator/Designee to monitor rooms and environment to ensure they are presenting in a safe, sanitary, functioning, and comfortable manner.

a. The Staff Development Coordinator/Designee will provide education to all departments within the center on the importance of a clean and homelike environment. Education on the utilization of tels system to identify needed work orders for repair or needing addressed.

4. The Director of Maintenance/Housekeeping and/or Designee will conduct a weekly rounding of the facility to ensure a safe, functional, sanitary, and comfortable environment for residents, staff and the public.

Findings from the audit will be submitted to the QAPI committee for review and recommendation monthly.

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	495272	A. BUILDING ______ B. WING ______	C 08/16/2023

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F 921	Continued From page 242 agents released into the environment due to construction, renovation, remediation, repair and demolition or related activities. The administrator or designee(s) will establish and maintain surveillance for airborne and waterborne environmental disease (e.g., aspergillosis, Legionnaire's disease) as appropriate throughout the project to protect immunocompromised patients. The administrator or designee(s) will monitor construction and renovation projects until completion to ensure adherence to current CDC/HICPAC (center disease control/healthcare infection control practices advisory committee) guidelines and state or local requirements." No further information was provided prior to exit.	F 921		