PRINTED: 09/14/2023 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		X3) DATE SURVEY COMPLETED
		495272	B. WING _			C 08/16/2023
	ROVIDER OR SUPPLIER BURY REHABILITATION	I AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
E 000	Initial Comments		E 0	00		
F 000	survey was conduct 8/11/2023 and 08/14 The facility was in s CFR Part 483.73, R Care Facilities. No e complaints were inv INITIAL COMMENT		F 0	00		
	survey was conduct and 08/14/23 throug required for compliants Federal Long Term complaints were inversely (VA00059039-unsult substantiated with conductive value) value (VA00057805-substative value) value (VA00057841-substative value) value (VA00057975-substative value) value (VA00059374-substative value) value (VA00058758-substative value) value (VA00	dedicare/Medicaid standard and 194 08/07/23 through 08/11/23 and 08/16/23. Corrections are since with 42 CFR Part 483 Care requirements. Ten restigated during the survey obstantiated; VA00058087 - deficiency; antiated with no deficiency; antiated with deficiency. The rvey report will follow.				
F 550 SS=E	183 at the time of the consisted of 47 currelosed record review Resident Rights/Exc CFR(s): 483.10(a)(1) §483.10(a) Resident The resident has a self-determination, a	ercise of Rights ()(2)(b)(1)(2)	F 5	50 TITLE		9/26/23

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

TITLE (X6) DATE

Electronically Signed 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.

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	, ,	TE SURVEY MPLETED
		495272	B. WING			C 8/ 16/2023
	ROVIDER OR SUPPLIER URY REHABILITATION	AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238		16/16/2023
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 550	outside the facility, in this section. §483.10(a)(1) A facili with respect and dig resident in a manner promotes maintenar her quality of life, recindividuality. The facility faces to quality car severity of condition must establish and repractices regarding the provision of services residents regardless. §483.10(b) Exercise The resident has the rights as a resident or resident of the Universident can exercise.	ity must treat each resident nity and care for each and in an environment that are or enhancement of his or cognizing each resident's ility must protect and a the resident. Incility must provide equal regardless of diagnosis, or payment source. A facility maintain identical policies and ransfer, discharge, and the under the State plan for all of payment source. Of Rights. Fright to exercise his or her of the facility and as a citizen	F 5.	,		
	free of interference, reprisal from the faci rights and to be supplexercise of his or he subpart. This REQUIREMEN by:	esident has the right to be coercion, discrimination, and lity in exercising his or her corted by the facility in the r rights as required under this T is not met as evidenced on, resident interview, staff		F550 Resident Rights / Exercis	se Rights	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED
		495272	B. WING _			C 08/16/2023
NAME OF PE	ROVIDER OR SUPPLIER	_		STREET ADDRESS, CITY		00/10/2023
				1776 CAMBRIDGE DRIV		
CANTERB	URY REHABILITATIO	N AND HEALTHCARE CENTER		RICHMOND, VA 2323		
				·		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH COR	ER'S PLAN OF CORRECTION RRECTIVE ACTION SHOULD BE ERENCED TO THE APPROPRIA DEFICIENCY)	
F 550	Continued From pa	ge 2	F 5	50		
	interview, facility do	ocument review, and clinical				
	record review, the f	facility staff failed to maintain		SS=E		
	resident dignity for	four of 57 residents in the				
	survey sample, Res	sidents #74, #48, #5, and #86.		1) Resident # 74 adverse effects	4 was reviewed with no related to cited	
	The findings include	e:			incontinence care re plan in a dignified	
	1. For Resident #74	4 (R74), the facility staff failed		manner.	1 3	
		ence care in a dignified				
	manner.	G		Resident # 48 w	as reviewed with no	
				adverse effects	related to cited	
	On the most recent	: MDS (minimum data set), an		occurrence, inco	ontinence care provided	1
	annual assessment	t with an ARD (assessment		per care plan an	nd resident dressed as	
	reference date of 6	/23/23), R74 was coded as		indicated to mai	ntain dignity.	
	having no cognitive	impairment for making daily				
	decisions, having s	cored 15 out of 15 on the		CNA #10, CNA #	#5, LPN #7, and LPN #	10
	BIMS (brief intervie	w for mental status). R74 was		were re-educate	ed by the Staff	
	coded as requiring	the extensive assistance of		Development Co	oordinator/Designee on	
	two staff members	for toileting, and coded as		treating each res	sident with respect and	
	being always incon	tinent of both bowel and		dignity and care	, in a manner and in an	
	bladder.			environment tha	at promotes maintenand	e
				or enhancement	t of his or her quality of	
		.m., the surveyor entered		life, recognizing	each resident□s	
		certified nursing assistant) #10		individuality. Thi	is includes but is not	
	•	om the bathroom (shared with		-	ing timely incontinence	
		the adjacent room), and			ly dressing and/or	
		o do this resident [pointing to a		_	nts as indicated to	
	•	vith her in the bathroom], then		maintain dignity.		
		Resident #48, R74's				
	_	em him [pointing to R74]. CNA			as reviewed with no	
		e bathroom door. R74 was		adverse effects		.
		the television on. He stated:			sident #5 was evaluated	
		g for an hour to get changed."		, , , , ,	ositioning and enhance	d
		ware of needing to have his		utensils as indic	ated with meals.	
		changed around 3:00 p.m., and		1.501.110		
		nother CNA whom he could not			educated by the Staff	
		ame in "a little after 3," (3:00		-	oordinator/Designee on	
		ght off, and told him it was			sident with respect and	
	"cnange of shift," a	nd that someone else would		dignity and care	e, in a manner and in an	

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		495272	B. WING _			1	C 16/2023
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 00/	10/2020
				17	76 CAMBRIDGE DRIVE		
CANTERB	URY REHABILITATION	AND HEALTHCARE CENTER			ICHMOND, VA 23238		
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F 550	Continued From page	ge 3	F 5	550			
	have to come in and "No one has still cor changed." He stated very good to be a grehanged." On 8/7/23 at 3:45 p. were observed stanunit. Two of the seven on their cell phones. On 8/7/23 at 4:12 p. R74 to have his incompared in part: "I leaded to physical incontinence care at neededcheck residence and provide in the control of the	In change him later. He stated: The back in. I really need to be It: "It certainly does not feel Town man and need my pants In m., seven staff members In ding at the desk for R74's In were tapping and scrolling In m., CNA #10 began preparing In ontinence brief changed. In a plan dated 6/25/23 In a part of the stated: The back in I really need to be I the stated: The back in I really need to be I the stated: The back in I really need to be I the stated: The back in I really need to be I the stated: The back in I really need to be I the stated: The back in I really need to be I the stated: The back in I really need to be I the stated: The back in I really need to be I the stated: The back in I really need to be I the stated: The back in I really need to be I the stated: The back in I really need to be I the back in I really need to b			environment that promotes maintenant or enhancement of his or her quality of life, recognizing each resident □s individuality. This includes setting up me 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 occurrer Resident #86 external urinary catheter collection canister is covered in a dignity manner. LPN #7 was re-educated by the Staff Development Coordinator/Designee or treating each resident with respect and dignity and care, to include maintaining cover on urinary catheter collection canisters. 2) Current residents that require incontinence assistance, require tray seems and the second continence assistance, require tray seems and the second can be a second continence assistance, require tray seems and the second continence assistance, require tray seems and the second can be a second continence assistance, require tray seems and the second continence assistance, require tray seems and the second continence assistance, require tray seems and the second continence assistance.	neal at nce. fied	
	simultaneously need changes, she stated would be quick in the Then I did [Resident asked if having to wincontinence care lestated: "No, it certain On 8/10/23 at 3:26 pinterviewed. When a hour for incontinence dignity, she stated it On 8/14/23 at 11:59	ads to resident dignity, she hly does not." b.m., CNA # 5 was asked if having to wait over an e care leads to resident			up for meals and /or use a urinary catheter collection canister have the potential to be affected. A list of reside that receive incontinent care, require sup for meal service and utilize an exterurinary catheter collection canister. A walking round audit was conducted during change of shift, care, and mealtimes by Unit Manager/Designee residents who require incontinence car and /or tray set up for meals to validate care was timely, residents were dresse resident positioned, and meal tray set and provided in a manner that maintain resident dignity. Rounds also include	nts et nal of ee ed,	

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		495272	B. WING _			08/	/16/2023
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
OANTEDD	LIDV DELLA DII ITATIONI	AND HEALTHOADE OFNITED		17	776 CAMBRIDGE DRIVE		
CANTERB	URY REHABILITATION	AND HEALTHCARE CENTER		R	CICHMOND, VA 23238		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	<	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 550	Continued From pag	e 4	F 5	550			
	maximum wait time f	or a resident who needs a			validating Residents that use urinary		
	brief change is "five t	to ten minutes, at the most."			catheter collection canister were provide	ded	
	She stated she would	d help a CNA with			with covers. No further variances were		
		she were asked, and if she			identified.		
	were not in the middle						
		ents. When asked if having			3) Licensed Nursing and C N A staff		
		for incontinence care leads			members were re-educated by the Sta	ff	
	to resident dignity, sh	ne stated it does not.			Development Coordinator / Designee	on	
					treating each resident with respect and		
	On 8/14/23 at 2:20 p	.m., LPN #10, a unit			dignity and care, in a manner and in ar	า	
	manager was interview	ewed. She stated if she were			environment that promotes maintenand	ce	
	aware of three reside	ents who needed			or enhancement of his or her quality of	:	
	incontinence care at	the same time, she stated: "I			life, recognizing each resident□s		
	would get to the mos	t dire one first. The second			individuality this includes but is not limi	ted	
	and third one would	have to wait." She added: "If			to providing timely incontinence care p	er	
	possible, I would ask	somebody to help me, if			care plan, dressing or covering resider	nt	
	anyone was available	e." She stated the time of			as indicated, positioning residents prio	r to	
	shift change does no	t alter the facility's			meals and setting up tray and overbed		
	responsibility to mee	t resident needs. She stated:			table per preference if resident choose	s to	
	"If it was me, I would	not want to wait any more			eat in their bed, maintain covering urin	ary	
	than 10 minutes to b	e changed." When asked if			catheter collection canister devices in	а	
	having to wait over a	n hour for incontinence care			dignified manner.		
	leads to resident digi	nity, she stated it does not.					
					4) An audit of 3 residents will be		
	·	.m., ASM (administrative			conducted via walking round audits du		
		e administrator, ASM #4, the			change of shift, care and/or mealtimes	•	
	_	ant, ASM #8, the regional			Unit Manager/Designee of residents w		
		l #7, the director of nursing,			require incontinence care and /or tray		
	were informed of the	se concerns.			up for meals to validate care was timel	у,	
					residents were dressed, resident		
		y policy, "Dignity," revealed,			positioned, and meal tray set up and		
	•	nt shall be cared for in a			provided in a manner that maintained		
		es and enhances his or her			resident dignity. Rounds also include		
		level of satisfaction with life,			validating Residents that use urinary		
	and feelings of self-v				catheter collection canister were provide		
		nts are treated with dignity			with covers. Variance will be addresse		
		esThe facility culture			These audits will be conducted weekly	x 4	
		respect for residents by			weeks, then monthly x 2 months. The		
	honoring resident go	als, choices, preferences,			findings of the audits will be submitted	by	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CO		0/10/2023
OANTEDD	UDV DELLA DIL ITATIONI	4ND UE41 TUG4 DE GENTED		1776 CAMBRIDGE DRIVE		
CANTERB	SURY REHABILITATION	AND HEALTHCARE CENTER		RICHMOND, VA 23238		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 550	Continued From pag	e 5	F 55	50		
	standards of care that prohibited. Staff are and assist residents,	Demeaning practices and at compromise dignity are expected to promote dignity for examplepromptly dent's request for toileting		the DON/Designee to the QA Committee for review and recommendation monthly for ongoing until compliance sus	r 3 months or	
	No further informatio	n was provided prior to exit.				
	provide a dignified vi	(R48), the facility staff failed ew of the resident, and failed ice care in a dignified				
	annual assessment of reference date) of 6/4 being cognitively into having scored 13 our interview for mental strequiring the extension members for toileting incontinent of bladde	MDS (minimum data set), an with an ARD (assessment 9/23, R48 was coded as act for making daily decisions, t of 15 on the BIMS (brief status). R48 was coded as we assistance of two staff g, as being frequently ar and always incontinent of a mitted to the facility with a ual disability/autism.				
	R48's room. CNA (ce opened the door from the two residents in the stated: "I'm going to resident standing with do him [pointing to Resident standing to Resi	m., the surveyor entered ertified nursing assistant) #10 in the bathroom (shared with the adjacent room), and do this resident [pointing to a h her in the bathroom], then 48]. CNA #10 then closed R48 was sitting in his wheelchair was fully facing ay. R48 was wearing only a se briefs. There was a strong inding R48. When asked how				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495272	B. WING				C 16/2023
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER	•	1	TREET ADDRESS, CITY, STATE, ZIP CODE 776 CAMBRIDGE DRIVE RICHMOND, VA 23238	1 001	10/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 550	Continued From page	e 6	F	550			
		iting to be changed, R48 n there [pointing to his					
	were observed stand	n., seven staff members ing at the desk for R48's n were tapping and scrolling					
		n., CNA #10 began preparing ntinence brief changed.					
	(related to) physical li incontinence carea approximately every incontinence care as incontinence r/t (relat	ave urinary incontinence r/t imitationsProvide s neededCheck resident 2 hours and provide neededI have bowel					
	When asked about the and how she handled simultaneously needs changes, she stated: would be quick in the Then I did [R48]." She R48 had been incontinueded to be changed just changed him, and again. I needed to do stated: "We usually he whole unit. That day, why." She stated she help from other CNAsthere." She stated she						

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	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER	•	17	TREET ADDRESS, CITY, STATE, ZIP CODE 776 CAMBRIDGE DRIVE ICHMOND, VA 23238	, 00.	10,2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 550	Continued From page	e 7	F s	550			
F 330	busy passing meds (if sitting with no pants and having to wait ovincontinence care aft leads to resident digridoesn't." On 8/10/23 at 3:26 p. interviewed. When as clear view of passers 22 minutes for incontincontinent of bowel is stated it does not. On 8/14/23 at 11:59 a nurse) # 7 was interviewed incontinence care if swere not in the middle medications to reside with no pants in clear having to wait over 20 care after being incorresident dignity, she is on 8/14/23 at 2:20 p. manager was interviewed incontinence care at incont	medications)." When asked in clear view of passersby, her 22 minutes for her being incontinent of bowel hity, she stated: "No, m., CNA # 5 was sked if sitting with no pants in by, and having to wait over inence care after being heads to resident dignity, she a.m., LPN (licensed practical liewed. She stated the for a resident who needs a so ten minutes, at the most." If help a CNA with the were asked, and if she her of administering herts. When asked if sitting the view of passersby, and 20 minutes for incontinence hitinent of bowel leads to stated it does not. m., LPN #10, a unit here were stated if she were		550			
	and third one would he possible, I would ask anyone was available shift change does no responsibility to meet "If it was me, I would	nave to wait." She added: "If somebody to help me, if e." She stated the time of					

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	ROVIDER OR SUPPLIER	I AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238		0/10/2023
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F 550	and having to wait of incontinence care at leads to resident dig. On 8/14/23 at 4:01 staff member) #1, the regional risk consultant, and ASN were informed of the No further information. 3. For Resident #5 provide the resident eating. On the most recent quarterly assessment reference date) of 7 being moderately of daily decisions. R5 extensive assistance transfers from bed to	p.m., ASM (administrative ne administrator, ASM #4, the tant, ASM #8, the regional M #7, the director of nassersby, sover 22 minutes for fter being incontinent of bowel gnity, she stated it does not.	F 5	,		
	with the head of the to feed herself food was on the overbed positioned across R that her nose was a lunch tray. R5's plat and vegetables. She herself using only h was going into the r	p.m., R5 was sitting in bed bed elevated and attempting from her lunch tray, which table. The overbed table was 5's bed. R5 was positioned so to the level of the plate on the electric contained chopped meat ele was attempting to feed er fingers. Some of the food esident's mouth; however, is landing on the resident's				

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F 550	nurse) #6, a unit may breakfast tray, and pacross R5's bed. R6 same position as shounch observation. It reposition the reside breakfast tray, inclusoatmeal, jelly on the at 7:59 a.m., R5 attender fork to feed hers down, and began at her fingers. Some of mouth; most of the bed linens, and the A review of R5's carevealed, in part: "FOO 8/14/23 at 9:16 assistant) #11 was in "When I take care of work with her as passhe stated R5 is no stated a resident's caresident gets food linens while she is evaluated, and treat 7/21/23. She stated treated for eating/sets.	inens, and floor. Im., LPN (licensed practical inager, delivered R5's positioned the overbed table is was in approximately the ine had been on 8/7/23 at the LPN #6 made no attempt to ent. LPN #6 set up the ding putting sugar on the interest of the entitle to the entitle the entitle to the entitle the entitle to the entitle the ent	F 55			

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F 550	"independent" means manipulate the utens no physical assistand the resident is missir evaluation. She state can evaluate for a podevice." She added: for her to eat." On 8/14/23 at 4:01 p staff member) #1, the regional risk consultate consultant, and ASM were informed of the No further information 4. For Resident #86 to store the resident's collection canister in multiple dates, the recatheter canister was nightstand and contain the contained of the most recent for the most recent	aur only baseline." She stated is that the resident is able to sills, bring hand to mouth with one, and eat. She stated: "If go the mouth, it warrants an eat: "If she is overshooting, we essible adaptive eating "That is not a dignified way." "That is no	F	550			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495272	B. WING		C 08/16/2023
	ROVIDER OR SUPPLIER	I AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	1 00/10/2020
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F 550	nightstand, and was of urine. At this tim with R86. R86 state nightstand made the undignified and the the canister was collocation. On 8/8/23 at 4:18 p in bed. The resider canister was observinghtstand, and was of urine. On 8/10/23 at 7:50 in bed. The resider canister was observinghtstand, and was of urine. On 8/10/23 at 2:19 conducted with LPN (a nurse who cares	ge 11 yed beside the bed, on the sapproximately one tenth full e, an interview was conducted ed the canister of urine on the eresident feel a little resident would feel better if yered or in a more private yed	F 55		
F 580 SS=E	staff member) #1 (the regional risk countries the above concern. Notify of Changes (CFR(s): 483.10(g)(14) Notify A facility must improve consult with the reservable consu	fication of Changes. mediately inform the resident; ident's physician; and notify, or her authority, the resident	F 58	30	9/26/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
		495272	B. WING _			C 08/16/2023	
	ROVIDER OR SUPPLIER	N AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	.	33, 13, 2323	
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F 580	Continued From pa	ge 12	F 5	80			
	results in injury and physician interventi (B) A significant charmental, or psychosor deterioration in hea status in either lifedilinical complication (C) A need to alter a need to discontinus treatment due to accommence a new from the fast (D) A decision to transident from the fast (B) A decision to transident from the fast (C) (1) (ii). (ii) When making not (14) (i) of this section all pertinent informatics available and prophysician. (iii) The facility must resident and the result when there is-(A) A change in room as specified in §483 (B) A change in result (e) (10) of this section (iv) The facility must update the address phone number of the representative (s). §483.10(g)(15) Admission to a composite §483.5) must disclose	ange in the resident's physical, pocial status (that is, a lth, mental, or psychosocial chreatening conditions or as); creatment significantly (that is, as an existing form of verse consequences, or to purpose or discharge the cility as specified in continuous paragraph (g) and the facility must ensure that action specified in §483.15(c)(2) and or request to the sident representative, if any, and or roommate assignment as 10(e)(6); or ident rights under Federal or ions as specified in paragraph on. It record and periodically (mailing and email) and					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495272	B. WING		C		
NAME OF P	ROVIDER OR SUPPLIER	400212		STREET ADDRESS, CITY, STATE, ZIP CODE	08/16/2023		
				1776 CAMBRIDGE DRIVE			
CANTERB	SURY REHABILITATION A	AND HEALTHCARE CENTER		RICHMOND, VA 23238			
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F 580	580 Continued From page 13		F 58	0			
	part, and must specify room changes between under §483.15(c)(9). This REQUIREMENT by:	se the composite distinct y the policies that apply to en its different locations is not met as evidenced		E590 Notify of Changes			
Based on staff interview, facility document			F580 Notify of Changes				
	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.			(Injury/Decline/Room) SS=E 1) Resident #90□s physician was no	otified		
	The findings include:			of the elevated blood sugar levels or 8/2/23, 8/3/23, 8/7/23, and 8/8/23. N orders at this time.			
	1. For Resident #90,	the facility staff failed to					
		per the physician order, of		LPN # 9 was re-educated by the Sta			
	elevated blood sugar			Development Coordinator / Designed the need to notify the physician per t	he		
		dated 3/24/2023 included,		physician orders regarding elevated	blood		
	•	. (milliliters) (Insulin Regular		sugars.	.		
	151 - 199 = 1; 200 - 2	sliding scale: if 0 - 150 = 0; 249 = 2; 251 - 299 = 3; 300 - 5; 400 - 450 = 6; > (greater		Resident #63 was discharged from the facility on 8/8/23.	ne		
	than) 450 give 8 units	and inform attending,		Resident #86□s physician was notifi	ed		
	subcutaneously at be bedtime ssi (sliding so	dtime for dm (diabetes) cale insulin).		that Levothyroxine sodium was not available for administration on 8/5/23 8/6/23. No new orders at this time.	3 and		
	The physician orders	dated 3/24/2023 included,					
	Injector 100 UNIT/ML Human) inject as per units; 151 - 199 = 2 u - 299 = 6 units; 300 - 10 units; 400+ CALL	Flex Pen Solution Pen (milliliters) (Insulin Regular sliding scale: if 0 - 150 = 0 nits; 200 - 249 = 4 units; 250 349 = 8 units; 350 - 399 = MD (medical doctor) FOR cously before meals for		Resident #115 s physician was noti the following medications (Lisinopril, Allopurinol, and Diltiazem) were not available for administration on 7/9/23 new orders at this time. Resident #360 was discharged from	3. No		
	diabetes."			facility on 8/19/23.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495272	B. WING _				C 16/2023	
NAME OF PR	ROVIDER OR SUPPLIER		1	S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	10/2020	
					776 CAMBRIDGE DRIVE			
CANTERB	URY REHABILITATION	AND HEALTHCARE CENTER			RICHMOND, VA 23238			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOUL			(X5) COMPLETION DATE	
F 580	Continued From page	e 14	F 5	580				
	The August MAR (medication administration record) documented the above two orders. On				LPN # 11 was re-educated by the Staff Development Coordinator / Designee of			
	the blood sugar was				the need to notify the physician if a star lab in not completed timely per the	t		
		ox where the amount of the was to be documented.			physician orders.			
The August MAR documented the above two orders. On the following dates at 1600 (4:00 p.m.) the following was documented:				Resident #95 s 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.				
	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.				Resident #358□s was discharged on 8/3023.			
	was documented in the insulin administer	documented as 445. An "11" he box where the amount of red was to be documented. documented as 425. An "11"			Residents that receive blood sugar monitoring, medication administration of that have stat lab	or		
	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.				orders have the potential to be affected Licensed nurses conducted an audit fo 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	r		
The chart codes on the MAR docume following: 11 = Vitals Outside of Parameters. 3 = Absent from facility.		f Parameters.			that were not completed timely to validate physician notification occurred. Variance were addressed. 3) Licensed Nursing staff were provide	ate ces		
	any documentation re	s notes failed to evidence elated to the resident's blood ntact made with the doctor, ers.			with re-education by the Staff Development Coordinator/Designee or Physician notification when elevated bl sugars outside of order parameters occ medications on hold, unavailable, or no	ood cur,		
	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				given, and when stat labs are not completed timely. 4) An Audit will be completed by the Ur			
administration of insulin.				Manager/Designee weekly on resident	S			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		495272	B. WING _			08/	16/2023
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F 580	practical nurse) #9, the the above information. The documentation a LPN #9. When asked LPN #9 stated that the parameters. LPN #9 resident insulin on 8/2 had given the resident she called the physic not contacted the physic not contacted the physic administered insulin on 8/7/2023 at 4:00 p.m. the resident 10 units called the doctor, she asked if the resident 8/8/2023 at 4:00 p.m. must have clicked the asked how much insuling LPN #9 stated, eight the doctor. When as physician orders, LPN asked if she was allow without a physician or Status," Statement: Our facility resident, his or her at resident representation and the policy Interpretation and the physician on call was also in the physician on call was also increased in the physician on the physician	ducted with LPN (licensed ne nurse that documented not on 8/9/2023 at 3:09 p.m. bove was reviewed with 1 what the "11" stood for, we blood sugar was out of the was asked if she gave the 2/2023, LPN #9 stated she not 10 units. When asked if sian, LPN #9 stated she had visician. LPN #9 was asked if all in to the resident on the resident on LPN #9 stated she gave that day. When asked if she stated, no. LPN #9 was was out of the facility on LPN #9 stated, no, she worng button. LPN #9 was all in she gave the resident, units and no, she didn't call ked if she was following the N #9 stated no. LPN #9 was wed to give medications order, LPN #9 stated, no. Thange in Resident's documented in part, "Policy by promptly notified the tending physician, and the we of changes in the cental condition and/or status. and Implementation: 1. The esident's attending physician	F	580	that had elevated blood sugars outside ordered parameters, medications on he unavailable, or not given, and stat labs that were not completed timely to valid physician notification occurred. 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 month for 3 months or ongoing until compliance sustained.	old, ate ces	

· ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP COL 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	DE	, 00.	10/2020	
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F 580	administrator, ASM # consultant, and ASM consultant, and ASM consultant, were made on 8/9/2023 at 5:30 p. No further information 2. For Resident #63 (to notify the physician Ceftriaxone Sodium (administration accord R63 was admitted with but were not limited to infection). The physicians order documented in part, 'Solution Reconstitute gram intravenously educated pays. Order Date: 00-8/04/2023." The eMAR (electronic record) for R63 dated the medication listed failed to evidence the Ceftriaxone Sodium of 08/06/2023; the number of 18/05/2023 and 08/06. Treatment Not Adminimation The facility's nurse's in part, "8/05/2023 nurse's pin part," 8/05/2023 nurse's pin sin part, "8/05/2023 nurse's pin sin part,"	staff member) #1, the 4, the regional risk #6, the clinical care le aware of the above finding o.m. In was provided prior to exit. (R63), the facility staff failed in that an antibiotic, 1), was not available for ling to the physician's orders th diagnoses that included to UTI (urinary tract Sheet dated August 2023 (Ceftriaxone Sodium and 1(one) GM (gram). Use 1 (very 24 hours for UTI for 5 (B/04/2023). Start Date: Comedication administration of August 2023 documented above. Review of the eMAR of administration of (Document of the emate) (Document o	F	580				
		Solution Reconstituted 1 avenously every 24 hours						

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 580	"8/06/2023 nurse's pr "Ceftriaxone Sodium GM. Use 1 gram intri for UTI for 5 Days. u per pharmacy." Furth progress notes failed the physician that the and not administered On 08/14/2023 at apr interview was conduct practical nurse) #6, u to describe the proce ordered medication is administration LPN # administering the me pharmacy, the physic or responsible party a that the medication is if and where it should physician was notified would be responsible nursing progress note nursing progress note stated above LPN #6 physician was notified available for administ no documentation no On 08/14/2023 at apr (administrative staff in and ASM #4, regiona aware of the above fi	ogress note documented, Solution Reconstituted 1 avenously every 24 hours navailable. on next delivery her review of the nurse's to evidence notification to medication was unavailable for the dates listed above. Proximately 11:40 a.m., an eted with LPN (licensed nit manager. When asked dure when a physician s not available for stated that the nurse dication would call the ian and the resident's family as soon as the nurse knows not available. When asked be documented that the de he stated that the nurse for documenting in the es. After reviewing the es and eMAR for the dates was asked if R63's de that the antibiotic was not ration. He stated there was tifying the physician.	F	580			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP C 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	ODE	1 001	10/2020
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F 580	different parts of the bobtained from the we Route) Description ar Clinic. 3. For Resident #86 (to notify the physiciar levothyroxine sodium administration on 8/5/4 A review of R86's clin physician's order data sodium 175 mcg (midday for hypothyroidist A review of R86's Augadministration record order for levothyroxin 8/6/23, the MAR documented, "Med or nurses' notes dated 8 documented, "Med or nurses' notes and the reveal documentation was administered to be and failed to reveal dophysician was notified On 8/11/23 at 8:23 a. conducted with LPN (LPN #1 stated that if for administration, the backup medication so not there then she castated it is important to "You don't want them scheduled dosage."	erial infections in many pody. This information was besite: Ceftriaxone (Injection and Brand Names - Mayo R86), the facility staff failed a when the medication (1) was not available for '23 and 8/6/23. ical record revealed a ged 4/1/23 for levothyroxine programs)- one tablet once a m. gust 2023 MAR (medication or prevealed the physician's ge sodium. On 8/5/23 and gumented the code, "5=Hold." B/5/23 and 8/6/23 or order." Further review of a August 2023 MAR failed to a that levothyroxine sodium R86 on 8/5/23 and 8/6/23, pocumentation that R86's december of the code of the cod	F	580			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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F 580	list revealed levothyr stocked in the supply	ty backup medication supply roxine sodium was not	F 5	80			
	staff member) #1 (th (the regional risk cor the above concern.	e administrator) and ASM #4 nsultant) were made aware of ed, "Unavailable Medication"					
	documented, "2. In to ordered for a resider	he event that a medication nt is noted to be unavailable is to be dispensed, nursing he physician of the					
	(condition where the produce enough thy information was obtained to be a conditional to the conditional to t	s used to treat hypothyroidism thyroid gland does not roid hormone)." This ained from the website: gov/druginfo/meds/a682461.h					
	failed to notify the ph medications lisinopri	5 (R115), the facility staff nysician when the I (1), allopurinol (2) and ot available for administration					
	following physician's 4/1/23-lisinopril 40 m high blood pressure 4/1/23-allopurinol 30	ng (milligrams) once a day for 0 mg once a day for gout ng (milligrams) every eight					
	A review of R115's M	IAR (medication					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION IG		OATE SURVEY OMPLETED
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	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	I	06/16/2023
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F 580	physician orders for diltiazem. On 7/9/23 MAR documented the notes dated 7/9/23 owere on order. Furth and the July 2023 M documentation that the lisinopril, allopurinol administered to R11 reveal documentation notified. On 8/11/23 at 8:23 aconducted with LPN LPN #1 stated that if for administration, the backup medication so not there then she castated it is important "You don't want them scheduled dosage. physicians] to know A review of the facilitist revealed lisinopri were not stocked in the control of the physicians of the facilitist revealed lisinopri were not stocked in the control of the physicians of the facilitist revealed lisinopri were not stocked in the facilitist revealed l	d) for July 2023 revealed the lisinopril, allopurinol and of for the morning doses, the le code, "5=Hold." Nurses' locumented the medications her review of nurses' notes AR failed to reveal the morning doses of and diltiazem were 5 on 7/9/23 and failed to in that R115's physician was clicensed practical nurse) #1. If a medication is not available then she goes to the facility supply and if the medication is alls the doctor. LPN #1 to call the doctor because, in [the residents] to miss a You want them [the so they can make a change."	F 5	80		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER BURY REHABILITATION	N AND HEALTHCARE CENTER		STREET ADDRESS, 1776 CAMBRIDGE RICHMOND, VA		1 00.	10,2020	
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F 580	Continued From pa	ge 21	F:	580				
	information was obth https://medlineplus.tml. (3) Diltiazem is use This information was https://medlineplus.tml. 5. For Resident #36 failed to notify the pordered on 8/3/23 wuntil 8/4/23. A review of R360's nurse practitioner's that documented, "A Nausea and vomitin diarrhea. Regular benign. Ordered Zonausea and vomitin mouth every) 6 hou vomiting x3d (times BMP (basic metabodehydration given pfluid intake, we can necessary, ordered hours. Discussed we R360's clinical recoorder dated 8/3/23 (complete blood covomiting. A nurse's note date out to draw stat CB obtain specimen, state out to draw stat CB obtain specimen, state out to draw stat CB obtain specimen, state out ordered labs to draw	dained from the website: gov/druginfo/meds/a682673.h d to treat high blood pressure. as obtained from the website: gov/druginfo/meds/a684027.h 60 (R360), the facility staff obysician that STAT labs were not able to be obtained clinical record revealed a note dated 8/3/23 at 8:47 a.m. Assessment and Plan: 1. In g without abdominal pain or owel movements. No chills or e stable, abdominal exam is offran (medication used to treat ag) 4 milligrams POQ (by are PRN (as needed) nausea at three days), ordered stated three days), ordered stated in the companient of the						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		I ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495272	B. WING				C 16/2023
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER		1776 CAM	DDRESS, CITY, STATE, ZIP CODE IBRIDGE DRIVE ND, VA 23238	,	
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F 580	back out today to atte be drawn in AM with of the BMP and CBC were collected on 8/4 review of R360's clini documentation that F on 8/3/23 and made would not be obtaine On 8/10/23 at 10:51 a conducted with LPN #11. LPN #11 stated outside company corlabs. LPN #11 stated comes from the comp for Sundays. LPN #1 do not routinely draw could if someone who available and presenstated that on 8/3/23, R360 so she called the someone came out, slabs, and asked LPN let them know. LPN company, then they dat the facility and said day. LPN #11 could or nurse practitioner made aware the STA until 8/4/23. On 8/11/23 at 8:23 a conducted with LPN labs should be obtain ordered and if the lab nurses should call the orders are not being	empt the blood draw, lab to routine lab orders." A review lab results revealed the labs 1/23 at 2:00 p.m. Further ical record failed to reveal 2/360's physician was notified aware that the STAT labs d until 8/4/23. a.m., an interview was (licensed practical nurse) phlebotomists from an me to the facility to obtain d she believed someone cany daily every day except 11 stated nurses at the facility blood but she guessed they be knew how to do it was to in the facility. LPN #11 a state labs were ordered for the outside company, said she couldn't obtain the #11 to call the company and #11 stated she called the called back to someone else d no one could come out that not recall that the physician was notified on 8/3/23 and T labs could not be obtained	F:	580			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
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	ROVIDER OR SUPPLIER	N AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	, 33.10.2020	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION	
F 580	staff member) #1 (the regional risk of the above concern. The facility policy tit Condition or Status will notify the reside physician on call will need to alter the resignificantly" References: (1) "A basic metabor measures eight diffiblood. It provides in your body's chemic Metabolism is the product of the body's most imposed in the body	a.m., ASM (administrative the administrator) and ASM #4 consultant) were made aware of titled, "Change in a Resident's to documented, "1. The nurse ent's attending physician or hen there has been a(an) e. sident's medical treatment to blic panel (BMP) is a test that ferent substances in your mportant information about cal balance and metabolism. Process of how the body uses a BMP includes tests for the a type of sugar and your er of energy. Calcium, one of portant minerals. Calcium is r functioning of your nerves, as Sodium, potassium, carbon de. These are electrolytes, it minerals that help control the did the balance of acids and	F 580			
	website: https://medlineplus panel-bmp/. (2) "Your blood cor white blood cells (V	.gov/lab-tests/basic-metabolic- ntains red blood cells (RBC), VBC), and platelets. Blood measure the number and types				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED C			
		495272	B. WING		08/16/2023
	ROVIDER OR SUPPLIER	N AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	, 33.10.2020
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE COMPLETION
F 580	obtained from the white hittps://medlineplus 6. For Resident #99 to notify the physicial Xtampza (1) was notify the physician for the physician's order of the physician's order of the physician's order for the physician's order for the physician's order for the physician's note of the physician for	d." This information was vebsite: .gov/bloodcounttests.html. (R95), the facility staff failed an when the medication of available for administration 23. Ilinical record revealed a ated 6/24/22 for Xtampza 18 ated 6/24/22 for Xtampza 18 ated aday for pain. MAR (medication rd) for June 2023 revealed the for Xtampza. For the evening the doses on 6/2/23 through ning dose on 6/5/23, the MAR de, "5=Hold." and 6/1/23 documented the ister the medication upon armacy. A nurse's note dated the medication was on order.	F 580	,	
	medication upon ar Further review of n 2023 MAR failed to doses of Xtampza v 6/1/23 through 6/5/ documentation that 6/1/23 through 6/4/ On 8/11/23 at 8:23 conducted with LPI LPN #1 stated that for administration, the	rival from the pharmacy. urses' notes and the June reveal documentation that the were administered to R95 23 and failed to reveal R95's physician was notified 23. a.m., an interview was N (licensed practical nurse) #1. if a medication is not available then she goes to the facility supply and if the medication is			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		DNSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		495272	B. WING _			1	C 16/2023
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER		1776	EET ADDRESS, CITY, STATE, ZIP CODE CAMBRIDGE DRIVE HMOND, VA 23238	1 00/	10/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 580	stated it is important "You don't want them scheduled dosage." physicians] to know s A review of the facilit list revealed Xtampz On 8/14/23 at 4:06 p staff member) #1 (the (the regional risk condirector of nursing) w above concern. Reference: (1) Xtampza is used information was obta https://medlineplus.g tml. 7. For Resident #358 notify the physician w oxycodone (1) was n administration on 6/2 A review of R358's c physician's order dat oral solution five mg (milliliters)- five ml or A review of R358's N administration record physician's order for 6/24/23, the MAR do "5=Hold."	alls the doctor. LPN #1 to call the doctor because, in [the residents] to miss a You want them [the so they can make a change." y backup medication supply a not stocked in the supply. i.m., ASM (administrative a administrator), ASM #4 isultant) and ASM #7 (the ivere made aware of the to treat pain. This ined from the website: ov/druginfo/meds/a682132.h it inical record revealed a and 3/21/23 for oxycodone (milligrams)/ five ml ince a day for pain. IAR (medication it) for June 2023 revealed the oxycodone oral solution. On	F	580			

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	PLE CONSTRUCTION G	, ,	E SURVEY IPLETED
		495272	B. WING		08	C 3/ 16/2023
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER	1	STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	08 EET ADDRESS, CITY, STATE, ZIP CODE CAMBRIDGE DRIVE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	ULD BE	(X5) COMPLETION DATE
F 580	failed to reveal docu was administered to to revealed documer was notified. On 8/11/23 at 8:23 at conducted with LPN LPN #1 stated that if for administration, the backup medication is not there then she constated it is important "You don't want then scheduled dosage. physicians] to know A review of the facilitalist revealed oxycode stocked in the supply On 8/14/23 at 4:06 per staff member) #1 (the regional risk condirector of nursing) vabove concern.	tes and the June 2023 MAR mentation that the oxycodone R358 on 6/24/23 and failed ntation that R358's physician I.m., an interview was (licensed practical nurse) #1. a medication is not available en she goes to the facility supply and if the medication is alls the doctor. LPN #1 to call the doctor because, in [the residents] to miss a You want them [the so they can make a change." It by backup medication supply one oral solution was not	F 58	30		
F 584 SS=D	information was obta https://medlineplus.g tml. Safe/Clean/Comforta CFR(s): 483.10(i)(1) §483.10(i) Safe Envi The resident has a ri	ronment.	F 58	34		9/26/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		495272	B. WING		C 08/16/2023
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	00/10/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 584	homelike environment use his or her person possible. (i) This includes ensureceive care and serve physical layout of the independence and do (ii) The facility shall ethe protection of the roor theft. §483.10(i)(2) Housek services necessary to and comfortable interested in good condition; §483.10(i)(4) Private resident room, as specific processing to the protection of the roor theft.	eiving treatment and and safely. ride- clean, comfortable, and and all belongings to the extent aring that the resident can vices safely and that the facility maximizes resident ones not pose a safety risk. exercise reasonable care for resident's property from loss are eeping and maintenance of maintain a sanitary, orderly, ior; red and bath linens that are	F 584		
	levels. Facilities initia	table and safe temperature lly certified after October 1, a temperature range of 71 to			
	sound levels. This REQUIREMENT by:	maintenance of comfortable is not met as evidenced ns, staff interview, clinical		F584 Safe/Clean/Comfortable/Homeli	ke

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		I` '		3) DATE SURVEY COMPLETED	
						'	С	
		495272	B. WING _			08/	/16/2023	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
CANTEDE	LIDV DEHARII ITATION A	AND HEALTHCARE CENTER		1	776 CAMBRIDGE DRIVE			
CANTERD	OKT KENABILITATION	AND HEALTHCARE CENTER		R	RICHMOND, VA 23238			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 584	Continued From page	e 28	F 5	584				
	record review and fac	cility document review, it was			Environment			
	determined the facility	y staff failed to provide a						
	safe and homelike en	vironment for one of 57			SS=D			
	residents, Resident#							
	bathrooms on the We	estham Unit.			1) Resident #129□s room hand sanitiz	er		
					wall mount, dry wall, missing flooring,			
	The findings include:				peeled wallpaper, and cove base and			
	4				missing tiles were repaired in resident			
		led to maintain a clean and			room area.			
homelike environment for Resident #129. During the initial resident screening on 8/7/23 at 2:59					The bathroom between rooms 222 and	J		
		om revealed a wall mounted			223 on the Westham Unit was cleaned	-		
		ser partially torn off the wall			include toilet, under toilet and toilet sea			
		of the resident's sink, a			include tollet, dilder tollet and tollet sea	11.		
		lry wall containing a hole			2) Current residents who reside at			
	_	hes below and to the left of			Canterbury Rehabilitation and Healthc	are		
	the resident's sink, m				have the potential to be affected by this			
	doorway between the	-			practice. Walking rounds were made b			
	bathroom, approxima	tely 12 inches of cove base			the Administrator/Designee of resident			
	torn off the wall with a	additional tearing of the dry			rooms and bathrooms to validate clear	l		
	wall between the hea	d of the residents beds and			and homelike environment for the			
	an approximate 12 in	ch piece of cove base falling			residents with no further variances in			
	off the wall to the left	side the HVAC unit at the far			cleanliness, mounted hand sanitizers,			
	side of the room.				missing dry wall, missing flooring, peel			
					wallpaper, and cove base and missing			
		dmitted to the facility on			tiles noted.			
	_	es that included but are not			0.7. 0.65			
	limited to: dementia	and metabolic			3) The Staff Development			
	encephalopathy.				Coordinator/Designee will provide			
	Booldont #120's mas	t recent MDS (minimum			re-education to facility staff on a Clean and Homelike Environment and			
	data set) assessment	t recent MDS (minimum			notification of maintenance and			
	,	assessment reference date			housekeeping staff of issues with			
		esident as scoring 04 out of			cleanliness or environment such as bu	t		
		interview for mental status)			not limited to mounted hand sanitizers.			
	,	resident was severely			missing dry wall, missing flooring, peel			
		MDS Section G- Functional			wallpaper, and cove base and missing			
		ident with walking and			tiles.			
	locomotion requiring							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED					
		495272	B. WING _			1	C 16/2023
NAME OF PROV	IDER OR SUPPLIER			ST	FREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	10/2020
	.,			17	776 CAMBRIDGE DRIVE		
CANTERBUR	Y REHABILITATION	AND HEALTHCARE CENTER		RI	ICHMOND, VA 23238		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
A 6/2 fall en sp im ad Or co #2 brodo as C1 Or co m: #1 wa re: sa is en it i Or me re; nu m: Ac po co	20/23, revealed, "is. INTERVENTIC prironment; floors ills, adequate light paired vision. Malequate lighting." 10 8/8/23 at 3:30 Planducted with CNA to when shown Report way between resident if this was a contract with the contract of the	prehensive care plan dated FOCUS: Resident is at risk for DNS: Create a safe clear of clutter, clean up ting. Resident has poor/ the sure that room has M, an interview was a (certified nursing assistant) the esident #129's room with led wallpaper and no tiles in the esident room/ bathroom and the environment, this is not clean or homelike. MM, an interview was and (other staff member) #3, the war. When shown Resident token dry wall, peeled the esin doorway between the esident, OSM #3 stated, no, it if this is a homelike the esident, OSM #3 stated, no the esident, OSM #3 stated, no the esident, OSM #4, the esident was th	F	584	4) The Director of Maintenance and Director of Housekeeping and/or Designee will conduct a bi-weekly rounding of the facility to include reside rooms and bathrooms for cleanliness a environment to include but not limited to securely mounted hand sanitizers, missing dry wall, missing flooring, peel wallpaper, and cove base and missing tiles. Variances will be addressed. The audits will be conducted weekly x 4 weeks, then monthly x 2 months. The findings of the audits will be submitted the Administrator/Designee to the QAF Committee for review and recommendation monthly for 3 months ongoing until compliance sustained.	and o ed se by	

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION IG		DATE SURVEY COMPLETED
		495272	B. WING _			C 08/16/2023
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238		00/10/2023
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR ((EACH CORRECTIVE ACTION SHORE) CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 584	the characteristics of personalized, homely characteristics include environment and plet. No further information 2. The facility staff fabathroom in the bath and 223 on the West on 8/7/23 at 12:50 possible of the bathroom between the toilet was full to liquid and feces. On 8/7/23 at 4:15 possible of the bathroom was some covering approximated on the state of dark brown flecks bottom of the bowl. On 8/8/23 at 7:58 a. in this bathroom, the smeared on it. The two follows of the bowl. On 8/8/23 at 10:30 and an urse of the state of the bathroom of the bathroom was some stated it lies between the bathroom of the bathroom was some debries of the stated: "Debris of leaves more debries stated every staff methe room should be bathroom, especially residents. He added the stated of th	ize, to the extent possible, f the facility that reflect a like setting. These de clean, sanitary and orderly easant, neutral scents." on was provided prior to exit. alled to provide a clean broom between rooms 222	F 5	84		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONST		(X3) DATE COMF	SURVEY PLETED
		495272	B. WING _				C 1 16/2023
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER		1776 CA	ADDRESS, CITY, STATE, ZIP CODE MBRIDGE DRIVE DND, VA 23238	1 00/	10/2023
(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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 622 SS=E	used, both LPN #6 an not. On 8/14/23 at 4:01 p. staff member) #1, the regional risk consultated consultant, and ASM were informed of these No further information Transfer and Dischart CFR(s): 483.15(c)(1) §483.15(c) Transfer at §483.15(c)(1) Facility (i) The facility must premain in the facility, discharge the resident (A) The transfer or diresident's welfare and cannot be met in the (B) The transfer or dibecause the resident sufficiently so the resident sufficiently so the resident sufficiently so the resident sufficiently so the resident (C) The safety of indirendangered due to the status of the resident (D) The health of indiotherwise be endang (E) The resident has	melike condition for resident and OSM #15 stated it was m., ASM (administrative administrator, ASM #4, the ant, ASM #8, the regional #7, the director of nursing, se concerns. In was provided prior to exit. ge Requirements (i)(ii)(2)(i)-(iii) and discharge-requirements-ermit each resident to and not transfer or at from the facility unless-scharge is necessary for the did the resident's needs facility; scharge is appropriate the facility; widuals in the facility is ne clinical or behavioral control in the facility would		584	DEFICIENCY)		9/26/23
	Nonpayment applies submit the necessary payment or after the	edicaid) a stay at the facility. if the resident does not r paperwork for third party third party, including d, denies the claim and the					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495272	B. WING		1	C 16/2023
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	1 00/	10/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 622	Continued From pag	e 32	F 62	22		
	resident refuses to president who become admission to a facility resident only allowals or (F) The facility cease (ii) The facility may president while the ap § 431.230 of this charge notice from 431.220(a)(3) of this discharge or transfer or safety of the residischarge or transfer or safety of the facility may that failure to transfer §483.15(c)(2) Docum When the facility transfer under any or in paragraphs (c)(1)(section, the facility mor discharge is documedical record and a communicated to the institution or provider (i) Documentation in must include: (A) The basis for the (i) of this section. (B) In the case of pasection, the specific be met, facility atternateds, and the servifacility to meet the net (ii) The documentation (2)(i) of this section resident with the section of the section o	ay for his or her stay. For a se eligible for Medicaid after y, the facility may charge a ole charges under Medicaid; es to operate. Ot transfer or discharge the peal is pending, pursuant to apter, when a resident right to appeal a transfer or in the facility pursuant to § chapter, unless the failure to awould endanger the health ent or other individuals in the nust document the danger or or discharge would pose. The circumstances specified in the circumstances specified in the resident's appropriate information is a receiving health care of the resident's medical record transfer per paragraph (c)(1) aragraph (c)(1)(i)(A) of this resident need(s) that cannot pts to meet the resident ce available at the receiving seed(s). On required by paragraph (c)				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG	, ,	ATE SURVEY OMPLETED
		495272	B. WING _			C 08/16/2023
	AME OF PROVIDER OR SUPPLIER CANTERBURY REHABILITATION AND HEALTHCARE CENTER (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 622 Continued From page 33 discharge is necessary under paragraph (c) (1) (A) or (B) 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 (C) Advance Directive information (D) All special instructions or precautions for		•	<u> </u>		
PRÉFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A	SHOULD BE	(X5) COMPLETION DATE
F 622	discharge is necessa (A) or (B) of this sec (B) A physician when necessary under parthis section. (iii) Information provimust include a minin (A) Contact informat responsible for the c	ary under paragraph (c) (1) tion; and a transfer or discharge is ragraph (c)(1)(i)(C) or (D) of ded to the receiving provider num of the following: ion of the practitioner are of the resident.	F6	522		
	contact information (C) Advance Directiv (D) All special instruction ongoing care, as app (E) Comprehensive (F) All other necess copy of the resident' consistent with §483 any other documents a safe and effective This REQUIREMEN by:	re information ctions or precautions for propriate. care plan goals; ary information, including a s discharge summary, .21(c)(2) as applicable, and ation, as applicable, to ensure transition of care. T is not met as evidenced				
	Based on staff inter and clinical record re facility staff failed to facility, the required	view, facility document review eview, it was determined the provide, to the receiving documents for four of 57 ey sample, Resident #155,		F622 Transfer and Dischar Requirements SS=E Resident #155 was discharged facility on 5/14/23.	-	
	send the comprehen resident upon transfe 5/14/2023.			Resident #508 was discharged facility on 3/27/23.	d from the	
	documented, "At 053	ed 5/14/2023 at 7:26 a.m. 30 (5:30 a.m.) patient was to verbal stimuli and sternum		Resident #3 Care plan is sent with resident when transferred		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION		ATE SURVEY MPLETED
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	ROVIDER OR SUPPLIER URY REHABILITATION	N AND HEALTHCARE CENTER		177	REET ADDRESS, CITY, STATE, ZIP CODE 76 CAMBRIDGE DRIVE CHMOND, VA 23238	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 622	Continued From page	ge 34	F	522			
	called and transport Hospital location und Hospital location und The "Acute Care Tradated 5/14/2023, farelated to the care point with the resident. An interview was concepted and the compactical nurse) #4 When asked what does not usually send the where she document with the resident usually send the where she document with the resident, LF in the nurse's note obackground, assess The facility-Initiated," do "Information Convey 1. Should a resident for any reason, the communicated to the care point and transport to the care point and transport to the care point and transport to the care point and the care po	ancy medical services] was ted out of facility via stretcher. Iknown at time of departure" ansfer Document Checklist" illed to evidence any notation plan being sent to the hospital onducted with LPN (licensed on 8/9/2023 at 12:33 a.m. documents are sent with the fer to the hospital, LPN #4 e medication administration et, DNR form, bed hold policy, and a copy of her last nurse's asked if she sends the care nt, LPN # 4 stated, she does e care plan. When asked hts what documents are sent PN # 4 stated she documents or on the SBAR (situation, sment, and response) forms. Transfer or Discharge, bournented in part, yed to Receiving Provider to be transferred or discharged following information is the receiving facility or provider: transfer or discharge.			Resident #106 was discharged from the facility on 8/21/23. LPN #4 was re-educated by the Staff Development Coordinator/Designee of the Transfer Discharge requirements include sending the receiving facility acopy of the comprehensive care plan. Current residents who are transferred from the facility to another receiving Healthcare facility have the risk of bein affected by this practice. An audit was conducted of residents that were transferred from the facility in the last days by Unit Manager/Designee to validate the comprehensive care plan included in the transfer/discharge pact with no further variance from policy not be staff Development Coordinator/Designer to include sending the receiving facility facility.	on to a ng s 7 was ket oted.	
	(1) If the resident is discharged because met at the facility, documentatia) the specific residb) this facility's atter	being transferred or e his or her needs cannot be ion will include: ent needs that cannot be met. mpt to meet those needs; and lity's service(s) that are			copy of the comprehensive care plan. The Director of Nurse/Designee will complete a review of 3 resident transf to the hospital per week to validate th appropriate documentation to include	ers	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			` '	PLE CONSTRUCTION G	1, ,	(X3) DATE SURVEY COMPLETED	
		495272	B. WING			C	
NAME OF P	ROVIDER OR SUPPLIER	433272		STREET ADDRESS, CITY, STATE, ZIP CO		8/16/2023	
TO THE OT THE	NOVIDER ON OUR FEIER			1776 CAMBRIDGE DRIVE	,52		
CANTERE	SURY REHABILITATION	AND HEALTHCARE CENTER		RICHMOND, VA 23238			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 622	Continued From pag	je 35	F 6	22			
	b. Contact information responsible for the contact information. c. Resident represer contact information. d. Advance directive e. All special instruction ongoing care, as apple (1) treatments and diversity (2) transmission-base contact, droplet, or a (3) special risks such bleeding, or pressure (4) aspiration precaution f. Comprehensive cargonal and the comprehensive cargonal composition of the composition of	on of the practitioner pare of the resident. Intative information including Information. Itions or precautions for propriate such as: evices (oxygen, implants, interpretate as: evices (oxygen, implants, interpretation, as: evices (oxygen, implants, interpretation, as: evices (oxygen, implants, interpretation), implants, implants, interpretate as: evices (oxygen, implants, interpretation, as: evices (oxygen, implants, interpretation, as: evices (oxygen, implants, interpretation, interpretation, as: evices (oxygen, implants, interpretation, interpretation, as: evices (oxygen, implants, interpretation, interpretation, as: evices (oxygen, implants, interpretation, interpretation, interpretation, interpretation, as: evices (oxygen, implants, interpretation, implants, interpretation, interpretat		comprehensive care plan was the resident. Variances will be These audits will be conduct weeks, then monthly x 2 mo findings of the audits will be the DON/Designee to the Qound Committee for review and recommendation monthly for ongoing until compliance sur	oe addressed. ted weekly x 4 nths. The submitted by API r 3 months or		
	send the compreher	8, the facility staff failed to asive care plan with the error to the hospital on 3/27/23.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495272	B. WING _				C 16/2023		
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP C 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	ODE	1 00/	10/2020		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			(X5) COMPLETION DATE		
F 622	Continued From pag	e 36	F	622					
		ce of required clinical the resident to the hospital							
	AM, revealed, "At 2 of chest painOrdere E.R. [emergency roo	ng note dated 3/27/23 at 3:38 2:40am Resident complained ed Resident to be sent to m]. RP [responsible party] at to hospital. Transported via							
	PM, with LPN (licens When asked what do resident upon transfe (licensed practical numedication administr DNR (do not resuscit list of MD (physician) last nurse's note. LPI the care plan with the she does not usually asked where she doc sent with the resident documents in the nur (situation, backgroun response) forms.	se's note or on the SBAR							
	member) #1, the adn regional risk consulta director of case mana clinical care consulta	ninistrator, ASM #4, the ant, ASM #5, the regional agement, ASM #6, the nt, ASM #7, the director of the regional consultant was							
		y's "Transfer-Discharge" ormation Conveyed to							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495272	B. WING		C 08/16/2023		
	ROVIDER OR SUPPLIER BURY REHABILITATION	N AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238			
(X4) ID PREFIX TAG	(EACH DEFICIE!	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION		
F 622	transferred or disch following information receiving facility or a. The basis for the (1) If the resident is discharged because met at the facility, documentat a) the specific reside b) this facility's atte c) the receiving fact available to meet the b. Contact informat responsible for the c. Resident represe contact information d. Advance directive. All special instruction ongoing care, as as (1) treatments and IVs, tubes/catheters (2) transmission-bact contact, droplet, or (3) special risks such bleeding, or pressuch aspiration precated. Comprehensive of an edition of the comprehensive of the co	Should a resident be larged for any reason, the provider: In transfer or discharge; In being transferred or It has been been been been been been been bee	F 62:				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495272	B. WING _			08/1) 16/2023
NAME OF PI	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP C	ODE	1 00/	10/2020
CANTERE	SURY REHABILITATION	AND HEALTHCARE CENTER		1776 CAMBRIDGE DRIVE RICHMOND, VA 23238			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BI HE APPROPRIA		(X5) COMPLETION DATE
F 622	Continued From page	e 38	F 6	622			
	, ` , •	entation, as applicable, to ective transition of care.					
	No further information	n was provided prior to exit.					
		ne facility staff failed to send are plan with the resident ospital on 7/21/23.					
	There was no evidendocuments sent with on 7/21/23.	ce of required clinical the resident to the hospital					
	7/21/23 at 7:36 PM, r staring and not respo postictal. She returne blood sugar and pt w	She was transferred to the					
	PM, with LPN (licensed When asked what do resident upon transfe (licensed practical numedication administration DNR (do not resuscit list of MD (physician) last nurse's note. LPN the care plan with the she does not usually asked where she does sent with the resident	rse) #4 stated she sends the ation record, transfer sheet, ate) form, bed hold policy, orders and a copy of her N # 4 was asked if she sends a resident, LPN # 4 stated, send the care plan. When suments what documents are to LPN # 4 stated she se's note or on the SBAR					
	On 8/14/23 at 4:00 Pl	M, ASM (administrative staff					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		495272	B. WING _			C 08/16/2023	
	ROVIDER OR SUPPLIER	N AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	•	00/10/2020	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOU		(X5) COMPLETION DATE	
F 622	622 Continued From page 39		F 6	22			
	member) #1, the ac	dministrator, ASM #4, the ltant, ASM #7, the director of 8, the regional consultant was					
	No further informat	ion was provided prior to exit.					
	send the comprehe	06, the facility staff failed to ensive care plan with the sfer 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.						
	6/29/23 at 9:43 PM to ED (emergency was called by daug having crying spells her back, legs and	sing progress note dated , revealed, "Resident was sent department) by daughter. 911 hter because resident was s, and complained of pain in sacrum. Ambulance arrived in ansported resident via					
	PM, with LPN (licer When asked what or resident upon trans (licensed practical medication administ DNR (do not resust list of MD (physicial last nurse's note. Let the care plan with the she does not usual asked where she documents in the notation of the she documents in the notation of the she with the resided documents in the notation of the she with the resided documents in the notation of the she with the resided documents in the notation of the she with the resided documents in the notation of the she with the she with the resided documents in the notation of the she with the she	onducted on 8/9/23 at 12:33 ased practical nurse) #4. documents are sent with the after to the hospital, LPN anurse) #4 stated she sends the attration record, transfer sheet, actitate) form, bed hold policy, an) orders and a copy of her PN # 4 was asked if she sends and the care plan. When accuments what documents are and, LPN # 4 stated she are urse's note or on the SBAR and, assessment and					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE	SURVEY PLETED
		495272	B. WING			C / 16/2023
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	1 00/	10/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 641 SS=D	member) #1, the adm regional risk consulta nursing and ASM #8, made aware of the fir No further information Accuracy of Assessm CFR(s): 483.20(g) §483.20(g) Accuracy The assessment must resident's status. This REQUIREMENT by: Based on observation record review, the fact an accurate MDS (mit assessment for one consumple, Resident #86 (R8 accurately code their external urinary cathewith an ARD (assess 7/17/23. On 8/7/23 at 12:37 p. 8/9/23 at 4:18 p.m., at R86 was observed ly urinary catheter drain A review of R86's climitation.	M, ASM (administrative staff ninistrator, ASM #4, the nt, ASM #7, the director of the regional consultant was nidings. In was provided prior to exit. It accurately reflect the is not met as evidenced in, staff interview and clinical cility staff failed to maintain nimum data set) of 57 residents in the survey Sc.	F 642		clude eter. d to ary	9/26/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495272	B. WING				C 16/2023
NAME OF PE	ROVIDER OR SUPPLIER	1002.12	 		REET ADDRESS, CITY, STATE, ZIP CODE	1 00/	16/2023
	10 715 21 1 01 1 001 1 212 1				76 CAMBRIDGE DRIVE		
CANTERB	URY REHABILITATION A	AND HEALTHCARE CENTER			CHMOND, VA 23238		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 641	Continued From page	÷ 41	F 6	641			
	A review of section H appliances of R86's of 7/17/23, revealed thaving an indwelling coded as having an ereview of section H10 appliances of the mod ARD of 7/17/23 reveal coded as having any On 8/10/23 at 1:57 p.	100- bladder and bowel uarterly MDS with an ARD he resident was coded as urinary catheter and not xternal urinary catheter. A 0-bladder and bowel dified quarterly MDS with an alled the resident was not urinary catheter. m., an interview was			Current Residents who reside at Canterbury Rehabilitation and Healthca 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.	s d	
	MDS coordinator). R urinary catheter shou catheter on the MDS	nt) manual when			The Regional MDS Clinical Consultant/Designee provided re-education to the licensed nurses tha complete the MDS on coding accuracy include external urinary catheters.		
	LPN #6 stated R86 had catheter for at least at The CMS RAI manual catheter as a receptathe labia majora for feddrainage bag. On 8/11/23 at 9:57 austaff member) #1 (the	licensed practical nurse) #6. as had the external urinary			An audit will be completed of 3 residen quarterly MDS weekly to validate cod accuracy of appliances to include exter catheters. Variances will be addressed These audits will be conducted weekly weeks, then monthly x 2 months. The findings of the audits will be submitted the Administrator/Designee to the QAP Committee for review and recommendation monthly for 3 months ongoing until compliance sustained.	ing rnal x 4 by	
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-	-(3)	F 6	355			9/26/23
	§483.21 Comprehens	sive Person-Centered Care					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED			
		495272	B. WING _			C 08/16/2023
	ROVIDER OR SUPPLIER BURY REHABILITATION	AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238		00/10/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 655	Planning §483.21(a) Baseline §483.21(a)(1) The fa implement a baseline that includes the insteffective and personthat meet profession. The baseline care pla (i) Be developed with admission. (ii) Include the minim necessary to properly including, but not lim (A) Initial goals base (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recomn §483.21(a)(2) The facomprehensive care care plan if the comp (i) Is developed with admission. (ii) Meets the require (b) of this section (exthis section). §483.21(a)(3) The faresident and their report the baseline care plimited to: (i) The initial goals of (ii) A summary of the dietary instructions. (iii) Any services and	Care Plans cility must develop and e care plan for each resident ructions needed to provide -centered care of the resident al standards of quality care. an must- nin 48 hours of a resident's num healthcare information y care for a resident ited to- d on admission orders. cility may develop a plan in place of the baseline orehensive care plan- in 48 hours of the resident's ments set forth in paragraph accepting paragraph (b)(2)(i) of accility must provide the oresentative with a summary plan that includes but is not of the resident. e resident's medications and	F			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495272	B. WING		C 08/16/2023	
NAME OF PI	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE	00/10/2023	
				1776 CAMBRIDGE DRIVE		
CANTERE	URY REHABILITATION	AND HEALTHCARE CENTER		RICHMOND, VA 23238		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION	
F 655	Continued From pag	e 43	F 65	5		
	of the comprehensiv This REQUIREMEN by:	rmation based on the details e care plan, as necessary. T is not met as evidenced				
	Based on staff internand facility document that the facility staff fimplement the baseling residents in the survey. The findings include: 1. For Resident #160 failed to A) implement non-pharmacological administration of as implement the care perfects of anticoagula care plan for diabeted. R160 was admitted the with diagnoses that in the staff of the s	O (R160), the facility staff nt the care plan to provide I interventions prior to needed pain medications, B) plan to monitor for adverse ant use and C) develop a s and the use of insulin. To the facility on 7/27/2023 ncluded but were not limited Mellitus, major depressive		Resident #160 Care Plan and MAR we updated to include Non-Pharmacologi Interventions prior to the use of unscheduled pain medication administration, Anticoagulant side effermonitoring, and Diabetes and the use insulin. LPN # 6, LPN#7 were re-educated by Staff Development Coordinator / Designee on Development of the Base line Care Plan to include but not limite updating the resident splan to reflect implementing non-pharmacological interventions prior to the use of unscheduled pain medication	cal ect of the ed d to	
	7/27/2023 the reside alert and oriented to assessment docume able to report pain, h with preferred pain repain relievers. The progress notes to "8/2/2023 9:37 a.m."	sessment for R160 dated nt was assessed as being person, place and time. The ented R160 being cognitively laving pain less than weekly elief measures of narcotic for R160 documented in part, Initial Navigation Guide lat in approx 2 weeks a plan will be held."		administration, anticoagulant side effer monitoring, and diabetes diagnosis and the use of insulin for resident that required diabetes management. Residents that received unscheduled medication, are on anticoagulant medication and/or have diabetes/receinsulin have the potential to be affecte An audit was conducted by the Unit Manager/Designee of current resident who receive unscheduled pain medication, are on anticoagulants, diabetic and who receive insulin to	d uire pain ive d.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495272	B. WING _			l ns	C 3/16/2023	
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 00	0/10/2023	
	10115211 011 001 1 21211				76 CAMBRIDGE DRIVE			
CANTERB	URY REHABILITATION	AND HEALTHCARE CENTER						
				KI	CHMOND, VA 23238			
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE	
F 655	Continued From pag	e 44	F6	555				
	The baseline care pl part, - "I have pain and/or to) being a dialysis p 07/27/2023." Under in part, "Encourage non-pharmacologica	an for R160 documented in potential for pain r/t (related atient. Date Initiated: "Interventions" it documented a me to try I interventions for pain relief			validate Baseline Care Plans were developed and/or implemented to meet the resident current care need. Varian were addressed as indicated.	ces		
	bathing, heat and co stimulation, ultrasour 07/27/2023" - "I am on anticoagu 07/28/2023." Under in part, " Monitor/re s/sx [signs/symptom complications: blood blood in urine, black red blood in stools, b headaches, nausea, lethargy, blurred visi breath], loss of appe mental status, signifi vital signs. Date Initia nurse PRN signs/sym	llant therapy. Date Initiated: "Interventions" it documented ecord/report PRN [as needed] s] of anticoagulant			Licensed Nursing staff were re-educated by the Staff Development Coordinator Designee on development and/or implementation of the Base line Care to meet the resident needs to include not limited to updating the residents to reflect implementing non-pharmacological interventions prict the use of unscheduled pain medication administration, anticoagulant side effermonitoring, and diabetes diagnosis and the use of insulin for resident that requidiabetes management.	/ Plan but plan or to on ct		
	in stool, black tarry siblurred vision, pain, changes in mental side Date Initiated: 07/28 The care plan failed of diabetes or the using The physician orders part, - "Hydrocodone-Ace 10-325 MG (milligram (Hydrocodone-Aceta)	tools, nausea, vomiting, shortness of breath, sudden tatus, weakness, lethargy. /2023." to evidence documentation e of insulin. s for R160 documented in taminophen Oral Tablet			The Unit Manager/Designee will audit residents who receive unscheduled pare 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. Varian 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 the DON/Designee to the QAPI Committee for review and recommendation monthly for 3 months.	et ces by		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495272	B. WING _				C 16/2023
NAME OF PR	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00.	10/2020
CANTEDD	LIDY DELIABILITATION	AND HEALTHCARE CENTER		1	1776 CAMBRIDGE DRIVE		
CANTERD	URT REHABILITATION	AND HEALTHCARE CENTER		F	RICHMOND, VA 23238		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 655	Continued From page	e 45	F	355			
		(). Order Date: 07/27/2023." et 5-325 MG (Oxycodone			ongoing until compliance sustained.		
	w/Acetaminophen) G hours as needed for p 07/28/2023."	ive 1 tablet by mouth every 6 pain. Order Date:					
	- "Apixaban Oral Table tablet by mouth two to (fibrillation). Order Date - "Humalog KwikPen Peninjector 100 UNIT (Insulin Lispro) Inject 199 = 2 UNITS; 200 - 6 UNITS; 300 - 349 = UNITS; 400+ CALL Murther instructions, sand at bedtime related Mellitus with Diabetic (E11.22)." The eMAR (electronic record) for R160 dated documented the Hydrogen Page 12 - 12 - 12 - 13 - 13 - 13 - 13 - 13 -	Subcutaneous Solution T/ML (unit per milliliter) as per sliding scale: if 151 - 249 = 4 UNITS; 250 - 299 = 8 UNITS; 350 - 399 = 10 MD (medical doctor) for ubcutaneously before meals d to Type 2 Diabetes Chronic Kidney Disease c medication administration d 7/1/2023-7/31/2023 rocodone-Acetaminophen					
	level of 8, at 5:24 p.m 9:24 p.m. for a pain le 3:27 a.m. for a pain le pain level of 8, at 4:5 and on 7/31/2023 at 9	/2023 at 1:36 a.m. for a pain n. for a pain level of 7, at level of 7, on 7/30/2023 at level of 8, at 9:45 a.m. for a 8 p.m. for a pain level of 7 9:41 a.m. for a pain level of a level of a level of 2 level of 3 pain level of 3 level of 2 level of 3 lev					
	administered on 7/30 level of 6 and on 7/31 level of 0. The eMAR document to R160 each day as 7/27/2023 at 5:00 p.n. The eMAR document scale insulin administ	documented the Percocet /2023 at 9:09 p.m. for a pain 1/2023 at 5:17 p.m. for a pain ted Apixaban administered ordered beginning on n. ted the Humalog sliding tered as required for blood any beginning on 7/27/2023					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495272	B. WING				C 16/2023
NAME OF PR	ROVIDER OR SUPPLIER			S1	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	10/2023
CANTERB	SURY REHABILITATION	AND HEALTHCARE CENTER		1776 CAMBRIDGE DRIVE RICHMOND, VA 23238			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	I	ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOU TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)			(X5) COMPLETION DATE
F 655	Continued From page	e 46	F	655			
	non-pharmacologic ir to administration of the medication. The eMA documentation of mo adverse effects.	AR failed to evidence nitoring for anticoagulant					
	documented the Hydrodoministered on 8/1/2 level of 3, on 8/4/202 level of 4, on 8/5/202 level of 6, at 5:42 p.m 8/6/2023 at 11:43 a.m a.m. for a pain level of 3. documented the Pero 8/1/2023 at 4:36 p.m. 8/2/2023 at 9:15 a.m. p.m. for a pain level of 5, at 5, on 8/5/2023 at 15, on 8/7/2023 at 11:0 and on 8/8/2023 at 7:3 The eMAR failed to enon-pharmacologic in to administration of the eMAR document to R160 as ordered at The eMAR document scale insulin administration each of the sugar reading each of the sug	for a pain level of 4, on for a pain level of 8, at 4:48 of 4, on 8/3/2023 at 8:00 a.m. at 2:30 p.m. for a pain level 1:00 a.m. for a pain level of 00 a.m. for a pain level of 5, 07 p.m. for a pain level of 5. vidence documentation of atterventions attempted prior					
		vidence documentation of nterventions attempted prior ne as needed pain					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495272	B. WING _				C 16/2023		
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER		177	REET ADDRESS, CITY, STATE, ZIP CODE 76 CAMBRIDGE DRIVE CHMOND, VA 23238	1 001	10/2020		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOUL			(X5) COMPLETION DATE		
F 655	Continued From page	e 47	F	355					
	medication. The eMA documentation of mo adverse effects.	AR failed to evidence nitoring for anticoagulant							
	the as needed pain mabove with the excep p.m. where reposition administration. The p	failed to evidence							
	conducted with LPN of LPN #7 stated that the was to let the staff know the particulars of the the care plan should should be able to go need to know what to familiar with their care anticoagulant monitor and was not sure who was taking an anticoa where there was document the monitor was alert and oriente and requested pain in it. LPN #7 stated than non-pharmacological repositioning prior to that they did this to see	ring was done every shift ere it was documented. LPN eMAR and stated that she agulant but she did not see umentation of monitoring for ere. She stated that a area on the eMAR to ring. She stated that R160 d to person, place and time nedication when they needed to they attempted interventions like the medications. She stated							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		495272	B. WING		,	C 08/16/2023	
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	•	06/16/2023	
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 655	medications. She stattempted each time medication and show medication administration on 8/9/2023 at 12:4' conducted with LPN stated that the staff ranticoagulants for blace documented on the He stated that R160 atrial fibrillation and bleeding although the for it. On 8/9/2023 at 1:20 was conducted with #6 stated that the bat triggered on the admitten nurses went in a needed. He reviewed stated that there should also have a diagnoses. On 8/9/2023 at 1:28 conducted with RN (director. RN #3 stat the baseline care plat the comprehensive of the MDS assessment.	dent having to get pain ated that these were prior to administration of the ald be documented in the ration notes. 7 p.m., an interview was #6, unit manager. LPN #6 monitored residents on	F 6	55			
	She stated that on a	A's (care area assessment). dmission the nurse would care plan based on the					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495272	B. WING _			08/1	; 16/2023
	ROVIDER OR SUPPLIER BURY REHABILITATION	AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238		007	. 67.2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE		(X5) COMPLETION DATE
F 656 SS=E	admission assessment the resident's diagnor nurses on the floor warelated to diabetes a The facility policy "Caperson-Centered" dadocumented in part, person-centered care measurable objective resident's physical, preeds is developed a resident" On 8/9/2023 at 5:40 administrator, ASM #ASM #6, the clinical aware of the concern No further information Develop/Implement (CFR(s): 483.21(b)(1) The faimplement a comprecare plan for each reresident rights set for §483.10(c)(3), that in objectives and timefineds that are identificated assessment. The condescribe the following (i) The services that or maintain the residiphysical, mental, and physical, mental, and present the following the resident physical physical places.	ent, the physician orders and ises. She stated that the would add the care plan and insulin use. are plans, comprehensive ated October 2022 "A comprehensive, e plan that includes es and timetables to meet the esychosocial and functional and implemented for each p.m., ASM #1, the #4, the risk consultant and care consultant were made in. In was provided prior to exit. Comprehensive Care Plan (3) Idensive Care Plans cility must develop and hensive person-centered sident, consistent with the orth at §483.10(c)(2) and includes measurable armes to meet a resident's indicated and psychosocial fied in the comprehensive mprehensive care plan must	F 6				9/26/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495272	B. WING		C 08/16/2023	
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/10/2020	
CANTERR	URY REHABILITATION A	AND HEALTHCARE CENTER		1776 CAMBRIDGE DRIVE		
OANTEND	OKI KENADILHANONA	TEACHIOARE GENTER		RICHMOND, VA 23238		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE	
F 656	Continued From page	e 50	F 650	6		
F 656	(ii) Any services that yunder §483.24, §483. provided due to the reunder §483.10, including treatment under §483. (iii) Any specialized single rehabilitative services provide as a result of recommendations. If findings of the PASAF rationale in the reside (iv) In consultation wit resident's representar (A) The resident's good desired outcomes. (B) The resident's prefuture discharge. Fact whether the resident's community was assessed local contact agencie entities, for this purposition, as appropriate, requirements set forth section. §483.21(b)(3) The see by the facility, as outlicate plan, must-(iii) Be culturally-common this REQUIREMENT by: Based on staff intervand clinical record regardle facility staff failed to othe comprehensive care.	would otherwise be required 25 or §483.40 but are not esident's exercise of rights ding the right to refuse 8.10(c)(6). ervices or specialized the nursing facility will PASARR a facility disagrees with the RR, it must indicate its ent's medical record. In the resident and the tive(s)-als for admission and eference and potential for illities must document as desire to return to the essed and any referrals to a sand/or other appropriate esse. In the comprehensive care in accordance with the in in paragraph (c) of this ervices provided or arranged and by the comprehensive estimated the levelop and/or implement are plan for 19 of 57	F 650	F656 Develop/Implement Comprehensive Care Plan SS=E		
	#144, #106, #358, #8	y sample, Resident #90, 6, #74, #48, #37, #43, #409, 142, #133, #34, #63, and		Resident #90 s Care Plan and MAR vupdated to include monitoring for side effects for the use of anticoagulants.	vere	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	20/4252 02 01/22/452	495272	D. WING _			08/	16/2023	
NAME OF PI	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE			
CANTERB	SURY REHABILITATION	AND HEALTHCARE CENTER		177	76 CAMBRIDGE DRIVE			
O, 22		7.11.2 11.2 11.107.11.2 02.11.2.11		RIC	CHMOND, VA 23238			
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F 656	Continued From pag	e 51	F 6	356				
	The findings include							
	implement the comp monitoring the reside of anticoagulants, Resident #90 had di	the facility staff failed to rehensive care plan for ent for side effects for the use agnoses that included but			Resident #144 s fall mat was placed a bedside as ordered. The podiatry conswas completed on 8/12/23. Urinary Catheter care is documented on the TA and is completed as ordered.	sult		
	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				Resident #106 was discharged from th facility on 8/21/23.	e		
	anticoagulant therap documented in part, (as needed) s/sx (sig anticoagulant compli blood in urine, black	y." The "Interventions" "Monitor/record/report PRN gns and symptoms) of ications: blood tinges or frank tarry stools, dark or bright			Resident #358 was discharged from th facility on 8/30/23.	e		
	headaches, nausea, lethargy, blurred visi breath), loss of appe mental status, signifi vital signs. Report to	vomiting, sudden severe vomiting, muscle joint pain, on, SOB (shortness of tite, sudden changes in cant or sudden changes in o nurse PRN signs/symptoms			Resident #86 s physician was notified that Levothyroxine sodium was not available for administration on 8/5/23 a 8/6/23. No new orders at this	and		
	in urine, blood in sto vomiting, blurred vis	ing bruising, bleeding, blood ol, black tarry stools, nausea, ion, pain, shortness of breath, nental status, weakness,			Resident #86 documentation to support Levothyroxine sodium administration is the medical record with no further variances noted at this time.			
		an Oral (1) tablet 5 mg ablet by mouth two times a			Resident # 74 is provided with incontinence care per the Care Plan w no further variances.	ith		
		2023 MAR (medication d) documented the above						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER	100212		ST	FREET ADDRESS, CITY, STATE, ZIP CODE	00	5/16/2023	
				17	776 CAMBRIDGE DRIVE			
CANTERB	URY REHABILITATION	AND HEALTHCARE CENTER			ICHMOND, VA 23238			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 656	Continued From page	e 52	F 6	556				
	having been administorder. There was no	n was documented as tered per the physician documentation of monitoring use of an anticoagulant.			Resident #48 is provided with incontinence care per the Care Plan w no further variances.	ith		
	The July and August 2023 TAR (treatment administration record) failed to evidence documentation of monitoring of side effects for the use of an anticoagulant.				Resident #48 was evaluated for contractures to fingers by 8/23/23, and Care Plan was updated to reflect flectic contracture.			
	practical nurse) #9 or When asked the purp stated it's how we giv #9 was asked if the co	erview was conducted with LPN (licensed cal nurse) #9 on 8/9/2023 at 3:09 p.m. asked the purpose of the care plan LPN #9 it's how we give care to the patient. LPN s asked if the care plan includes to monitor			Resident #37 Care Plan was updated include Trauma Informed Care.	to		
		icoagulants, and it's not s that following the care plan,			Resident #37 has been seen by the Psychiatry team at the VA 8/14/23.			
	Person - Centered," of comprehensive, person includes measurable meet the resident's p	are Plans, Comprehensive documented in part, "A on-centered care plan that objectives and timetables to hysical, psychosocial and eveloped and implemented	Resident #43 Care Plan was updated resident preferences for offloading he and implemented. Heels offloaded w HLSB as tolerated and pillows at time with resident preference /tolerance.		els h			
	administrator, ASM # consultant, and ASM	#6, the clinical care le aware of the above finding			Resident #43 Physician orders were updated to include HLSB as tolerated. Resident #409 was discharged from the control of the	e		
	No further information was provided prior to exit.				facility on 1/23/23.			
	prevent strokes or bloatrial fibrillation (a co) Apixaban is used help bod clots in people who have ndition in which the heart easing the chance of clots			Resident #118 POC documentation indicates turning, repositioning, and provision of incontinence care and bar	rier		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	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)		F 656		cream application per the Care Plan.		
	and pulmonary embolung) in people who a or knee replacement used to treat DVT and to prevent DVT and Fafter the initial treatmis in a class of medical inhibitors. It works by certain natural substatorm. This information following website: https://medlineplus.go	lood clot, usually in the leg) lism (PE; a blood clot in the are having hip replacement surgery. Apixaban is also d PE and may be continued PE from happening again ent is completed. Apixaban ations called factor Xa blocking the action of a lince that helps blood clots to a was obtained from the			C N A and Licensed nursing staff assigned to the resident on the dates outlined in the citation were re-educate 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 physic and documentation of the care in the medical record.	n, f	
	tml 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:				Resident #5 was provided with Palm Guard. Resident #5 was provided with music a bedside per her listening preference.		
	at 7:45 AM, 8/8/23 at AM.	M, 8/7/23 at 2:45 PM, 8/8/23 t 11:30 AM, and 8/10/23 9:15			Resident #54 was reviewed with clinical provider with oxygen order revised to reflect current assessed need to include oxygen saturation monitoring every ships.	е	
	4/27/23 and revised 6 Resident is at risk for deconditioning/ weak safety awareness. R (activities of daily livin Deficit related to Cog	rehensive care plan dated 6/11/23, revealed, "FOCUS: falls related to confusion, ness, history of falls, poor esident has an ADL ng) Self Care Performance nitive Impairment, Impaired obilityINTERVENTIONS:			Resident#149 s care plan was update 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:	l ` ′	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
		495272	B. WING_		C 08/16/2023	
NAME OF PE	ROVIDER OR SUPPLIER		 	STREET ADDRESS, CITY, STATE, ZIP CODE	00/10/2023	-
				1776 CAMBRIDGE DRIVE		
CANTERB	URY REHABILITATION A	ND HEALTHCARE CENTER		RICHMOND, VA 23238		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION	
F 656	PM, with RN (register about the fall mats for observed there were used to have fall mats them to give to another active. When asked i was the care plan beinstated, no, it is not be the compart of the facility of the facili	ed nurse) #1. When asked Resident #144, RN #1 no fall mats and stated he s, and believed they took er resident who was more f fall mats were not in place, ng implemented, RN #1 ing implemented. M, ASM (administrative staff inistrator, ASM #4, the nt, ASM #7, the director of the regional consultant was dings. ty's "Comprehensive Care nprehensive, plan: a. includes s and timeframes; b. s that are to be furnished to resident's highest mental, and psychosocial (1) services that would If for the above, but are not esident exercising his or her ght to refuse treatment; (2) the stop be provided as a commendations; and (3) rvices are responsible for c. includes the resident's mission and desired in the resident's strengths; thy recognized standards of	F 6	,	tion itoring. ted to ation for c as well h f I to and/or at s.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
CANTERB	URY REHABILITATION	AND HEALTHCARE CENTER		17	776 CAMBRIDGE DRIVE			
				R	ICHMOND, VA 23238			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE	
F 656	Continued From pag	e 55	F	656				
	2. b. For Resident #1	144, the facility staff failed to			Resident #127 was discharged from the	ne		
		pplement the comprehensive care plan for			facility on 8/17/23.			
	podiatry consults as							
	poundary contounts do	J. 45. 54.						
	Observation on 8/8/2	23 at 11:23 AM, of Resident						
		aled the following: right foot			Current Residents have the potential t	o be		
		a trim being 1/4 - 1/2 second			affected by this practice.			
		ne underneath of his big toe.			·			
	Left foot - all nails ne				An audit was completed by the Unit			
					Manager/Designee of current resident	s		
	A review of the physic	ician order, dated 4/24/23,			that utilize anticoagulation therapy, to			
	revealed, "Podiatry 0	Consult and Treatment."			validate the development of a			
					comprehensive Care Plan to include s	ide		
		rehensive care plan dated			effect monitoring.			
		6/11/23, revealed, "FOCUS:						
		r falls related to confusion,			An audit was completed for current			
	_	kness, history of falls, poor			residents by Unit Manager/Designee of			
	safety awareness. F				current residents□ care planned for th	е		
		ng) Self Care Performance			utilization of fall mats to validate			
	_	gnitive Impairment, Impaired			implementation.			
	•	obilityResident has						
		ITERVENTIONS: Bilateral fall						
		ults for Diabetic Foot Care.			An audit was sompleted for surrent			
		y. Avoid tight, pinching edness, blistering, open areas			An audit was completed for current residents by Unit Manager/Designee of	\f		
	to physician or desig	• .			current residents for the need for podia			
	to physician or desig	nee promptly.			services as ordered/care planned.	au y		
	A review of the nodic	atry appointments for			services as ordered/care planned.			
		aled, no appointment for April						
		ew of the podiatry note for						
		oenails trim/care." There			An audit was completed for current			
	was no evidence of toenail care provided in				residents by the Unit Manager/Design	ee		
	2023.	,,			that utilizes urinary catheters for			
	-				documentation to support completion	of		
	An interview was cor	nducted on 8/8/12 at 12:30			catheter care.			
	PM, with LPN (licens	sed practical nurse) #2, when						
		nail care for the residents,						
		resident is diabetic or has						
	thick toenails, podiat	ry cuts the toenails.			An audit was completed for current			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495272	B. WING		C 08/16/2023
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	00/10/2023
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CANTERB	SURY REHABILITATION A	AND HEALTHCARE CENTER		RICHMOND, VA 23238	
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F 656	#2. When asked who #2 stated, "We look a getting bathed. If the toenails, we let the nu podiatry list. If they a can trim them." An interview was con AM, with OSM (other director of social serv podiatry appointment are too many residen next visit and those re Podiatry did not come 8/16/23 and there is a coming in August. An interview was con PM, with RN (register about the podiatry can stated, there was poor asked if podiatry conswas not consistently in the policy of the consistently in the policy of the consistently in the consistent in the consis	, an interview was (certified nursing assistant) o provides toenail care, CNA	F 65		gnee ow air on per ignee on an cation. ignee inence for
	member) #1, the adm regional risk consulta nursing and ASM #8, made aware of the fir No further information	n was provided prior to exit.		incontinence care products, turning repositioning per the Care Plan. An audit will be conducted for curre residents by the Unit Manager/Desi who have contractures to validate c plan interventions including splints a implemented as ordered. A trauma informed care review was	nt gnee are are
		44, the facility staff failed to ehensive care plan for		completed for current residents by t Social Service Director/Designee to	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF D	ROVIDER OR SUPPLIER	400212		ς.	TREET ADDRESS, CITY, STATE, ZIP CODE	08/	16/2023
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CANTERE	SURY REHABILITATION A	AND HEALTHCARE CENTER			RICHMOND, VA 23238		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 656	Continued From page	e 57	F	656			
	urinary catheter care.				identify residents with the need for furt development of the Care Plan, and		
		cian order dated 6/27/23, but every shift for Foley Cath and reflux uropathy."			psychological support systems to mee the resident needs.	I	
	A review of the comp 4/27/23 and revised 6 "FOCUS:Resident I catheter related to Ot Resident has Diabete INTERVENTIONS: care every shift and a A review of the July a (treatment administra output documented e no evidence of urinar for Resident #144 for An interview was con	rehensive care plan dated 6/11/23, revealed, has an indwelling urinary postructive Uropathy. See Mellitus. Provide urinary catheter as needed"			An audit was completed for current residents by the Unit Manager/Designed to identify residents who are care plant 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/Designed of current residents requiring wound/st 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/Designed.	ee kin ng ort	
	where urinary cathete #1 state, it is on the T no documentation of Resident #144, was t RN #1 stated, no, it is An interview was con AM, with LPN (license When asked were uri documented, LPN #1 on the TAR. When as documentation of urin care plan implemente not being implemente On 8/14/23 at 4:00 Pl	er care is documented, RN FAR. When asked if there is urinary catheter care for the care plan implemented, anot being implemented. ducted on 8/14/23 at 10:20 the practical nurse) #13. nary catheter care is 3 stated, it is documented the sked if there is no the sked if there is no the stated, it is documented the sked if there is no the sked if there is no the sked if there is no the sked if the stated, no, it is			of current residents who utilize palm guards for implementation of device pet 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 activities to meet the resident needs. An audit was completed for current residents by the Respiratory Therapist/Unit Manager of oxygen administration orders, oxygen saturatic level monitoring and documentation th of to meet the resident Plan of Care needs.	on	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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TAG	,	OR LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED	TO THE APPROPRIATE CIENCY)	DATE	
F 656	Continued From p	-	F 6	556			
		ultant, ASM #7, the director of					
	_	#8, the regional consultant was		An audit was completed			
	made aware of the	e findings.		residents by the Unit M			
				of current residents on	•		
	No further informa	ition was provided prior to exit.		medication to ensure a	· · · · · · · · · · · · · · · · · · ·		
	0.5.0			Care Plan is developed			
		106, the facility staff failed to		effect monitoring, and la	abs as indicated.		
	implement the comprehensive care plan for monitoring pulse oximetry as ordered.			An audit was conducted	d for current		
	Information in graph of the	oximetry as ordered.		residents by the Unit M			
	Resident #106 wa	is admitted to the facility on		for those residents who			
		gnoses that include but are not		medication for the docu	• •		
		(chronic obstructive pulmonary		location, characteristics			
		estructive sleep apnea), and		non-pharmacological in			
	CHF (congestive I			attempted prior to admi			
	, ,	,		pain medication and the			
	A review of the co	mprehensive care plan dated		the comprehensive Car	re Plan.		
	7/2/23, revealed, '	'FOCUS: Resident requires					
		gen. INTERVENTIONS:		An audit was completed			
		per facility protocol. 02 per MD		residents by the Unit M			
		al signs, including pulse		of current residents for			
		saturation level], as ordered		per resident preference	•		
		ated. Monitor and document		POC. Variances were	addressed.		
		eathing patterns, and dyspnea		The Ote # Development			
		hile lying flat. Report abnormal		The Staff Development			
	indings to physici	an or designee."		Coordinator/Designee v	-		
	A ravious of the ph	ysician orders dated 7/1/23,		Develop/Implement Co			
		n at 2-4 liters/minute via nasal		Plan to include but not	=		
		SPO2 (peripheral capillary		Tian to molado bat not	miniou to.		
) above 88% every 24 hours as					
		less of Breath maintain SPO2					
	sat above 88%."			Addressing utilization o	of anticoagulation		
				therapy, to include side			
	A review of Reside	ent #106's oxygen saturation		implementation of fall n			
		d oxygen saturation were		prevention device as or			
		ast every 24 hours from 7/1/23		trimming of nails and th			
		was no oxygen saturation		services as ordered/Ca			
	levels documented	d from 7/18/23 -8/10/23 under		catheter care, and docu	umentation to		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
							С	
		495272	B. WING _			08	/16/2023	
NAME OF PR	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE			
				1770	6 CAMBRIDGE DRIVE			
CANTERB	URY REHABILITATION	N AND HEALTHCARE CENTER		RIC	:HMOND, VA 23238			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 656	Continued From pa	ge 59	F 6	556				
	vital signs tab. TAR	(treatment administration			support urinary catheter care is			
	record) or progress			- 1	accomplished, Oxygen administration			
				- 1	orders, pulse oximetry monitoring and			
	On 8/9/23 at 2:15 P	M, an interview was			documentation thereof to meet the			
		(registered nurse) #1. When			resident current Plan of Care needs,			
		of the care plan, RN #1			Pressure Ulcer prevention, orders for	low		
	stated, it is to define	e the care for the patient.			air mattresses, HLSB, Offloading and			
	When asked if oxyg	en saturation/pulse oximeter			preventative measures, Administration	n of		
	as ordered are not	evidenced in Resident #106's			medications and documentation to			
	medical record, is the	ne care plan being			support whether medication is given o	n		
	implemented, RN#	1 stated, no, it is not			hold, unavailable, or not given, physic	ian		
	implemented.				notification, and timely obtainment of			
				- 1	orders. Timely incontinence care,			
		PM, ASM (administrative staff		- 1	bathing/showering per resident			
		Iministrator, ASM #4, the			preference, and the documentation of			
		tant, ASM #7, the director of			care provided, use of splints/palm gua			
	_	8, the regional consultant was		- 1	as ordered, Trauma Informed care and			
	made aware of the	findings.		- 1	implementation of psychological supp	ort		
	No further informati	on was provided prior to exit		- 1	systems to meet the resident needs,			
		on was provided prior to exit.			obtaining timely wound/skin treatment			
		58 (R358), the facility staff the resident's comprehensive		- 1	orders, and following the Care Plan fo pressure injury prevention, documenta			
	care plan for a low			- 1	to support care and treatments were	ation		
	care plair for a low a	all 1055 Mattless.			provided, offering of Activities to meet	the		
	R358's comprehens	sive care plan dated 1/2/23			residents□ current needs per plan of o			
		resident has a pressure ulcer		- 1	psychotropic medication use are care	Jaio,		
	or has the potential			- 1	planned to include side effect monitori	na		
	-	ated to) history of pressure			and labs as indicated, and the need for	-		
		eral vascular disease) and			the development of the comprehensiv			
		ntions: [low] Air Loss Mattress		- 1	Care Plan for PRN pain medication			
	to bed at all times				usage, to include the documentation of location, characteristics, and	of		
	On 8/7/23. 8/8/23 a	nd 8/9/23, observations of			non-pharmacological intervention			
		vere conducted. The resident		- 1	attempts prior to administration of prn	pain		
		facility mattress and was not			medication.	-		
	on an air loss mattr							
		p.m., an interview was (registered nurse) #3. RN #3			The DON/Designee will complete an a	audit		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495272	B. WING		C 08/16/2023	
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	1 00/10/2023	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION	
F 656	of the resident so it sl good picture of the rewhat's going on, what is at risk for, and what "We always want to meet for the resident. Process for the IDT (iff 3 stated care plans a because the goal is to resident. On 8/14/23 at 4:06 p. staff member) #1 (the (the regional risk condirector of nursing) wabove concern. 5. For Resident #86 (to implement the resiplan for thyroid replacement of the plan for thyroid replacement the review of 86's clinic physician's order date sodium 175 mcg (mic day for hypothyroidist). A review of R86's Augadministration record order for levothyroxin 8/6/23, the MAR docunted, "Med or Nurses' notes dated 8 documented, "Med of the resident of the plan for thyroidist order for levothyroxin 8/6/23, the MAR docunted, "Med of the plan for the plan for thyroxin 8/6/23, the MAR docunted, "Med of the plan for the plan for thyroxin 8/6/23, the MAR docunted, "Med of the plan for the plan for thyroxin 8/6/23, the MAR docunted, "Med of the plan for the plan fo	are plan should be reflective thould be informative and a sident to let staff know the needed, what the resident at is current. RN #3 stated, make sure we are doing the It's always an ongoing interdisciplinary team)." RN should be implemented to have what's best for the m., ASM (administrative exadministrator), ASM #4 sultant) and ASM #7 (the ere made aware of the example of the	F 65	of 3 residents to validate the develor of the comprehensive Care Plan we completed per resident needs, order and preferences. Variances will be addressed. These audits will be conducted weekly x 4 weeks, then monthly x 2 months. The findings of audits will be submitted by the DON/Designee to the QAPI Comm for review and recommendation may for 3 months or ongoing until compositions.	of the nittee onthly	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULT A. BUILDII	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	N AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP COE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	•	30.13.232		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
F 656	was administered to On 8/10/23 at 1:57 conducted with RN stated a resident's of the resident so it good picture of the what's going on, whis at risk for, and will "We always want to best for the resident process for the IDT #3 stated care plant because the goal is resident. On 8/11/23 at 9:57 staff member) #1 (to (the regional risk continued to the above concerns.) 6. For Resident #74 to follow the resident care. On the most recent annual assessment reference date of 60 having no cognitive decisions, having so BIMS (brief intervier coded as requiring two staff members being always incombladder.	on that levothyroxine sodium of R86 on 8/5/23 and 8/6/23. p.m., an interview was (registered nurse) #3. RN #3 care plan should be reflective should be informative and a resident to let staff know nat's needed, what the resident that is current. RN #3 stated, of make sure we are doing the st. It's always an ongoing (interdisciplinary team)." RN is should be implemented into have what's best for the sam., ASM (administrative the administrator) and ASM #4 consultant) were made aware of the R74), the facility staff failed int's care plan for incontinence making daily cored 15 out of 15 on the worm of t	F	656				
		.m., the surveyor entered certified nursing assistant) #10						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		495272	B. WING				C /16/2023
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER		1776	ET ADDRESS, CITY, STATE, ZIP CODE CAMBRIDGE DRIVE IMOND, VA 23238	1 00	10/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 656	opened the door from the two residents in the stated: "I'm going to resident standing with do him [pointing to Resident standing with do him [pointing to Resident standing with the lying in his bed with light "change of shift," and have to come in and "No one has still come changed." On 8/7/23 at 3:45 p.r were observed stand unit. Two of the seve on their cell phones. On 8/7/23 at 4:12 p.r R74 to have his incoord have his incoord have his incoord hours and provide in On 8/10/23 at 1:57 pronducted with RN (in light	the bathroom (shared with the adjacent room), and do this resident [pointing to a th her in the bathroom], then tesident #48, R74's in him [pointing to R74]. CNA bathroom door. R74 was the television on. He stated: for an hour to get changed." ware of needing to have his tranged around 3:00 p.m., and other CNA whom he could not one in "a little after 3," (3:00 int off, and told him it was do that someone else would change him later. He stated: the back in. I really need to be to the image of th	F	656			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCT AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCT A. BUILDING			(X3) DATE SURVEY COMPLETED C		
		495272	B. WING		08/16/2023
	ROVIDER OR SUPPLIER BURY REHABILITATIO	N AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	1 33/.10/2020
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 656	good picture of the what's going on, whis at risk for, and whis at risk for, and whis at risk for the resider process for the IDT #3 stated care plan because the goal is resident. On 8/14/23 at 11:5 nurse) #7 was intented it should incompare about the restated it should incompare able to update On 8/14/23 at 4:01 staff member) #1, for a going and that floor are able to update On 8/14/23 at 4:01 staff member) #1, for going a risk consultant, and AS were informed of the No further informated. 7. For Resident #4 to follow the care pfailed to develop a hand contractures. 7. a. On the most reserved as being coded as being coded.	t should be informative and a resident to let staff know hat's needed, what the resident that is current. RN #3 stated, o make sure we are doing the nt. It's always an ongoing (interdisciplinary team)." RN ns should be implemented is to have what's best for the sto have what's best for the sident's needs for care. She lude any treatment and pecific to a resident. She stated is ible for implementing the care increase and management staff care plans in real time. p.m., ASM (administrative the administrator, ASM #4, the litant, ASM #8, the regional in the material in the staff care concerns. it ion was provided prior to exit. 8 (R48), the facility staff failed olan for incontinence care, and care plan for the resident's	F 656		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495272	B. WING				C 16/2023	
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER		17	REET ADDRESS, CITY, STATE, ZIP CODE 76 CAMBRIDGE DRIVE CHMOND, VA 23238	1 00/	10/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 656	BIMS (brief interview coded as requiring the two staff members for frequently incontinent incontinent of bowel. On 8/7/23 at 3:38 p.r. R48's room. CNA (coopened the door from the two residents in the stated: "I'm going to resident standing with do him [pointing to Rich the bathroom door. For wheelchair, and the with the door to the hallwashirt and incontinent odor of feces surrour long he had been was stated: "It burns down incontinence brief]." On 8/7/23 at 3:45 p.r. were observed stand unit. Two of the seve on their cell phones. On 8/7/23 at 4:00 p.r. R48 to have his incontinence carea approximately every incontinence care as incontinence r/t (related to) incontinence care as incontinence r/t (related sincontinence r/t (related sin	r for mental status). He was the extensive assistance of the toileting, as being the of bladder and always m., the surveyor entered the strified nursing assistant) #10 the bathroom [shared with the adjacent room], and do this resident [pointing to a the her in the bathroom], then 48]. CNA #10 then closed 48 was sitting in his wheelchair was fully facing ay. R48 was wearing only a the briefs. There was a strong anding R48. When asked how witting to be changed, R48 the there [pointing to his m., seven staff members ling at the desk for R48's the were tapping and scrolling m., CNA #10 began preparing the plan dated 6/12/23 ave urinary incontinence r/t imitationsProvide s neededCheck resident 2 hours and provide neededI have bowel	F	656				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG		(X3) DATE COMP	
		495272	B. WING _			08/·) 16/2023
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP C 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X (EACH CORRECTIVE ACT CROSS-REFERENCED TO T	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 656	coded as being impa both left and right upp On the following date observed in his room R48's left and right hat there was no evidence contracture in either I	ent MDS, an annual ARD of 6/9/23, R48 was ired for range of motion in per extremities. s and times, R48 was In each observation, both and were contracted, and se of a device to treat the nand: 8/7/23 at 3:38 p.m., and 10:22 a.m.; and 8/9/23 at	F	356			
	revealed no informating hand contractures. On 8/10/23 at 1:57 p. conducted with RN (restated a resident's case of the resident so it is good picture of the rewhat's going on, what is at risk for, and what "We always want to resident. process for the IDT (if #3 stated care plans because the goal is to resident. On 8/14/23 at 11:59 and the stated it should it services that are speeveryone is responsitions.	on related to the resident's					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		495272	B. WING			C 08/16/2023	
	ROVIDER OR SUPPLIER	N AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	<u> </u>	00/10/2023	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 656	On 8/14/23 at 4:01 staff member) #1, the regional risk consult consultant, and ASI were informed of the No further information. 8. For Resident #37 to develop a care poor of the most recent annual assessment reference date) of States being moderately in decisions, having some BIMS (brief intervies scored a zero on the indicating he had not dysfunction during the look back the facility with diagochronic PTSD (position), and visual hallution. A review of R37's consultant consultant in the look back the facility with diagochronic PTSD (position).	p.m., ASM (administrative ne administrator, ASM #4, the tant, ASM #8, the regional W #7, the director of nursing, ese concerns. on was provided prior to exit. Y (R37), the facility staff failed lan for trauma informed care. MDS (minimum data set). an with an ARD (assessment 5/21/23, R37 was coded as npaired for making daily cored 11 out of 15 on the w for mental status). He was e mood severity evaluation, o symptoms of mood the look back period. He was emonstrated no behaviors k period. R37 was admitted to inoses including depression, t-traumatic stress disorder)	F 6	,			
	facility, OSM (other was dated 7/19/22. in part: "The patient state that he had so familial issues, but moodThe psycho	longer employed at the staff member) #17. The note A review of the note revealed, was doing well todayHe did ome depression from his otherwise has been in a good therapist and patient on positive thinking,					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI		DNSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		495272	B. WING			1	C 16/2023
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER	•	1776	EET ADDRESS, CITY, STATE, ZIP CODE CAMBRIDGE DRIVE HMOND, VA 23238	1 00	10/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	I	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPRIATE OF CORRECTIVE ACTION SHOULD DEFICIENCY)			(X5) COMPLETION DATE
F 656	especially when it co that the patient will be familyThe psychoth following weeks, con rapportTreatment in psychotherapist will westablishing coping in depressedThis psychotherapist will we establishing coping in depressedThis psychotherapist will we mindfulness to reduce the psychotherapist will we mindfulness to reduce that R37 counseling services in the review of R37's car revealed no information informed services for the R37's car revealed no information informed services for the resident so it is good picture of the rewhat's going on, what is at risk for, and what's going on, what is at risk for, and what's going on, what is at risk for, and what's going on, what is at risk for, and what's going on, what is at risk for, and what's going on, what is at risk for, and what's going on, what is at risk for, and what is at risk for the resident.	ncerns family. They resolved to mindful when talking to herapist will monitor over the tinuing to build Plan Progress/GoalsThis work with the patient on hechanisms to feel less chotherapist will work to mbating emotional distress unit well. This encourage use of the anxiety through deep herescribed Frequency: 7's clinical record revealed to had received any since he was seen on the plan dated 11/27/22 toon related to trauma	F	656			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	FIPLE CONSTRUCTION NG		(X3) DATE SI COMPLE	
		495272	B. WING _			08/16	6/2023
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER	1	STREET ADDRESS, CITY, STATE, ZIP CO 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	ODE	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 656	social services, was i role in trauma informed completing the assess the MDSs. She stated about the resident's mexperienced any traumot have a role in deverauma informed care responsible for that. On 8/14/23 at 11:59 and nurse) #7 was interviced plan tells us about the She stated it should it services that are specially and that floor nuare able to update care ab	nterviewed. She stated her ed care is limited to sments that are required for d: "We ask the questions mood and if they have ma." She stated she does reloping a care plan for a, and was not sure who was a.m., LPN (licensed practical ewed. She stated a care exceeded a care exceeded and treatment and cific to a resident. She stated ple for implementing the care are sand management staff for plans in real time. In ASM (administrative exadministrator, ASM #4, the ent, ASM #8, the regional #7, the director of nursing, see concerns. In was provided prior to exit. In was provided prior to exit. In some people who have exact in danger." This is some the website gov/health/topics/post-traum	F	656			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495272	B. WING _			C 98/16/2023	
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP COL 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238		0/10/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 656	Continued From pag	e 69	F6	56			
	to follow the care plate prevention. On the most recent I quarterly assessment reference date) of 5/being at risk of deve as currently having at observed sitting up it direct contact with pit underneath her feet: 4:16 p.m.; 8/8/23 at a.m. and 4:20 p.m. Theel suspension both bedside. When asked currently being floated in contact with any sheels aren't floated." important to float this the heels should be breakdown. When asheel lift device for the We just float them." pillow or uses a wed heels from coming in or a pillow. A review of R43's cli	es and times, R43 was in her bed with both heels in illows which had been placed 8/7/23 at 12:35 p.m. and 10:39 a.m.; 8/9/23 at 11:01 There was no evidence of bits for R43. m., CNA (certified nursing isserved standing at R43's id if R43's heels were ed (elevated so they were not inface), she stated: "No, her when asked why it is is resident's heels, she stated floated to prevent skin isked if she was aware of a ite resident, she stated: "No. She stated she usually rolls a ge to prevent the resident's into direct contact with the bed inical record revealed the inical record reveale					
	A review of R 43's ca	are plan dated 10/21/22					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONST	RUCTION	(X3) DATE COMF	SURVEY PLETED
		495272	B. WING _				C 1 16/2023
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER		1776 CAN	NDDRESS, CITY, STATE, ZIP CODE MBRIDGE DRIVE DND, VA 23238	1 00/	10/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD & CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 656	revealed, in part: "Ad orderedHeel lift boo On 8/10/23 at 1:57 p. conducted with RN (r stated a resident's car of the resident so it s good picture of the rewhat's going on, what is at risk for, and what "We always want to resident. process for the IDT (iff #3 stated care plans because the goal is to resident. On 8/14/23 at 11:59 and nurse) #7 was interviplan tells us about the She stated it should is services that are speeveryone is responsiplan, and that floor mare able to update car on 8/14/23 at 4:01 p. staff member) #1, the regional risk consultant, and ASM were informed of these No further information 10. For Resident #40	minister treatments as obts to bilateral heels." m., an interview was egistered nurse) #3. RN #3 are plan should be reflective hould be informative and a esident to let staff know it's needed, what the resident it is current. RN #3 stated, make sure we are doing the It's always an ongoing interdisciplinary team)." RN should be implemented to have what's best for the a.m., LPN (licensed practical ewed. She stated a care in resident's needs for care. Include any treatment and coffic to a resident. She stated be for implementing the care curses and management staff are plans in real time. m., ASM (administrative is administrator, ASM #4, the int, ASM #8, the regional #7, the director of nursing, see concerns. In was provided prior to exit. 9 (R409), the facility staff re plan for pressure injury	F	556			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		495272	B. WING _			C 08/16/2023	
	ROVIDER OR SUPPLIER	I AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	CODE	33/10/2020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN O X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 656	On the most recent admission assessm reference date) of 1 being in a persistent coded as having twinjuries. Resident # facility on 1/13/23. A review of R409's assessment dated had one pressure in wound measuring 5 with a depth of 0.3 of A review of R409's 1/6/23 revealed, in pressure ulcer and development r/t (relincontinence, admit pressure ulcer on have treatments as order effectiveness." Furt record failed to revessacral wound until of the resident so it good picture of the what's going on, whis at risk for, and who "We always want to best for the residen process for the IDT #3 stated care plant."	MDS (minimum data set), an ent with an ARD (assessment /13/23, R409 was coded as t vegetative state. He was o unstageable pressure 409 was discharged from the admission nursing 1/6/23 revealed the resident higher on admission, a sacral orm (centimeters) by 6 cm, cm. baseline care plan dated part: "The resident has a is at risk for further ated to) immobility, bowel ted with an unstageable is sacrumAdminister ed and monitor for ther review of R409's clinical eal treatment orders for this	F	656			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495272	B. WING			C 08/16/2023
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER		STREET ADDRESS, CITY, ST 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	I	06/16/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	((EACH CORRECT CROSS-REFEREN	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIAT DEFICIENCY)	
F 656	On 8/14/23 at 11:59 nurse) #7 was interviplan tells us about the She stated it should services that are speeveryone is responsiplan, and that floor nare able to update care informed of the No further information. 11. For Resident #11 failed to follow the care update as requiring the two staff members for (turning/repositioning risk for developing a one unstageable prevaled, in part: "I hulcer development least every 2 hours, to barrier cream after extended the state of	a.m., LPN (licensed practical lewed. She stated a care e resident's needs for care. include any treatment and edific to a resident. She stated ble for implementing the care urses and management staff are plans in real time. a.m., ASM (administrative e administrator, ASM #4, the eart, ASM #8, the regional #7, the director of nursing, se concerns. a.m. was provided prior to exit. 8 (R118), the facility staff are plan for pressure injury MDS (minimum data set), a seessment with an ARD ce date) of 6/9/23, R118 was ne extensive assistance of or bed mobility g). He was coded as being at pressure injury, and having	F	656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495272	B. WING _			C 08/16/2023	
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238		00/10/2023	
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F 656	or had barrier cream following dates in Jur 6/19 through 6/21, 6/3 July 2023, 7/2 throug 7/14, 7/16 through 7/2 7/28. The review reverelated to the resident On 8/10/23 at 1:57 p. conducted with RN (restated a resident's car of the resident so it slegood picture of the rewhat's going on, what is at risk for, and what "We always want to resident. process for the IDT (if #3 stated care plans is because the goal is to resident. On 8/14/23 at 11:59 and the stated it should it services that are specieveryone is responsible plan, and that floor nuare able to update car on 8/14/23 at 4:01 p. staff member) #1, the regional risk consultant, and ASM were informed of these states in Jury 10 p. staff member) #1, the regional risk consultant, and ASM were informed of these	applied on day shift on the e 2023: 6/1 through 6/16, 23, 6/26 through 6/30; and in in 7/7, 7/7 through 7/11, 7/13, 21, 7/24, 7/25, 7/27. and ealed no progress notes it's refusal of care. m., an interview was egistered nurse) #3. RN #3 are plan should be reflective hould be informative and a sident to let staff know it's needed, what the resident it is current. RN #3 stated, hake sure we are doing the It's always an ongoing interdisciplinary team)." RN should be implemented in have what's best for the interview what's best for the interview in the stated acare include any treatment and crific to a resident. She stated one for implementing the care include any treatment and crific to a resident. She stated one for implementing the care include any treatment and crific to a resident. She stated one for implementing the care include any treatment and crific to a resident. She stated one for implementing the care include any treatment and crific to a resident. She stated one for implementing the care include any treatment and crific to a resident. She stated one for implementing the care include any treatment and crific to a resident. She stated one for implementing the care include any treatment and crific to a resident. She stated one for implementing the care include any treatment and crific to a resident. She stated one for implementing the care include any treatment and crific to a resident. She stated one for implementing the care include any treatment and crific to a resident. She stated one for implementing the care include any treatment and crific to a resident. She stated one for implementing the care include any treatment and crific to a resident of the formation and	F 6	556			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	\ \ \ \ \ \ \	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495272	B. WING _				C 16/2023
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP COI 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	DE	1 001	10/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	N SHOULD BI E APPROPRIA		(X5) COMPLETION DATE
F 656	follow the care plant guards. 12. a. On the most reset), a quarterly asset (assessment referenceded as being mode for making daily decinaving impairment in and right upper extree. On the following date observed in her bed, left hand: 8/7/23 at 18/8/23 at 7:55 a.m. at 4:13 p.m., R5 was of rolled washcloth in hobservations, R5 had of her left hand. A review of R5's care revealed, in part: "I referenced as the care plant is a set of the care plant i	(R5), the facility staff failed to for activities and palm ecent MDS (minimum data essment with an ARD ce date) of 7/22/23, R5 was erately cognitively impaired sions, and was coded as range of motion for both left emities. es and times, R5 was with no palm guard in her 2:24 p.m. and 4:14 p.m.; and 10:20 a.m. On 8/9/23 at oserved in bed. She had a er left hand. At all d contractures in the fingers	F	DEFICIENCY.			
	and skin checks." 12. b. On the most re ARD of 3/9/23, R5 w expressed the follow important:" listening outside when weather in religious services. On the following date observed in her bed, 8/7/23 at 12:24 p.m.	ecent annual MDS with an as coded as having ing activities as "very to music she likes, going er permits, and participating es and times, R5 was with no music playing: and 4:14 p.m.; 8/8/23 at 7:55 and 8/9/23 at 4:13 p.m.					

` ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED	
		495272	B. WING			C 08/16/2023	
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	•	00/10/2023	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 656	Continued From pag	ge 75	F 6	56			
	in part: "I am dependence cognitive stimulation to) I require assistant activities/participation bedside/in-room visitattend events." On 8/10/23 at 1:57 producted with RN is stated a resident's confucted with RN is stated a resident's confucted with good picture of the rewhat's going on, while at risk for, and who "We always want to best for the resident process for the IDT #3 stated care plans because the goal is resident. On 8/14/23 at 11:59 nurse) #7 was interviously plan tells us about the She stated it should services that are speeveryone is responsible, and that floor rare able to update consultant, and ASN were informed of the stated it should consultant, and ASN were informed of the stated it should services that are speeveryone is responsible.	c.m., an interview was (registered nurse) #3. RN #3 are plan should be reflective should be informative and a resident to let staff know at's needed, what the resident at is current. RN #3 stated, make sure we are doing the . It's always an ongoing (interdisciplinary team)." RN is should be implemented to have what's best for the a.m., LPN (licensed practical riewed. She stated a care ne resident's needs for care. include any treatment and recific to a resident. She stated aible for implementing the care nurses and management staff are plans in real time.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTII	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		495272	B. WING			C 08/16/2023	
	ROVIDER OR SUPPLIER	I AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238		35, 16, 2023	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 656	Continued From pa	ge 76	F 6	56			
	to follow the care pl	44 (R54), the facility staff failed an for oxygen administration.					
	admission assessm reference date) of 5	MDS (minimum data set), an ent with an ARD (assessment 5/30/23, the resident was oxygen in the facility.					
	observed in bed rec cannula via a conce per minute (3 lpm):	tes and times, R54 was beiving oxygen through a nasal entrator at a rate of three liters 8/7/23 at 12:10 p.m. and 4:18 B a.m., and 8/9/23 at 11:14					
		rders revealed the following : "O2 (oxygen) at 2 lpm for O2 % (less than 90%)."					
	administration recor that the resident's o	ugust 2023 MAR (medication d) failed to reveal evidence xygen saturation was less le supplemental oxygen					
		are plan dated 5/31/23 have altered respirator oxygen as ordered."					
	conducted with RN stated a resident's confident so it good picture of the what's going on, whis at risk for, and who	p.m., an interview was (registered nurse) #3. RN #3 care plan should be reflective should be informative and a resident to let staff know at's needed, what the resident nat is current. RN #3 stated, make sure we are doing the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		I ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495272	B. WING _				C 16/2023
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER		1776	EET ADDRESS, CITY, STATE, ZIP CODE 6 CAMBRIDGE DRIVE HMOND, VA 23238	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 656	process for the IDT (#3 stated care plans because the goal is resident. On 8/14/23 at 11:59 nurse) #7 was interv plan tells us about the She stated it should services that are speeveryone is responsiplan, and that floor nare able to update care. On 8/14/23 at 4:01 p staff member) #1, the regional risk consultate consultant, and ASM were informed of the No further information 14. Facility staff failed comprehensive care.	It's always an ongoing interdisciplinary team)." RN should be implemented to have what's best for the a.m., LPN (licensed practical fewed. She stated a care to e resident's needs for care, include any treatment and the properties of the area of the stated ble for implementing the care the urses and management staff for e plans in real time. Image: ASM (administrative to administrator, ASM #4, the lant, ASM #8, the regional art, the director of nursing, see concerns. In was provided prior to exit. and to develop a	F	356			
	dated 6/16/23 for Litt (milligrams) twice da disorder bipolar type Further review of the order dated 6/30/23 and to administer 20 mg in the evening fo A review of the comp	clinical record revealed an for Lithium Orotate 5 mg tabs mg in the morning and 30					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
		495272	B. WING _			C 08/16/2023	
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	.	00,10,2020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 656	Continued From pag	ge 78 oxicity of Lithium was care	F 6	56			
	planned. On 8/14/23 at 12:18	PM, LPN #10 (Licensed					
	there should be care	s interviewed. She stated that e plan for the use and ffects and toxicity of Lithium.					
	conducted with LPN	AM, an interview was #1. She stated that there for the use and monitoring of city of Lithium.					
	ASM #1 (Administrated Administrator, ASM Consultant, ASM #7 ASM #8 the Region	PM at an end-of-day meeting, tive Staff Member) the #4 the Regional Risk the Director of Nursing and al Consultant, were made s. No further information was of the survey.					
	References:						
	bipolar disorder and Information obtained	•					
		ed to develop a plan for the use and icoagulant medication for					
	dated 6/9/23 for End	cal record revealed an order oxaparin (1) inject 40 mg uneously daily to prevent					

		IDENTIFICATION NUMBER:		2) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
		495272	B. WING			C 8/ 16/2023	
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CO. 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238		0/10/2023	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 656	Continued From pag		F 6	56			
	reveal any evidence	prehensive care plan failed to that the use, side effects, anticoagulant medication					
	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.						
	ASM #1 (Administrar Administrator, ASM Consultant, ASM #7 ASM #8 the Regiona	PM at an end-of-day meeting, tive Staff Member) the #4 the Regional Risk the Director of Nursing and al Consultant, were made s. No further information was of the survey.					
	References:						
	Information obtained	ed to prevent blood clots. from lov/druginfo/meds/a601210.h					
	comprehensive care	failed to implement the plan related to (A) pain and unitoring for Resident #133.					
	comprehensive care	e clinical record revealed the plan which included one are pain and/or potential for					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		ATE SURVEY DMPLETED	
		495272	B. WING _			C 08/16/2023
	ROVIDER OR SUPPLIER	N AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	CITY, STATE, ZIP CODE DRIVE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 656	dated 5/1/23 for "Er non-pharmacologic as applicable e.g. p bathing, heat and c stimulation, ultrason A review of the clini physician's order da	an included the intervention incourage me to try all interventions for pain relief ositioning, relaxation therapy, old application, muscle und." cal record revealed a ated 8/1/23 for Oxycodone (1) ne capsule every six hours as	Fé	956		
	Administration Recowas administered at 8/1/23 at 8:19 PM 8/2/23 at 1:22 AM at 8/3/23 at 5:29 AM 8/4/23 at 2:32 AM at 8/5/23 at 12:00 AM 8/7/23 at 4:09 AM at 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 reveal evidence of characteristics, and non-pharmacologic	and 12:59 PM and 12:10 PM and 9:00 PM and 12:10 PM e clinical record failed to bain location and/or pain /or attempts at al interventions.				
	Practical Nurse) wa given this resident's non-pharmacologic really be offered is	B PM, LPN #10 (Licensed is interviewed. She stated that is condition, the only all interventions that could a change in position, which lent did not like to do. She				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		495272	B. WING _			C 08/16/2023	
	ROVIDER OR SUPPLIER	N AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238		=		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 656	anything else. She characteristics and interventions should that if there was no non-pharmacologic attempted, then the On 8/14/23 at 4:00 ASM #1 (Administrator, ASM Consultant, ASM # ASM #8 the Region aware of the finding provided by the end References: (1) Oxycodone is usevere pain. Information obtained https://medlineplustml 16. B. A review of order dated 7/7/23 (milligrams) twice dictors. A review of the concrevealed one dated "Monitor/record/rep (signs and symptor complications: blood contractions: blood contractions and symptor complications: blood contractions and con	dent did not like to get up for stated that pain location and non-pharmacological d be documented. She stated evidence that gal interventions were a care plan was not followed. PM at an end-of-day meeting, attive Staff Member) the M #4 the Regional Risk of the Director of Nursing and hal Consultant, were made gs. No further information was d of the survey. Just to treat moderate to the different economics of the survey and for Apixaban (1) 5 mg laily for the prevention of blood enprehensive care plan	F6	56			
	nausea, vomiting, r blurred vision, SOE	sudden severe headaches, nuscle joint pain, lethargy, 3 (shortness of breath), loss of nanges in mental status,					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495272	B. WING		08/1	; 16/2023
	ROVIDER OR SUPPLIER BURY REHABILITATION	AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	, 00/1	. 67.2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 656	A review of the clinic weekly skin check withen not again until 8 weekly skin checks indicate monitoring from anticoagulant medic On 8/14/23 at 12:18 Practical Nurse) was the weekly skin check monitoring for signs of anticoagulant medic On 8/15/23 at 9:24 A conducted with LPN checks was the only that could be done for bruising and bleedin anticoagulant medic not being done, ther followed. On 8/14/23 at 4:00 F ASM #1 (Administration ASM #3 (Administration ASM #7 ASM #8 the Regional aware of the findings provided by the end References: (1) Apixaban is used Information obtained.	al record revealed that a as completed on 6/22/23 and 8/10/23. There were no between these two dates to or the use of an ation from 6/2/23 to 8/10/23. PM, LPN #10 (Licensed interviewed. She stated that eks would qualify as of bruising related to the use dication. AM, an interview was #1. She stated that skin kind of monitoring she knew or signs and symptoms of grelated to the use of an ation, and that if they were in the care plan was not being PM at an end-of-day meeting, tive Staff Member) the #4 the Regional Risk the Director of Nursing and al Consultant, were made is. No further information was of the survey.	F 65			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		495272	B. WING _			C 08/16/2023
	ROVIDER OR SUPPLIER	I AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	E	00/10/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 656	Continued From pa	ge 83	F 6	56		
	-	led to implement the eplan related to grooming for				
	for assistance with	iagnoses that included "need personal care." Of note, ot have a diagnosis of				
	made of Resident # toenail was 1/2 to 3	AM, an observation was 34's feet. The left foot big /4 inch long. On the right foot, be trimmed. The great toenail long.				
	revealed one dated (activities of daily liv Deficit r/t (related to Devices/Medical Ed included an interver	prehensive care plan 11/1/22 for "I have an ADL ving) Self Care Performance) Disease Process, External juipment." This care plan ntion dated 11/2/22 for ENE: I am dependent on staff nal hygiene."				
		cal record revealed a ated 2/14/23 for "Podiatry ent as needed."				
	evidence of when the On 8/9/23 at 3:05 P a request for evider care for Resident # was requested. A limit who received podiant however Resident # evidence was proving the content of the province of the content of the province of the content of the province of the content of th	cal record failed to reveal any ne toenails were last trimmed. M and on 8/14/23 at 5:00 PM, nee of all podiatry care/toenail 34 since admission (11/1/22) st was provided of residents try care in June 2023, 434 was not on the list. No ded that Resident #34 had penail care/podiatry services.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		495272	B. WING _			C 08/16/2023		
	ROVIDER OR SUPPLIER URY REHABILITATION	AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238		10/2023		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 656	conducted with RN a #3 stated a resident reflective of the resid informative and a go let staff know what's what the resident is current. RN #3 state sure we are doing the always an ongoing p (interdisciplinary teal should be implement have what's best for On 8/15/23 at 9:24 A conducted with LPN Nurse) She stated the grooming, and if the should attempt to tri the nails are too thic try and file them. Si have a podiatry considered they get too I plan was followed, so On 8/14/23 at 4:00 for ASM #1 (Administrate Administrator, ASM Consultant, ASM #7 ASM #8 the Regional aware of the finding provided by the end	PM, an interview was #3 (Registered Nurse). RN is care plan should be dent so it should is detailed. The should should be dent so it should should be dent should should should be dent should should should should should should should should be dent should should should should be dent should shoul	F 6	56				
		to address pain. MDS (minimum data set), a nt with an ARD (assessment						

F 656 Continued From page 85 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, 07/08/2023, 07/13/2023, 07/18/2023, 07/18/2023, 07/18/2023, 07/19/2023, 07/12/2023, 07/12/2023, 07/12/2023 and on 07/25/2023.	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
MAME OF PROVIDER OR SUPPLIER CANTERBURY REHABILITATION AND HEALTHCARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG			495272	B. WING _				
F 656 Continued From page 85 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, 07/11/2023, 07/11/2023, 07/11/2023, 07/11/2023, 07/12/2023, 07/12/2023, 07/12/2023, 07/12/2023, 07/12/2023, 07/12/2023, 07/12/2023, 07/12/2023, 07/12/2023, 07/12/2023, 07/12/2023, 07/12/2023, 07/12/2023, 07/12/2023 and on 07/25/2023.			AND HEALTHCARE CENTER		1776 CAMBRIDGE DRIVE	DE	1 001	10/2020
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, 07/18/2023, 07/18/2023, 07/18/2023, 07/18/2023, 07/19/2023, 07/24/2023 and on 07/25/2023.	PRÉFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI	N SHOULD BE E APPROPRIA		COMPLETION
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	F 656	reference date) of 05 scored 15 out of 15 of for mental status), independence of 15 out of 15 of for mental status), independence of 15 out of 15 of for mental status), independence of mental status), independence of mental status), independence of "Acetaminophen Tab (milligrams) by mouth needed for pain not to Order Date: 05/06/20. The eMAR (electronic record) for R63 dated physician's orders as revealed that R63 revealed that R63 revealed that R63's pain on 07/03/07/08/2023, 07/13/20/07/19/2023, 07/12/20/07/25/2023. The eMAR (electronic record) for R63 dated the physician's ordered hat Revealed that Acetaminophen with non-pharmacological attempted or docume R63's pain on 08/01/20. The nursing progress list above failed to evaluate the physician's ordered attempted or docume R63's pain on 08/01/20. The nursing progress list above failed to evaluate the physician's ordered attempted or docume R63's pain on 08/01/20.	in the BIMS (brief interview dicating the resident was making daily decisions. for R63 documented in part, let (1). Give 325 mg hevery 6 (six) hours as o exceed 3000mg per day. 1022." c medication administration during July 2023 documented the estated above. The eMAR decived 325mgs of no evidence of linterventions being entation of the location of 2023, 07/06/2023, 1023, 07/17/2023, 07/18/2023, 1023, 07/24/2023 and on during the location of 2023, 07/06/2023, 1023, 07/24/2023 and on during the location of 2023 and on 08/04/2023. Interventions being entation of the location of 2023 and on 08/04/2023. Interventions being entation of the location of 2023 and on 08/04/2023. Interventions prior to the entaminophen and the location of 2023 and the location and 2023	F	356			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY PLETED
		495272	B. WING				C / 16/2023
	ROVIDER OR SUPPLIER BURY REHABILITATION	AND HEALTHCARE CENTER	•	1776 C	T ADDRESS, CITY, STATE, ZIP CODE AMBRIDGE DRIVE MOND, VA 23238	·	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 656	address R63's pain a interventions. On 8/10/23 at 1:57 p conducted with RN (coordinator. RN #3 should be reflective informative and a golet staff know what's what the resident is current. RN #3 state sure we are doing the always an ongoing p (interdisciplinary teanshould be implemented have what's best for about a care plan to stated that after revience evidence that the pain. On 08/11/2023 at ap (administrative staff and ASM #4, regional aware of the above for the above for the above for the adaches, muscles and reactions to vac reduce fever. This in the website: https:	evidence documentation to and documentation of pain a.m., an interview was registered nurse) #3, MDS stated a resident's care plan of the resident so it should be od picture of the resident to going on, what's needed, at risk for, and what is ed, "We always want to make the best for the resident. It's process for the IDT m)." RN #3 stated care plans the because the goal is to the resident. When asked address R63's pain RN # 3 rewing his care plan there was care plan addressed R63's proximately 9:50 a.m., ASM member) #1, administrator al risk consultant, were made	F	656			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495272	B. WING _				C / 16/2023	
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238		1 00/	10/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	FIX (EACH CORRECTIVE ACTION SHOU		3E	(X5) COMPLETION DATE	
F 656	19. For Resident #12	e 87 27 (R127), facility staff failed aprehensive care plan for	F	656				
	bathing. R127 was admitted w	vith diagnoses that included o Alzheimer's disease (1).						
	quarterly assessment reference date) of 06, scored zero out of 15 for mental status), ind severely impaired of decisions. Section G	IDS (minimum data set), a t with an ARD (assessment /30/2023, the resident on the BIMS (brief interview dicating the resident was cognition for making daily "Functional Status" coded tensive assistance of one conal hygiene.						
	for R127 dated Febru day shift (7:00 a.m. to	POC (point of care) sheet pary 2023 had blanks for the possible 3:00 p.m.) on 02/14/2023, 23 and on 02/23/2023.						
	March 2023 had a bla (7:00 a.m. to 3:00 p.n documented "N/A (no	POC sheet for R127 dated ank area for the day shift on n.) on 03/10/2023 and of applicable)" during the day 03/11/2023, 03/19/2023 and						
	06/17/2022 documen and ADL (activities of Performance Deficit. Under "Interventions" "Provide me with sho promote independent washcloth in your har	care plan for R127 dated ted in part, "Focus. I have daily living) Self Care Date Initiated: 06/17/2022." It documented in part, rt, simple instructions to bathing such as: Hold your nd. Put soap on your ur face, etc. date Initiated:						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		ATE SURVEY DMPLETED
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	ROVIDER OR SUPPLIER URY REHABILITATIO	N AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	•	00/10/2020
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 656	conducted with RN coordinator. RN #3 should be reflective informative and a glet staff know what' what the resident is current. RN #3 state we are doing always an ongoing (interdisciplinary te should be implemented have what's best for the conduction of the conduc	p.m., an interview was (registered nurse) #3, MDS 3 stated a resident's care plan e of the resident so it should be cood picture of the resident to s going on, what's needed, s at risk for, and what is ted, "We always want to make the best for the resident. It's process for the IDT am)." RN #3 stated care plans anted because the goal is to or the resident. Approximately 2:26 p.m., an aucted with LPN (licensed After reviewing the POCs for a oral care for the dates listed the that R127 did not receive the state that were blank and coded and of the care plan for R127, the care plan was being g. She stated that the care	F6	,		
	References: (1) A brain disorder	ion was provided prior to exit. that seriously affects a arry out daily activities) This				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUC	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER		STREET ADDR 1776 CAMBR RICHMOND		,	
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F 656	information was obtained from the website:		F 65	6			
F 657	sease.html.	gov/medlineplus/alzheimersdi	F 65	7		9/26/23	
SS=E	CFR(s): 483.21(b)(2)		F 03	1		9/20/23	
	be- (i) Developed within the comprehensive a	prehensive care plan must 7 days after completion of ussessment. terdisciplinary team, that					
	(A) The attending ph(B) A registered nurs resident.						
	(E) To the extent pra the resident and the An explanation must medical record if the and their resident rep not practicable for th resident's care plan. (F) Other appropriate	d and nutrition services staff. cticable, the participation of resident's representative(s). be included in a resident's participation of the resident presentative is determined be development of the e staff or professionals in sined by the resident's needs					
	or as requested by the (iii)Reviewed and reviewed and reviewed and reviewed assessments. This REQUIREMENT by: Based on observation document review and r	ne resident. vised by the interdisciplinary essment, including both the		F657 SS=E	Care Plan Timing and Revisio	on	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER			S.	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	16/2023	
					776 CAMBRIDGE DRIVE			
CANTERE	SURY REHABILITATION	AND HEALTHCARE CENTER			ICHMOND, VA 23238			
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F 657 Continued From page 90		∍ 90	F	657				
		plan for four of 57 residents Residents #95, #86, #358			Resident #95 Resident Comprehensive Care Plan was revised to include the u of Bilateral Side Rails per the physiciar order.	se		
	to review and revise to comprehensive care A review of R95's clir physician's order date (bed rails) to aide in p	plan for bed rails. nical record revealed a ed 10/6/20 for two grab bars positioning and mobility.			Resident #86 Resident Comprehensive Care Plan was revised to include use of external urinary catheter.			
	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				Resident #358 was discharged from th facility on 8/30/23.	e		
	LPN #1 stated the pu give the care the pati				Resident #510 Comprehensive Care P was revised to include current wound c needs / wound vac was discontinued.			
	nurses are responsib anything that pertains care plans should be include bed rails, "Be have to have consent On 8/14/23 at 4:06 p. staff member) #1 (the (the regional risk con director of nursing) w above concern.	rses are responsible for updating care plans for ything that pertains to nursing. LPN #1 stated re plans should be reviewed and revised to clude bed rails, "Because they [the residents] we to have consent for bed rails." 18/14/23 at 4:06 p.m., ASM (administrative aff member) #1 (the administrator), ASM #4 e regional risk consultant) and ASM #7 (the ector of nursing) were made aware of the ove concern. 18 facility policy titled, "Care Plans,			Current residents who utilize bedrails, of an external urinary catheter, develop pressure injuries and utilize a wound we 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 so Care Plan reflects the upof bedrails. An audit was accomplished the Unit Manager/Designee on current residents who utilize external catheters was completed to validate the resident	ac y te se I by		
	Comprehensive Pers	on-Centered" documented,			Care Plan reflects the use of an extern	al		

		` ′		' '	(X3) DATE SURVEY COMPLETED	
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Continued From pag	ge 91	F 6	57			
care plans are revise	ed as information about the		the Unit Manager/Designee on with current wound care to valid	residents date		
to review and revise comprehensive care	the resident's plan for the use of an		has been accomplished to refle current residents□ need to inclu	ect the ude use of		
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.			provided re-education for the Li Nursing staff on the Care Plan Revision of the Care Plan with the resident care needs to inclu rails, catheter usage, and woun	icensed Timing and changes in ude side nd care to		
			The DON/Designee will completed of 3 residents who utilize side revalidate the resident and the use of bedrails. Audit will al 3 residents who utilize external to validate the resident action addition, an audit of 3 residents current wound care orders will accompleted to validate revision of Comprehensive Care Plan has accomplished to reflect the curresidents need to include use vac as indicated. Variances will addressed. These audits will be conducted weekly x 4 weeks, the	ete an audit ails to lan reflects so include catheters Plan catheter. In s with be of the been rent of wound I be		
	ROVIDER OR SUPPLIER BURY REHABILITATION SUMMARY S (EACH DEFICIENT REGULATORY OR PROGULATORY OR	ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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.	ROVIDER OR SUPPLIER BURY REHABILITATION AND HEALTHCARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 7:50 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	ROVIDER OR SUPPLIER SURY REHABILITATION AND HEALTHCARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH OFFICIENCY MUST BE PRECEDED BY PULL (REACH ORRECTIVE ACTIONS A REGULATORY OR LSC IDENTIFYING INFORMATION)) Continued From page 91 "11. Assessments of residents are ongoing and care plans are revised as information about the residents and the resident's 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 8/17/23 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. 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 to let staff know what's poing on, what's needed, what the resident is at risk for, and what is current. RN #3 stated, are plans should be reflective of 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	A BUILDING 495272 8. WIND STREET ADDRESS, CITY, STATE, 2P CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238 SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST ER PRECEDED BY PULL REGULATORY OR I.Sc. IDENTIFYING INFORMATION) 17.1. 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 87/1/23 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. On 8/10/23 at 12:37 p.m., an interview was conducted with RN (registered nurse) #3. 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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495272	B. WING _			1	C 1 6/2023
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER		17	TREET ADDRESS, CITY, STATE, ZIP CODE 76 CAMBRIDGE DRIVE ICHMOND, VA 23238	1 00	10/2020
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOUL			(X5) COMPLETION DATE
F 657	57 Continued From page 92		F	657			
		plan when the resident njuries on 2/21/23, 3/28/23			DON/Designee to the QAPI Committee for review and recommendation month for 3 months or ongoing until compliant sustained.	ly	
	checks and wound re resident developed progression 3/28/23 and 4/26/23. comprehensive care preveal the care plan version of the care plan version	nical record revealed skin ports that documented the ressure injuries on 2/21/23, A review of R358's blan dated 1/2/23 failed to was reviewed and revised for that developed on 2/21/23,					
	LPN #1 stated the pu give the care the patie their care." LPN #1 s nurses are responsible anything that pertains	licensed practical nurse) #1. rpose of the care plan is, "To ent needs; to personalize tated the unit managers and le for updating care plans for to nursing. LPN #1 stated reviewed and revised when					
	staff member) #1 (the (the regional risk considerator of nursing) we above concern. 4. For Resident #510	m., ASM (administrative administrator), ASM #4 sultant) and ASM #7 (the ere made aware of the the facility failed to revise are plan to include the use of					
	Resident #510 was of place on 8/7/23 at 12	bserved in with wound vac in :00 PM.					
	12/30/22 and revised	rehensive care plan dated 8/1/23, revealed, "FOCUS: ure ulcer or has the potential velopment related to					

i i i i i i i i i i i i i i i i i i i		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
		495272	B. WING _			C 08/16/2023		
	ROVIDER OR SUPPLIER BURY REHABILITATION	AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	· · · · · ·	00/10/2020		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
F 657	immobility. INTERVI treatments as ordere effectiveness. Offlo tolerated using: (pille during care to ensur Report loose dressir reminding/assistance every 2 hours, more requested. Keep re moisturized as need bony prominences a peri-care and bathin A review of the phys revealed, "SACRUM solution. Apply black vac dressing to wou (millimeters of merc suction may apply D	ENTIONS: Administer ed and monitor for ad my heels when in bed as ows). Monitor wound dressing re it is intact and adhering. Ing to nurse. Resident need e to turn/reposition at least often as needed or sident's skin clean and led. Do not massage over and use mild cleansers for	F 6	57				
	asked the purpose of stated, it is to define When asked if the win the care plan, RN On 8/10/23 at 1:57 pconducted with RN acare plan should be should be informative resident to let staff keneeded, what the resis current. RN #3 stanke sure we are desident to the staff keneeded and the staff kenee	M, an interview was (registered nurse) #1. When of the care plan, RN #1 the care for the patient. Yound vac should be included #1 stated, yes, it should. D.m., an interview was #3. RN #3 stated a resident's reflective of the resident so it the and a good picture of the know what's going on, what's sident is at risk for, and what ated, we always want to oning the best for the IDT						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495272	B. WING _			C 08/16/2023
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER	•	STREET ADDRESS, CITY, STATE, 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	ZIP CODE	33.10.222
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	X (EACH CORRECTIVE CROSS-REFERENCED	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 657	should be implemented have what's best for the regional risk consultanursing and ASM #8, made aware of the firm. A review of the facility Plan" policy, reveals, reviews and updates has been a significant condition; b. when the met; c. when the residual the facility from a hos quarterly, in conjuncting quarterly MDS assess. No further information. Reference: (1) Vacuum-assisted alternative method of uses the negative prefor spontaneous healing reconstructive options includes thorough del haemostasis and appedressing. A fenestrate foam and wound is seen make it air tight. The story a vacuum pump with the machine delivers suction, ranging from	a). RN #3 stated care plans and because the goal is to the resident. M, ASM (administrative staff inistrator, ASM #4, the nt, ASM #7, the director of the regional consultant was dings. I's "Comprehensive Care "The interdisciplinary team the care plan: a. when there is change in the resident's a desired outcome is not dent has been readmitted to pital stay; and d. at least on with the required sment." I was provided prior to exit. Closure (VAC) is an wound management, which ssure to prepare the wounding or by lesser as Method of VAC application or idement, adequate lication of sterile foams and tube is embedded in the caled with adhesive tape to fenestrate tube is connected the fluid collection container. Continuous or intermittent	F	657		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		495272	B. WING _			l	16/2023	
	ROVIDER OR SUPPLIER	I AND HEALTHCARE CENTER		17	REET ADDRESS, CITY, STATE, ZIP CODE 76 CAMBRIDGE DRIVE CHMOND, VA 23238	<u>, 00,</u>	10/2020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFII TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 658 F 658 SS=D		Meet Professional Standards		658 658			9/26/23	
					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.			
	The physician order documented, ""Nove Solution Pen Injecto (Insulin Regular Hu scale: if 0 - 150 = 0	me ssi (sliding scale insulin). s dated 3/24/2023 blin R (regular) Flex Pen or 100 UNIT/ML (milliliters) man) inject as per sliding units; 151 - 199 = 2 units; 200 - 299 = 6 units; 300 - 349 = 8			Resident #11 s clinical provider was made aware of cited occurrence, orders were reviewed and clarified with medication on hand to reflect ordered dose.	S		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		L ADENTIFICATION NUMBER		E) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		495272	B. WING _			C 08/16/2023		
NAME OF PI	ROVIDER OR SUPPLIER	L	<u> </u>	STF	REET ADDRESS, CITY, STATE, ZIP CODE	1 00/	10/2023	
				177	76 CAMBRIDGE DRIVE			
CANTERB	URY REHABILITATION	AND HEALTHCARE CENTER			CHMOND, VA 23238			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 658	Continued From page	e 96	F 6	658				
		units; 400+ CALL MD						
		R ORDERS; subcutaneously						
	before meals for diab	_			RN #2 was re-educated by the			
					DON/Designee on Services Provided to	o		
		edication administration			Meet Professional Standards □ To incl			
	•	the above two orders. On			administration of medication per physic			
		00 p.m.) it was documented			orders, communication to the physician	1		
	the blood sugar was documented in the bo			when clarification is required. The 6				
	insulin administered			RIGHTS of medication administration. Right resident, right medication, right				
	modili administred	was to be documented.			dosage, right time, right route, and righ	ıt		
	The August MAR doo	cumented the above two			order.	-		
	_	ving dates at 1600 (4:00						
	p.m.) the following wa	as documented:						
		sugar) was documented as						
		cumented in the box where			Current residents who receive			
		ulin administered was to be			medications have the potential to be			
	documented.	da a			affected by this practice. An audit was			
		documented as 445. An "11" he box where the amount of			completed of residents who have order for sliding scale insulin was accomplish			
		red was to be documented.			by the Unit Managers to validate	ieu		
		documented as 425. An "11"			notification to the physician was made	and		
		he box where the amount of			documentation is in place to support			
	the insulin administer	red was to be documented.			amount of insulin given in the medical			
	8/8/2023 - BS - was o	documented as 478. A "3"			record. Variances were addressed.			
		he box where the amount of						
	the insulin administer	red was to be documented.						
	The chart codes on the	ne MAR documented the			An audit was completed for residents of	n		
	following:				Lokelma single dose packs to validate			
	11 = Vitals Outside of				order clarification obtained as needed			
	3 = Absent from facili	ity.			that the correct dosage is on hand and administered. Variances were addresse			
		s notes failed to evidence				ĺ		
	_	elated to the resident's blood				ĺ		
		tact made with the doctor,			TI 0. "D	ĺ		
	per the physician ord	ers.			The Staff Development	ĺ		
	The comprehensive	care plan dated, 3/4/2023,			Coordinator/Designee will re-educate Licensed Nursing staff on Services			
	THE COMPLEMENSIVE (baro pian ual c u, 3/4/2023,			LICENSEU MUISING STAIL ON SELVICES			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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		495272	B. WING			08/	16/2023
NAME OF PR	ROVIDER OR SUPPLIER			S ⁻	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
			1776 CAMBRIDGE DRIVE				
CANTERB	URY REHABILITATION A	AND HEALTHCARE CENTER		R	ICHMOND, VA 23238		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG	•	REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFEREN		(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE	
F 658	Continued From page	97	F	658			
	documented in part. "	Focus: I have Diabetes			Provided Meet Professional Standards		
	· ·	of the interventions failed to			the RIGHTS of medication administration		
	evidence any docume	entation related to the			the administration of medication/insulin		
	administration of insu				per the physician order, documentation	to	
					support your administration amount,		
	An interview was con-	ducted with LPN (licensed			physician notification when medications	5	
		ne nurse that documented			are outside of parameters as directed a		
		ı, on 8/9/2023 at 3:09 p.m.			obtaining order clarification as needed	to	
		as reviewed with LPN #9,			validate the correct dose is given.		
		t the "11" stood for, LPN #9					
	stated that the blood	_					
	-	was asked if she gave the					
		2/2023, LPN #9 stated she It 10 units. When asked if					
	~	an, LPN #9 stated she had			The DON/Designee will accomplish an		
		sician. LPN #9 was asked if			audit of 3 residents who have orders fo	r	
	she administered insu				sliding scale insulin to validate notificat		
		, LPN #9 stated she gave			to the physician was made when result		
	· ·	that day. When asked if she			were outside of parameters and		
		stated, no. LPN #9 was			documentation is in place to support		
	asked if the resident v	was out of the facility on			amount of insulin given in the medical		
	8/8/2023 at 4:00 p.m.	, LPN #9 stated, no, she			record. Variances were addressed. In		
		wrong button. LPN #9 was			addition, an audit will be completed for		
		ılin she gave the resident,			residents on Lokelma single dose pack		
		units and no, she didn't call			to validate order clarification obtained a		
		ked if she was following the			needed and that the correct dosage is		
	· ·	N #9 stated no. LPN #9 was			hand and administered. Variances will	pe	
		wed to give medications			addressed. These audits will be		
	without a physician of	rder, LPN #9 stated, no.			conducted weekly x 4 weeks, then monthly x 2 months. The findings of the	<u>.</u>	
	The facility policy, "In	sulin Administration"			audits will be submitted by the		
		Steps in the procedure			DON/Designee to the QAPI Committee	:	
		Syringe): 2. Check blood			for review and recommendation month		
		order or facility protocol8.			for 3 months or ongoing until compliand		
	Check the order for the	ne amount of insulin12.			sustained.		
	Double check the ord	er for the amount of					
	-	k that the amount of insulin					
		e matches the amount of					
	insulin orderedDocu	ımentation: 2. The dose and					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRU	(X3) DATE SURVEY COMPLETED			
		495272	B. WING_			C 08/16/2023		
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER		1776 CAMB	DRESS, CITY, STATE, ZIP CODE BRIDGE DRIVE ID, VA 23238	1 00/	16/2023	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG			3E	(X5) COMPLETION DATE	
F 658	concentration of the in The facility policy, "M Orders" documented be administered only person duly licensed such medications in t ASM (administrative s administrator, ASM # consultant, and ASM consultant, were mad on 8/9/2023 at 5:30 p No further information 2. For Resident #11 to verify the dosage of Zirconium Cyclosilica administration on 8/8, On 8/8/2023 at 8:35 a made of RN (register medications at the fac preparing medication scheduled medication including a single dos "Lokelma 10 gm (grat dissolving the entire p water and administer Review of the physici documented in part, " Cyclosilicate Oral Pac Zirconium Cyclosilica one time a day for hy 05/01/2023."	ediation and Treatment in part, "1. Medications shall upon the written order of a and authorized to prescribe his state. Staff member) #1, the 4, the regional risk #6, the clinical care le aware of the above finding .m. In was provided prior to exit. (R11), the facility staff failed of Lokelma (Sodium te) (1) prior to the (2023. I.a.m., an observation was eed nurse) #2 administering cility. RN #2 was observed as for R11. RN #2 prepared as to administer to R11 sing packed labeled m)" which she was observed packet contents into a cup of ing to the resident. In was provided prior to exit. In was	F	558				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495272	B. WING _			08/	C 16/2023		
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	ODE	, 00.			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
F 658	one time a day for hy 05/02/2023 0900 (9:0 documented RN #2 a scheduled for 9:00 a. On 8/8/2023 at 10:55 conducted with RN # medication administrative they had the comedication, correct documedication, correct documedication, correct documedication, correct documedication, correct documedication, correct documedication, correct documedication correct documedication cart and schecked the physicial Sodium Zirconium Cythe 10 GM packets of medication cart and schecked the dosage was supposed to get 10 GM. The facility policy "Accepted April 2019, doindividual administering the label THREE (3) resident, right medication on 8/8/2023 at approximation of 8/8/2023 at approximation	Is 8/1/2023-8/31/2023 Sodium Zirconium cket 5 GM (Sodium te) Give 1 packet by mouth perkalemia -Start Date- 00 a.m.)." The eMAR administered the medication m. on 8/8/2023. Is a.m., an interview was 2. RN #2 stated that prior to ation they checked to make rect person, correct cosage, correct time, correct cumentation. RN #2 an order for the 5 GM of colosilicate Oral Packet and of the medications on the stated that they should have closer because the resident 5 GM and they had received Iministering Medications" coumented in part, "The ing the medication checks times to verify the right ation, right dosage, right time atte, of administration before"	F	658					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER	1	STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	00/10/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE.
F 658	hyperkalemia (high le blood). Sodium zircor for emergency treatm	cyclosilicate is used to treat vels of potassium in the nium cyclosilicate is not used ent of life-threatening	F 658		
F 677	work. Sodium zirconiu of medications called agents. It works by re from the body. This ir from the website: https://medlineplus.go tml	e it takes some time to um cyclosilicate is in a class potassium removing moving excess potassium uformation was obtained ov/druginfo/meds/a618035.h or Dependent Residents	F 677		9/26/23
SS=E	S483.24(a)(2) A reside out activities of daily I services to maintain opersonal and oral hydris REQUIREMENT by: Based on observation interview, staff interviand clinical record revito provide ADL (activity seven of 57 residents Residents #74, #48, #127. The findings include: 1. For Resident #74 (ent who is unable to carry iving receives the necessary good nutrition, grooming, and		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.	
	On the most recent M	IDS (minimum data set), an		Resident # 48 was reviewed with no adverse effects related to cited	

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NAME OF PI	ROVIDER OR SUPPLIER		,		TREET ADDRESS, CITY, STATE, ZIP CODE			
CANTERE	URY REHABILITATION	AND HEALTHCARE CENTER			776 CAMBRIDGE DRIVE ICHMOND, VA 23238			
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE		
F 677	Continued From page	e 101	F	677				
	annual assessment was reference date of 6/2 having no cognitive in decisions, having scouling blmS (brief interview)	vith an ARD (assessment 3/23), R74 was coded as npairment for making daily red 15 out of 15 on the for mental status). He was			occurrence, incontinence care provided per care plan and resident dressed as indicated to maintain dignity.	d		
	wo staff members for toileting. He was coded as being always incontinent of both bowel and bladder.				C N A # 10 and C N A staff members identified as sitting at the desk on 8/7/2 were provided with re-education on AD Care Provided for Dependent Resident	L s		
	R74's room. CNA (ce opened the door from the two residents in the stated: "I'm going to come the two residents in the stated."	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			in a timely manner, and use of cell pho while at work by the by the Staff Development Coordinator/Designee.	nes		
	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				Resident # 5 was reviewed with no adverse effects related to cited occurrence. Resident #5 was evaluated by therapy for positioning and enhance utensils as indicated with meals. Resid #5 care plan was also updated to reflect schedule for resident to get out of bed.	to cited #5 was evaluated ng and enhanced ith meals. Resident updated to reflect a		
	"change of shift," and have to come in and "No one has still com changed." He stated:	t off, and told him it was that someone else would change him later. He stated: e back in. I really need to be "It certainly does not feel wn man and need my pants			LPN #6 was re-educated by the Staff Development Coordinator/Designee or ADL Care Provided for Dependent Residents, Meeting the resident needs and evaluation and positioning of the resident during meals.			
	were observed stand unit. Two of the sever on their cell phones.	n., seven staff members ing at the desk for R74's n were tapping and scrolling n., CNA #10 began preparing			Resident #118 was provided with a shower. The shower/Bath schedule wareviewed and implemented to meet the resident preference with documentation	!		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495272	B. WING _			C 08/16/2023		
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	10/2023	
TO THE OT THE	TO VIDER OR GOLF EIER				776 CAMBRIDGE DRIVE			
CANTERB	URY REHABILITATION	AND HEALTHCARE CENTER						
				R	ICHMOND, VA 23238			
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F 677	Continued From page	e 102	F 6	677				
	R74 to have his incor	ntinence brief changed.			place.			
	(related to) physical lincontinence care an neededcheck residences and provide income.	ave urinary incontinence r/t imitationsprovide d apply moisture barrier as ent approximately every 2 continence care as needed."		C N A staff members noted to have documented care on the dates out the citation were re-educated on the provision of care and documentation required to support the care provid include Charge Nurse notification were to have a support the care provides the care prov				
	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.				documentation to support the refusal is applicable.	3		
	Then I did [Resident stated she was aware R74's room and cut harrived for duty. She	48]. Then I did [R74]." She e that another CNA had been his call light off before she stated: "We usually have hole unit. That day, we had			Resident #361 was discharged from th facility on 2/6/23.	e		
	five. I'm not sure why usually ask for help fr "it's just not there." Sl	." She stated she does not rom other CNAs because he stated she does not nurse for help because			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			
	interviewed. She stat too many residents n time, I will ask for hel	at 3:26 p.m., CNA # 5 was She stated: "We have teamwork. If sidents need something at the same sk for help." applicable.		applicable. Resident #358 was discharged from th				
	nurse) # 7 was interv maximum wait time for brief change is "five to She stated she would	he were asked, and if she			facility on 8/30/23. Resident #127 was discharged from th facility on 8/17/23.	e		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER		<u>'</u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE	, 00,	10/2020	
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CANTERE	OURT REHABILITATION A	AND HEALTHCARE CENTER		R	CICHMOND, VA 23238			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE				
F 677	aware of three reside	nts. m., LPN #10, a unit wed. She stated if she were nts who needed	F 6	677	C N A staff members noted to have not documented Shower/Bath and oral car on the dates outlined in the citation we re-educated on the provision of care ar	e re		
	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."				documentation required to support the care provided to include Charge Nurse notification with documentation to supp the refusal is applicable. Residents who receive ADL care have	ort		
	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 hygieneAppropriate care and services will be provided for residents who are unable to carry out ADLs independentlyin accordance with the plan of care, including appropriate support and assistance withhygiene (bathing, dressing, grooming, and oral care),mobility (transfer and ambulation, including walking)diningand communication."				potential to be affected by this practice The Unit Manager/Designee will compl rounds and an audit of documentation validate that residents who require ADL care including but not limited to incontinence care, mouth care, shower repositioning, set up for meals are provided timely per care plan. Variance will be addressed. The Staff Development Coordinator/Designee will complete re-education for the Licensed Nursing a C N A staff members on ADL Care Provided for Dependent Residents, the completion of the care, the documentation care provided and the Charge Nurse role in monitoring documentation and contents.	ete to - s, es		
	No further information	n was provided prior to exit.			provided.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		495272	B. WING			C 08/16/2023		
NAME OF D	DOVIDED OD CUDDUED	433212	D: WillO	STREET ADDRESS, CITY, STATE, ZIP CO		6/2023		
NAME OF P	ROVIDER OR SUPPLIER			1776 CAMBRIDGE DRIVE	DDE			
CANTERE	BURY REHABILITATIO	ON AND HEALTHCARE CENTER		RICHMOND, VA 23238				
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F 677	Continued From p	age 104	F 6	677				
	2. For Resident #4 to provide incontin on 8/7/23.	18 (R48), the facility staff failed ence care in a timely manner at MDS (minimum data set), an		The DON/Designee will aud Dependent Residents via ro documentation to validate the who require ADL care included limited to incontinence care.	unds and nat residents ling but not			
	annual assessment with an ARD (assessment reference date) of 6/9/23, R48 was coded as being cognitively intact for making daily decisions,			showers, repositioning, set are provided with services to plan. Variances will be addressed to the services to the services to the services with the services will be addressed to the services with the services with the services are services.	mely per care			
	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			audits will be conducted we weeks, then monthly x 2 monthly sides findings of the audits will be	onths. The submitted by			
	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.			the Administrator/Designee Committee for review and recommendation monthly fo ongoing until compliance su	r 3 months or			
	R48's room. CNA opened the door from the two residents is stated: "I'm going is resident standing to the bathroom door wheelchair, and the door to the hall shirt and incontine odor of feces surrollong he had been stated: "It burns do incontinence brief]							
	were observed sta	p.m., seven staff members inding at the desk for R48's iven were tapping and scrolling is.						
		p.m., CNA #10 began preparing continence brief changed.						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		495272	B. WING			08/16/2023		
	ROVIDER OR SUPPLIER URY REHABILITATION	I AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238		10/2023		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 677	revealed, in part: "I	are plan dated 6/12/23 have urinary incontinence r/t	F 6	77				
	incontinence care approximately every incontinence care a incontinence r/t (rela	limitationsProvide as neededCheck resident / 2 hours and provide s neededI have bowel ated to) physical de incontinence careas						
	When asked about and how she handle simultaneously need changes, she stated would be quick in the Then I did [R48]." SR48 had been incorneeded to be changiust changed him, a again. I needed to stated: "We usually whole unit. That day why." She stated shelp from other CNA there." She stated sak a nurse for help busy passing meds							
	too many residents time, I will ask for he On 8/14/23 at 11:59 nurse) # 7 was inter maximum wait time	ated: "We have teamwork. If need something at the same						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION IG	(XS	(X3) DATE SURVEY COMPLETED		
		495272	B. WING _			C 08/16/2023		
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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	(EACH CORRECTIVE ACTION SI	VIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD BE EFERENCED TO THE APPROPRIATE DEFICIENCY)			
F 677	She stated she would help a CNA with		F 6	77				
	incontinence care if s were not in the middle medications to reside							
	aware of three reside incontinence care at the would get to the most and third one would his possible, I would ask anyone was available shift change does not responsibility to meet "If it was me, I would than 10 minutes to be On 8/14/23 at 4:01 p. staff member) #1, the regional risk consulta	ewed. She stated if she were ints who needed the same time, she stated: "I dire one first. The second have to wait." She added: "If somebody to help me, if e." She stated the time of alter the facility's resident needs. She stated: not want to wait any more e changed." m., ASM (administrative administrator, ASM #4, the int, ASM #8, the regional #7, the director of nursing,						
	No further information 3. For Resident #5 (Rassess for and provident)	n was provided prior to exit. 25), the facility staff failed to le appropriate services for get her out of bed on 8/7/23,						
	On the most recent M quarterly assessment reference date) of 7/2 being moderately cog daily decisions. She wextensive assistance transfers from bed to	IDS (minimum data set), a with an ARD (assessment 2/2/3, R5 was coded as initively impaired for making was coded as requiring the of two staff members for chair, and as requiring the erson (physical assistance)						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		I ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER	,	STREET ADDRESS, CITY, STATE, Z 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	IP CODE	00,10		
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F 677	bed with the head of attempting to feed he tray, which was on the overbed table was por R5 was positioned so level of the plate on the contained chopped in was attempting to fee fingers. Some of the resident's mouth; how landing on the residentinens, and floor. On 8/8/23 at 7:55 a.m. nurse) #6, a unit many breakfast tray, and placross R5's bed. R5 same position as she lunch observation. Lifter position the resident breakfast tray, included oatmeal, jelly on the at 7:598 a.m., R5 attemption at the form of the electron of R5's care revealed, in part: "Fee A review of R5's weig significant weight loss."	the bed elevated. R5 was erself food from her lunch be overbed table. The ositioned across R5's bed. To that her nose was at the he lunch tray. R5's plate heat and vegetables. She ed herself using only her food was going into the wever, most of the food was nt's face, clothing, bed In., LPN (licensed practical hager, delivered R5's ositioned the overbed table was in approximately the had been on 8/7/23 at the PN #6 made no attempt to ht. LPN #6 set up the ing putting sugar on the toast, and opening the milk. The engret unsuccessfully to herself eggs. She put the fork empting to eat the eggs with the eggs went into her togs landed on her clothing, oor. The plan dated 12/15 20 eds herself after tray set up." The plan dated no evidence of is in the past six months.	F	577				
	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) MULT A. BUILDI	TIPLE CONSTRUCTIONG	N	(X3) DATE SURVEY COMPLETED		
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F 677	Continued From page	e 108	F	677				
	"When I take care of work with her as part She stated R5 is not On 8/14/23 at 10:38 a member) #14, an occ was interviewed. She R5 eating before. She oatmeal cream pie. I it for her. She tried to lot of it feel on her go food all over her. I do feed herself a comple (occupational therapy there is the ability to teach. Sometimes the helplessness." She shas the ability to carr	a.m., OSM (other staff supational therapy assistant, e stated she has observed e stated: "She asked for an got one for her and opened bring it to her mouth, but a wn." She stated: "I notice in't know how she's able to set meal." She stated OT y) addresses concerns "if carry over the skills that we ere is a learned tated she did not believe R5 y over the skills that OT the resident might benefit						
	On 8/14/23 at 11:25 a of rehab, an occupati interviewed. She stat OT screenings on all She stated: "These a what we can see on a stated if the therapist staff interviews identi evaluation would be was last screened, evaluated or treated stated the most receivaluation had been was documented as feeding. She added:	a.m., OSM #12, the director onal therapist, was ed her staff does periodic long term care residents. re only screenings, only a quick observation." She observes a concern of if fy a concern, then a full OT performed. She stated R5 valuated, and treated from 23. She stated R5 was not for eating/self-feeding. She						

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	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER		177	EET ADDRESS, CITY, STATE, ZIP CODE 6 CAMBRIDGE DRIVE CHMOND, VA 23238	1 00	10/2020		
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F 677	mouth with no physic stated: "If the resider warrants an evaluation overshooting, we can adaptive eating devict dignified way for her. On 8/14/23 at 1:20 printerviewed. She state efforts to feed herselion her positioning. So can try adaptive equification in the physical assistance of the state of the s	the utensils, bring hand to cal assistance, and eat. She at is missing the mouth, it can. She stated: "If she is a evaluate for a possible ce." She added: "That is not a to eat." .m., OSM #12 was ted she had observed R5's f. "We definitely need to work the has tremors as well. We pment. At the end of the day, issue. She is going to need the nand to mouth." .m., ASM (administrative the administrator, ASM #4, the end, ASM #8, the regional #7, the director of nursing, see concerns. In was provided prior to exit. If dates and times, R5 was or sitting up in bed: 8/7/23 at p.m.; 8/8/23 at 7:55 a.m. and 10:20 a.m. and 4:13 p.m. At wheelchair was observed at int's bed.	F	677					
		cal record revealed no d refused attempts to get her							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238		33,13,2323	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 677	using mechanical lift. On 8/10/23 at 2:19 p. nurse) #7 was intervieresidents should be gif possible." She state the CNA (certified nur a resident refuses, the and the nurse should record. On 8/14/23 at 9:16 a. interviewed. She state by herself. She is a total added: "There is no resident resident when she makes sure the resident stated sometimes the is the case, she report on 8/14/23 at 10:38 a member) #14, was in required a mechanicated did not know of any resident of bed unless she reform the staff member) #1, the	plan dated 10/16/20 ave an ADL self care t (related to) limited berson assist with transfers m., LPN (licensed practical ewed. She stated that otten out of bed "every day, ed this task is delegated to rsing assistant). She stated if e CNA should tell the nurse, document this in the clinical m., CNA #11 was ed: "[R5] can't get out of bed otal assist times two." She eason she is not getting up." takes care of her, she ent gets out of bed. She e resident refuses, and if that tts it to the nurse. a.m., OSM (other staff terviewed. She stated R5 al lift for transferring, but she eason R5 could not get out	F6	·			
	consultant, and ASM were informed of thes	#7, the director of nursing,					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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F 677	Continued From page	e 111	F	577				
	failed to provide evide	(R118), the facility staff ence that baths or showers Itiple dates in June and July						
	significant change as (assessment reference coded as being sever making daily decision 15 on the BIMS (brief He was coded as bei	MDS (minimum data set), a sessment with an ARD ce date) of 6/9/23, R118 was rely cognitively impaired for as, having scored two out of finterview for mental status). In a completely dependent on staff members for bathing.						
	and July 2023 reveals documentation) for decare) on the following 6/19 through 6/21, 6/2 through 7/7, 7/7 through 7/21, 7/24, 7/2 review also revealed bath/shower on the fo	ay shift bathing (morning g dates: 6/1 through 6/16, 23, 6/26 through 6/30; 7/2 agh 7/11, 7/13, 7/14, 7/16 //25, 7/27. and 7/28. The blanks for R5's scheduled bllowing dates: 6/2, 6/6, 6/9, 6, 6/27, 7/4, 7/7, 7/11, 7/14,						
	A review of R118's ca to reveal any informa dependent on staff fo	<u> </u>						
	assistant) #5 was into she provides evidence resident morning care stated: "I chart in the record portion to whice	m., CNA (certified nursing erviewed. When ask how se that she has given a e or a bath/shower, she ADLs [electronic medical ch CNAs have access]." She all aspects of ADL care,						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	ULTIPLE CONSTRUCTION LDING			(X3) DATE SURVEY COMPLETED	
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F 677	Continued From pag		F	677				
	nurse) #10, a unit ma When asked how a 0	.m., LPN (licensed practical anager, was interviewed. CNA evidences care they stated: "They sign it off on ecord] kiosk."						
	staff member) #1, the regional risk consulta	.m., ASM (administrative e administrator, ASM #4, the ant, ASM #8, the regional l #7, the director of nursing, se concerns.						
	5. For Resident #36 ² failed to provide mou	n was provided prior to exit. I (R361), the facility staff Ith care, and turning and le shifts in January 2023.						
	admission assessment reference date) of 1/15 on the BIMS (bries indicating the resident impaired for making coded the resident at one staff with person	MDS (minimum data set), an ent with an ARD (assessment 31/23, R361 scored 0 out of if interview for mental status), not was severely cognitively daily decisions. Section G is being totally dependent on the lally dependent on two or mobility.						
	records and nurse's to reveal evidence the hygiene, including m positioning on 1/26/2 1/27/23 during the day shift and 1/31/23	DL (activities of daily living) notes for January 2023 failed nat staff provided personal outh care, and turning and 3 during the evening shift, ay shift, 1/30/23 during the during the evening shiftm., an interview was						
	On 8/10/23 at 3:25 p	during the evening shift. .m., an interview was (certified nursing assistant)						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	ZIP CODE			
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F 677	CNA #5 stated resides should be turned and and mouth care show before bedtime. CNA turns and positions recare, they should do records. On 8/14/23 at 2:11 p conducted with CNA should be turned and and mouth care show shift every day. CNA evidenced in the poir (ADL records). On 8/14/23 at 4:06 p staff member) #1 (the (the regional risk condirector of nursing) was above concern. 6. For Resident #358 failed to provide turn multiple shifts in June On the most recent Multiple shifts in June Condirector of the BIMS (bried indicating the resider impaired for making coded the resident and the should be turned and the shifts in June Conditions and the shifts in June Conditions are shown as a should be turned and the shifts in June Conditions are shown as a shift and the shifts in June Conditions are shown as a shift and the shifts in June Conditions are shown as a shift and the shifts in June Conditions are shown as a shift and the shifts in June Conditions are shown as a shift and the shifts in June Conditions are shown as a shift and the shifts in June Conditions are shown as a shift and the shifts in June Conditions are shown as a shift and the shifts in June Conditions are shown as a shift and the shifts in June Conditions are shown as a shift and the shifts in June Conditions are shown as a shift and the shifts in June Conditions are shown as a shift and the shifts in June Conditions are shown as a shift and the shifts in June Conditions are shown as a shift and the shifts in June Conditions are shown as a shift and the shifts in June Conditions are shown as a shift and the shifts in June Conditions are shown as a shift and the shifts in June Conditions are shown as a shift and the shifts are shifts as a shift and the shifts ar	who worked evening shift. ents who need assistance d positioned every two hours, ald be provided every night A #5 stated that when staff esidents and provides mouth cument this in the ADL .m., an interview was #9. CNA #9 stated residents d positioned every two hours, ald be provided during each A #9 stated this care is not of care computer system .m., ASM (administrative e administrator), ASM #4 asultant) and ASM #7 (the evere made aware of the B (R358), the facility staff ing and positioning on e 2023. MDS (minimum data set), a at with an ARD (assessment 10/23, R358 scored 0 out of f interview for mental status), at was severely cognitively daily decisions. Section G s being totally dependent on all hygiene, including mouth	F	577				
	On 8/7/23 at 12:24 p	.m., an interview was						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULT IDENTIFICATION NUMBER: A. BUILDI		IULTIPLE CONSTRUCTION LDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER		177	REET ADDRESS, CITY, STATE, ZIP CODE 6 CAMBRIDGE DRIVE CHMOND, VA 23238	1 00/	10/2023	
(X4) ID PREFIX TAG	(EACH DEFICIENC	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SH		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE		
F 677	family member voice was not being turned. A review of R358's A records and nurse's a reveal evidence that positioning on 6/3/23 6/12/23 during the day evening shift, and 6/2 On 8/10/23 at 3:25 p conducted with CNA #5. CNA #5 stated reassistance should be two hours, and when residents, they shoul records. On 8/14/23 at 2:11 p conducted with CNA should be turned and and this care is evided computer system (All On 8/14/23 at 4:06 p staff member) #1 (the (the regional risk condirector of nursing) wabove concern. 7. For Resident #12 failed to provide show R127 was admitted with the regional risk condirector of nursing) was a staff member had a staff mem	d's family member. The d'concern that the resident and positioned. DL (activities of daily living) notes for June 2023 failed to staff provided turning and during the evening shift, ay shift, 6/17/23 during the 18/23 during the day shift. .m., an interview was (certified nursing assistant) esidents who need turned and positioned every staff turns and positions d document this in the ADL .m., an interview was #9. CNA #9 stated residents to positioned every two hours enced in the point of care	F	677				
	quarterly assessmen	MDS (minimum data set), a t with an ARD (assessment /30/2023, the resident						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
	495272	B. WING			C 08/16/2023	
NAME OF PROVIDER OR SUPPLIER CANTERBURY REHABILITATION AN	ND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	DE	, 00.	
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
for mental status), indices severely impaired of condecisions. Section G "R127 as requiring extestaff member for personal mouth/denture care" Personal mouth/dent	on the BIMS (brief interview cating the resident was ognition for making daily Functional Status" coded ensive assistance of one anal hygiene. OC (point of care) sheet ary 2023 revealed blanks ring the day shift on (7:00 12/14/2023, 02/15/2023, 123/2023. OC sheet for R127 dated a blank during the day shift on) on 03/10/2023 and applicable)" during the day 3/11/2023, 03/19/2023 and applicable) during the day 3/11/2023, 03/19/2023 and applicable of care) sheet y 2023 revealed blanks (7:00 a.m. to 3:00 p.m.) on 3, 01/21/2023 and on mented "N/A (not day shift on 01/11/2023. I hygiene including OC (point of care) sheet ary 2023 revealed blanks (7:00 a.m. to 3:00 p.m.) on 3, 01/21/2023 and on mented "N/A (not day shift on 02/01/2023, 3, 02/04/2023, 02/05/2023, 3, 02/08/2023, 02/09/2023, 3, 02/08/2023, 02/09/2023, 3, 02/08/2023, 02/09/2023, 3, 02/08/2023, 02/09/2023, 3	F6				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495272	B. WING _				C 16/2023	
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER		1776	ET ADDRESS, CITY, STATE, ZIP CODE CAMBRIDGE DRIVE IMOND, VA 23238	<u>, oo.</u>	10/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 677	evening shift on 02/1002/19/2023, 02/20/20 The comprehensive 06/17/2022 document and ADL (activities of	ot applicable)" during the	Fé	377				
	"Provide me with sho promote independent washcloth in your hai	' it documented in part, rt, simple instructions to t bathing such as: Hold your nd. Put soap on your ur face, etc. date Initiated:						
	03/24/2023 document oral/dental health pro- natural teeth. Date In "Interventions" it docu							
	#5, a CNA who worke stated residents who provided mouth care CNA #5 stated that w	m., an interview was (certified nursing assistant) ed evening shift. CNA #5 need assistance should be every night before bedtime. Then staff provides mouth cument this in the ADL						
	should be provided mevery day. CNA #9 s	m., an interview was #9. CNA #9 stated residents nouth care during each shift stated this care is evidenced omputer system (ADL						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X'		(X2) MULTIF IDENTIFICATION NUMBER: (X2) MULTIF A. BUILDING		MULTIPLE CONSTRUCTION UILDING			(X3) DATE SURVEY COMPLETED	
		495272	B. WING _			C 08/16/2023		
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	E, ZIP CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	(EACH CORRECTI) CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BI ED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE	
F 677	interview was conducted practical nurse) #1. A R127's bathing and of above, LPN #1 stated bathing or oral care for and coded as N/A. On 08/14/2023 at approximate the code of the code of the above for the code of the code of the above for the code of the above for the code of the code of the above for the code of the code of the above for the code of t	proximately 2:26 p.m., an exted with LPN (licensed After reviewing the POCs for oral care for the dates listed at that R127 did not receive for the dates that were blank proximately 5:00 a.m., ASM member) #1, administrator, a consultant, ASM #5, ase management, ASM #6, BM #7, director of nursing, I consultant, were made	F	677				
F 679 SS=D	person's ability to car information was obtainttps://www.nlm.nih.gsease.html. Activities Meet Intere CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The fact the comprehensive a and the preferences of program to support reactivities, both facility individual activities and designed to meet the physical, mental, and	nat seriously affects a rry out daily activities) This ined from the website: gov/medlineplus/alzheimersdi st/Needs Each Resident cility must provide, based on ssessment and care plan of each resident, an ongoing esidents in their choice of esponsored group and and independent activities, interests of and support the psychosocial well-being of raging both independence	F	379			9/26/23	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		CONSTRUCTION		PLETED
		495272	B. WING _				C 1 6/2023
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238		, 50.	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 679	Continued From pag	e 118	F6	579			
F 679	and interaction in the This REQUIREMEN' by: Based on observation document review, and facility staff failed to needs of one of 57 resample, Resident #5 The findings include: For Resident #5 (R5 provide evidence of to the resident. On the most recent in quarterly assessment reference date) of 7/being moderately condaily decisions. She impairment in range right upper extremities annual MDS with an coded as having expactivities as "very im she likes, going outs and participating in resident in the ped, 8/7/23 at 12:24 p.m. a.m. and 10:20 a.m.; A review of R5's care in part: "I am dependent in the second in the ped, and a manual manu	community. T is not met as evidenced on, staff interview, facility d clinical record review, the meet the assessed activities esidents in the survey on, the facility staff failed to coroviding individual activities MDS (minimum data set), a t with an ARD (assessment 22/23, R5 was coded as gnitively impaired for making was coded as having of motion for both left and es. On the most recent ARD of 3/9/23, R5 was ressed the following cortant:" listening to music ide when weather permits, eligious services. es and times, R5 was with no music playing: and 4:14 p.m.; 8/8/23 at 7:55 and 8/9/23 at 4:13 p.m. e plan dated 1/2/23 revealed, ent on staff for activities,	F 6	579	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 need of each resident. Residents who currently reside at Canterbury Health and Rehabilitation in the potential to be affected by this practice. An audit will be conducted by Life Enrichment Director/Designee on current residents to review individual activity needs/preferences and documentation will be implemented to	as y ent the	
	to) I require assistan activities/participation				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 A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495272	B. WING			C 08/16/2023	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		00/10/2023	
				1776 CAMBRIDGE DRIVE			
CANTERB	URY REHABILITATION A	AND HEALTHCARE CENTER		RICHMOND, VA 23238			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
F 679	member) #13, the life interviewed. He stated over this position. Whe evidence the facility was for activities for 1:1 victurized a week, we go be besides watching tv." of his time on a differe "Once we get staff as round more often." He write, and he hopes than different and writing materials. be a great candidate program." He stated he staff has been providicards or games for Resolved for the staff member) #1, the regional risk consultant consultant, and ASM were informed of these A review of the facility revealed, in part: "In cophysical, mental and residents, an activity of maintained for each relifelong interests, spiristrengths, needs, and preferences are includent activity evaluation is to	a.m., OSM (other staff enrichment director, was do he had only recently taken en asked to provide was following R5's care plan sits, he stated: "Once or by and offer them something He stated he spends much ent resident unit. He stated: it needs to be, we can estated R5 can read and ney can offer her reading He added: "I think she will for our music therapy he could not say the facility ang any 1:1 activities like 5. The ASM (administrative administrator, ASM #4, the ent, ASM #8, the regional #7, the director of nursing, he concerns. Topolicy, "Activity Evaluation," order to promote the posychosocial well-being of evaluation is conducted and esidentThe resident's ituality, life roles, goals, activity pursuit patterns and ded in the evaluationThe used to develop an individual	F 6	,	f on of each to ridual Designee ats to sident so sident so sident so sident sees audits eks, then so of the API anonths or		
	-	nat will allow the resident to s of his/her choice and					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495272	B. WING		08/16/2023
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER	'	STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	1 00.1012020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	5.475
F 679 F 684 SS=D	Continued From page No further information Quality of Care CFR(s): 483.25	e 120 n was provided prior to exit.	F 679		9/26/23
	applies to all treatme facility residents. Bas assessment of a resident residents received accordance with profipractice, the compredicare plan, and the resident resident resident resident record resident record resident record resident resident resident resident resident record resident review of R360's clinit resident resid	indamental principle that int and care provided to led on the comprehensive dent, the facility must ensure extreatment and care in lessional standards of mensive person-centered sidents' choices. To is not met as evidenced lew, facility document review view, the facility staff failed ervices to maintain the peing for one of 57 residents, Residents #360. R360), the resident was yon 7/31/23 with a diabetic wound. The facility staff ment for the diabetic ulcer it to initiate treatment for the 3/3/23. To the facility on 7/31/23. A cal record revealed a wound it 8/2/23 that documented the lith a diabetic neuropathic intar heel on 7/31/23. Further cal record revealed		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 can needs have the potential to be affected this practice. An audit was accomplish on current residents with wounds to include but not limited to surgical wour diabetic ulcers, and pressure injury was completed to validate the initiation of timely treatment. Variances were addressed.	re d by ed nds,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		, ,	(X3) DATE SURVEY COMPLETED	
		495272	B. WING _			C / 16/2023	
NAME OF PR	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE	1 55	, 10,2020	
CANTERB	SURY REHABILITATION	AND HEALTHCARE CENTER		1776 CAMBRIDGE DRIVE			
				RICHMOND, VA 23238			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION DATE	
F 684	water, pat dry and ap wound progress repo	tar heel with soap and ply skin prep every shift. A rt dated 8/2/23 documented	F 6	The Staff Development Coordinator/Designee will re-education			
	lower leg on 7/31/23. clinical record reveals initiated until 8/3/23. 8/3/23 documented to with soap and water, gauze, and an ace with	A physician's order dated or cleanse the left lower leg pat dry and apply rolled rap every day shift.		Licensed Nursing staff on Quality of provision of care and services to me the highest level of Well-Being, to it but limited to notification of the province obtain orders to initiate treatment of diabetic, surgical, and other wound a timely manner.	aintain nclude vider to or		
F 686 SS=E	stated that when resinurses complete a he and if a wound is prescontact the physician wet to dry dressing upractitioner can evalustated treatment should admission. On 8/11/23 at 9:57 a. staff member) #1 (the (the regional risk conthe above concern. Treatment/Svcs to Pr CFR(s): 483.25(b)(1) §483.25(b) Skin Integ §483.25(b)(1) Pressure Based on the compression.	egistered nurse) #1. RN #1 dents are admitted, the ead-to-toe skin assessment sent, the nurses should and ask for an order for a ntil the wound care nurse late the wound. RN #1 ald be initiated on the day of m., ASM (administrative la administrator) and ASM #4 sultant) were made aware of event/Heal Pressure Ulcer (i)(ii) prity re ulcers. The same admitted in the same and the same are same as a series of the same are	F 6	An audit will be completed by the unanager/designee for 3 residents of new wounds to validate that physico 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 audits will be submitted by the Administrator/Designee to the QAF Committee for review and recommendation monthly for 3 more ongoing until compliance sustained.	vith ian f the I	9/26/23	
	professional standard pressure ulcers and d ulcers unless the indi	nust ensure that- is care, consistent with its of practice, to prevent does not develop pressure vidual's clinical condition bey were unavoidable; and					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495272	B. WING			C 8/16/2023	
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238		8/16/2023	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 686	necessary treatment with professional star promote healing, prenew ulcers from dev This REQUIREMEN by: Based on observative record review, and fawas determined that provide care and settreat a pressure injuit the survey sample, fawas 60, and #510. The findings include 1. For Resident #43 float her heels while On the most recent float quarterly assessmer reference date) of 5/being at risk of deve as currently having a construction on the following date observed sitting up it direct contact with predict the profession of the suspension book and the s	ressure ulcers receives and services, consistent indards of practice, to event infection and prevent eloping. T is not met as evidenced on, staff interview, clinical acility document review, it is the facility staff failed to rvices to promote healing and ry for five of 57 residents in Residents #43, #118, #409, (R43), the facility failed to she was in bed. MDS (minimum data set), a not with an ARD (assessment 12/23, R43 was coded as loping pressure injuries, and a pressure injury. The sand times, R43 was in her bed with both heels in allows which had been placed 8/7/23 at 12:35 p.m. and 10:39 a.m.; 8/9/23 at 11:01 There was no evidence of outs for R43.	F 6	F686 Treatment/Services to Prevent/Heal Pressure Ulcers SS=E Resident #43 orders were review care plan updated to reflect resineeds and preferences to includare floated with the use of pillow preference, and HLSB ordered a resident tolerates. Resident #118 was turned, reported and provided with incontinence barrier cream per the Care Plant C N A and Licensed nursing states assigned to the resident on the coutlined in the 2567 were re-eduted the Staff Development Coordinator/Designee on Treatment/Services to Prevent/Pressure Ulcers to include but not the pressure Ulcers to include but not prevent the staff Development to include but not prevent the pressure Ulcers to include but not prevent the pressure Ulcers to include but not prevent the pressure Ulcers to include but not prevent the pressure under the prevent the pre	dent de heels vs per as esitioned, care and . ff dates ucated by		
	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			to turning and repositioning, app barrier cream as ordered by the and documentation of the care is medical record.	physician,		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	2) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
		495272	B. WING _				C 1 16/2023
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	10/2020
					776 CAMBRIDGE DRIVE		
CANTERB	URY REHABILITATION	N AND HEALTHCARE CENTER			CICHMOND, VA 23238		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFII TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 686 Continued From page 123		ge 123	F	686			
	any surface), she st	tated: "No, her heels aren't			Resident #409 was discharged fro	m	
		ed why it is important to float			the facility on 1/13/23.		
		s, she stated the heels should					
		nt skin breakdown. When			Resident #360 was discharged fro	m	
		vare of a heel lift device for the			the facility on 8/19/23.		
		d: "No. We just float them."			and radiiity on 6/16/20.		
		ally roils a pillow or uses a			Resident #510 pressure ulcer care was	3	
		ne resident's heels from			provided in a sanitary manner. Reside		
		ontact with the bed or a pillow.			#510 pressure injury was reviewed by		
	g				clinical provider with no s/s of infection		
	A review of R43's c	linical record revealed the			Pressure injury site continues to heal n		
		en 10/21/22: "Bilateral heel lift			new orders.		
	suspensions when						
	•	•			Licensed Practical Nurse #2 was		
	A review of R 43's of	care plan dated 10/21/22			re-educated by the Staff Development		
	revealed, in part: "A	administer treatments as			Coordinator on Treatment/Services to		
	orderedHeel lift be	oots to bilateral heels."			Prevent/Heal Pressure wounds, provid	ing	
					pressure ulcer care in a sanitary mann	er,	
	On 8/14/23 at 11:59	a.m., LPN (licensed practical			the standard of care related to pressure	е	
	nurse) #7 stated: "[I	R43]'s heels should be floated.			injury care, to include dating dressings		
	End of sentence." S	She stated the resident			and cleaning instruments before and a	fter	
	currently has a pres	ssure injury on her sacrum,			use.		
	and has previously	had sink breakdown on her					
	heels.				Current residents who are at risk for		
					pressure injury or receive wound care		
		p.m., ASM (administrative			have the potential to be affected by this		
	,	he administrator, ASM #4, the			practice. An audit was completed by th		
		tant, ASM #8, the regional			unit manager/designee of residents at		
		M #7, the director of nursing,			for pressure injury to validate that care		
	were informed of th	ese concerns.			plan interventions such as timely		
					incontinence care, HLSB and/or offload		
	No further informati	on was provided prior to exit.			devices, turning, and repositioning and		
					barriers creams as indicated were		
	0 E D	10 (D440) II 6 "" 6 " 1			implemented and documented. Varian		
		8 (R118), the facility failed to			were addressed. An audit was complet	ied	
	• • • • • • • • • • • • • • • • • • • •	ation of barrier cream and			by the unit manager/designee for		
		g the resident on multiple			residents that had new pressure injurie		
	dates in June and J	July 2023.			the last 14 days to validate that physici	an	
					orders were obtained timely and		

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495272	B. WING _				C / 16/2023
NAME OF PR	ROVIDER OR SUPPLIER	_L		STRE	EET ADDRESS, CITY, STATE, ZIP CODE	1 00	710/2023
				1776	CAMBRIDGE DRIVE		
CANTERB	URY REHABILITATION	AND HEALTHCARE CENTER			HMOND, VA 23238		
(V4) ID	SLIMMARYS	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTIO	NI	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	COMPLETION DATE
F 686	F 686 Continued From page 124		F 6	86			
	significant change as (assessment referenced as requiring the two staff members for (turning/repositioning risk for developing a	MDS (minimum data set), a ssessment with an ARD note date) of 6/9/23, R118 was not extensive assistance of or bed mobility g). He was coded as being at pressure injury, and as anstageable pressure injury.		t c	mplemented. Audit also included rar observations of wound care to valida that dressings are dated, and that wo care was provided in a sanitary maninclude instruments such as scissors cleaned pre and post use. Variances addressed.	te ound ner to are	
	following wound care Onset 5/10/23FacilinjuryR (right) hip.' record revealed that R118 was still receive unstageable pressure. Further review of the evidence that R118 or had barrier cream following dates: 6/1 6/21, 6/23, 6/26 through 7/11, 7/13, 7/25, 7/27. and 7/28	e clinical record revealed no was turned and repositioned applied on day shift on the through 6/16, 6/19 through ugh 6/30; 7/2 through 7/7, 7/7 7/14, 7/16 through 7/21, 7/24, . The review revealed no		r F F a r t	The Staff Development Coordinator vare-educate Licensed Nursing staff on wound/skin treatment to Prevent/HeatPressure Ulcers, utilization of preventative/offloading devices, application of barrier creams, turning repositioning, treatment initiation in a simely manner, provision of pressure care in a sanitary manner and dating dressings.	and ulcer	
	A review of R118's or revealed, in part: "I hulcer development least every 2 hours, barrier cream after e On 8/10/23 at 2:19 purse) #7 was intervenurse is ultimately repositioning of a resthe CNAs (certified responses).	are plan dated 4/7/22 have potential for pressure I need to turn/reposition at more often as neededapply each incontinence care." b.m., LPN (licensed practical iewed. She stated: "The esponsible for turning and sident. This is delegated to hursing assistants." She uld be turned/repositioned		t s a r i c a t	The DON/Designee will complete an on of 3 residents at risk for pressure to validate that care plan intervention such as timely incontinence care, HL and/or offloading devices, turning, ar repositioning and barriers creams as indicated were implemented and documented. Variances will be addressed. An audit will be complete the unit manager/designee for 3 residuith new wounds to validate that phyorders were obtained timely and implemented. Audit will also include random observations of wound care	injury s SB id d by dents sician	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495272	B. WING _				C 1 16/2023
NAME OF PR	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	10/2020
				1	1776 CAMBRIDGE DRIVE		
CANTERB	URY REHABILITATION	AND HEALTHCARE CENTER		F	RICHMOND, VA 23238		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 686	Continued From page		F 6	386			
		stated the CNAs document			validate that dressings are dated, and		
		the electronic medical			wound care was provided in a sanitary		
		ne writes a progress note if a			manner to include instruments such as		
	CNA tells her that a r	esident has refused care.			scissors are cleaned pre and post use. Variances will be addressed. These au		
	On 8/10/23 at 3:26 p.	m CNA #5 was			will be conducted weekly x 4 weeks, th		
		ed she turns residents every			monthly x 2 months. The findings of the		
		off on what she has done in			audits will be submitted by the		
		l record. She stated if a			Administrator/Designee to the QAPI		
		lets the nurse know, and			Committee for review and		
	the nurse also docum				recommendation monthly for 3 months	or	
	· -	tated the same is true for			ongoing until compliance sustained.		
	applying barrier crear changed after inconti						
	staff member) #1, the regional risk consulta	m., ASM (administrative e administrator, ASM #4, the nt, ASM #8, the regional #7, the director of nursing, se concerns.					
	No further information	n was provided prior to exit.					
	with a sacral pressure	(R409), who was admitted e injury on 1/6/23, the facility eatment for this pressure					
	admission assessme reference date) of 1/1 being in a persistent coded as having two	MDS (minimum data set), an nt with an ARD (assessment 13/23, R409 was coded as vegetative state. He was unstageable pressure 09 was discharged from the					
	A review of R409's ac assessment dated 1/	dmission nursing 6/23 revealed the resident					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495272	B. WING _			C 08/16/2023	
	ROVIDER OR SUPPLIER BURY REHABILITATION	AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238)E	33. 13.2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		ON
F 686	Continued From pag	e 126	F 6	586			
		ury on admission, a sacral cm x 6 cm (centimeters) , m.					
		09's clinical record failed to ers for this sacral wound until					
	1/6/23 revealed, in progressure ulcer and is development r/t (rela incontinence, admitted	ted to) immobility, bowel ed with an unstageable s sacrumAdminister					
	January 2023 reveals repositioning and the cream were signed of these interventions h	oint of care records for ed that both the turning and e application of the barrier off for every shift, indicated ad been implemented. ursing assistant) who cared of tay at the facility were of during the survey.					
	On 8/10/23 at 2:58 p #1 was interviewed. admitted residents sl to toe by the admittin resident is identified checks the resident's facility to see if an or there is already an or treatment, with the a attending physician. order for treatment p	.m., RN (registered nurse) She stated that newly nould all be assessed head ag nurse. She stated if a with a pressure injury, she a record from the discharging der was in place there. If order, she initiates that pproval of the facility's She stated if there is no rior to the resident's arrival at the admitting physician at the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495272	B. WING			C 08/16/2023	
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238		70/10/2023	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 686	this is an order for a wound specialist car different orders. She should have a treatr possible to prevent or the possible to progress report data resident presented or the presented	order. She states ordinarily, wet to dry dressing until the assess the wound and write estated the pressure injury ment initiated as soon as worsening. o.m., LPN (licensed practical anager, was interviewed. leted R409's admission referenced above. She a pressure spot on his it. I didn't put the order in for ed the facility's protocol is to ment for pressure injuries, ing physician's orders, until seen by the wound specialist. o.m., ASM (administrative see administrator, ASM #4, the ant, ASM #8, the regional M #7, the director of nursing,	F 6	36			
	treatment was not in	nical record revealed hitiated until 8/2/23. A ted 8/2/23 documented to					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495272	B. WING				C 1 6/2023		
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER		1776	ET ADDRESS, CITY, STATE, ZIP CODE CAMBRIDGE DRIVE MOND, VA 23238	1 00/	10/2020		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
F 686	cleanse the right hee apply a hydrocolloid of wound progress reports and progress reports apply a hydrocolloid of wound progress reports and progress reports reports and progress reports reports and progress reports repo	I with normal saline and dressing once a day. A rt dated 8/2/23 documented a stage four pressure injury 7/31/23. Further review of revealed treatment was not A physician's order dated of cleanse the sacral wound oply green foam to the h plastic drape and attach to cing of 125 mm/Hg ry), and to change every day ursday and Saturday. m., an interview was egistered nurse) #1. RN #1 dents are admitted, the ead-to-toe skin assessment ry is present, the nurses hysician and ask for an order ing until the wound care in evaluate the pressure treatment should be initiated fon. m., ASM (administrative endaministrator) and ASM #4 sultant) were made aware of its localized damage to the off tissue usually over a related to a medical or other in present as intact skin may be painful. Jury: Partial-thickness skin rmis	F	586					

,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495272	B. WING_			C 8/ 16/2023	
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238		10/10/2023	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR	SHOULD BE	(X5) COMPLETION DATE	
F 686	moist, and may also present as serum-filled blister. Stage 4 Pressure In tissue loss Full-thickness skin a or directly palpable f ligament, cartilage o information was obta https://cdn.ymaws.c gr/online_store/npial . 5. For Resident #510 pressure injury care On 8/08/23 at 12:41 Resident #510 was to right and left heel The top dressing wa vac was removed ar care. The NP (nurse specialist, debrided was otherwise red w (licensed practical n nurse, was observed care: she removed b right scrub top pocke foam that would go i without cleaning the vac, obtained a seal applied. Then put b her scrub top pocke When outside of the	ge 129 ped is viable, pink or red, an intact or ruptured gury: Full-thickness skin and and tissue loss with exposed fascia, muscle, tendon, ar bone in the ulcer" This ained from the website: com/npiap.com/resource/resm o_pressure_injury_stages.pdf O, the facility failed to provide in a sanitary manner. PM, pressure injury care for observed including heel care DTI, and sacral Stage 4 care. s dated 8/5/23. The wound and then replaced after wound be practitioner) wound care some yellow tissue, wound with granulation. LPN urse) #2, the wound care d completing sacral wound be andage scissors from her let and used them to cut the nside of the sacral wound, m. She applied the wound andage scissors back into a without cleaning them. resident room at 12:30 PM, around care nurse, when the	F 6				
	will be. When asked been cleaned prior to	eaned, she stated, now, they I if the scissors should have o use, she stated, yes, they eaned prior to using. When					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495272	B. WING			C 8/ 16/2023	
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238		10/10/2023	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 686	how would I date it? resident's skin. Whe dressing prior to app that could be tried. On 8/10/23 at 7:45 A Resident #510's sac The dressing that wa The wound care nurs sacral wound care: s scissors from her rig them to cut the foam sacral wound, without applied the wound views dated and applied hands at the resident.	e 130 he dressing, LPN #2 stated, You cannot write on the en asked if she could date the lying it, LPN #2 stated, yes, M, pressure injury care for ral wound was observed, as in place was not dated, se was observed completing the removed bandage th scrub top pocket and used that would go inside of the at cleaning them. She ac, obtained a seal. Dressing ted. Surveyor was washing t's sink when LPN #2 tossed is into the sink. LPN #2	F6	86			
	have any of them too When asked if she h prevention measures cleaning of the band no, they were not cle A review of physiciar revealed, "SACRUM solution. Apply black foam vac dress to wound vac at 123 mercury) of suction. apply Dakin's wet to a day every Tuesday On 8/8/23 at 12:41 F LPN #2, the wound of following the standar	ibacterial wipes, I do not day to clean my scissors." ad followed the infection of for wound care regarding age scissors, LPN #3 stated, eaned prior to using them. In orders dated 8/2/23, - Cleanse with 0.25% Dakin's sing to wound vac dressing mm Hg (millimeters of If VAC lose suction may dry dressing daily. One time of the transport of transport of the trans					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	(X3) DATE	E SURVEY PLETED
		495272	B. WING _			C / 16/2023
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	1 00.	110/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 686	member) #1, the adn regional risk consultar nursing and ASM #8, made aware of the file. No further information Foot Care CFR(s): 483.25(b)(2) §483.25(b)(2) Foot care and care to maintain health, the facility mu (i) Provide foot care a with professional start to prevent complication medical condition(s) (ii) If necessary, assist appointments with a arranging for transposition appointments. This REQUIREMENT by: Based on observation document review, and facility staff failed to pare to the start of the start	M, ASM (administrative staff ninistrator, ASM #4, the int, ASM #7, the director of the regional consultant was ndings. In was provided prior to exit. (i)(ii) are. Into receive proper treatment mobility and good foot ist: Indid treatment, in accordance indiards of practice, including ons from the resident's and st the resident in making qualified person, and intation to and from such I is not met as evidenced in staff interview, facility indicator in the corovide foot care for five of urvey sample, Residents	F 6		/ided	9/26/23
				Resident #63 was discharged from	the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495272	B. WING _				C 16/2023	
NAME OF P	ROVIDER OR SUPPLIER		 	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	10/2023	
	101.52.1.01.100.1.2.2.1				776 CAMBRIDGE DRIVE			
CANTERB	URY REHABILITATION	AND HEALTHCARE CENTER	RICHMOND, VA 23238					
					·		(X5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	· ·	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		
F 687	Continued From page	Continued From page 132						
	annual assessment w reference date) of 6/9	IDS (minimum data set), an with an ARD (assessment ol/23, R48 was coded as we assistance of staff for			facility on 8/8/23.			
	ADLs (activities of da	ily living), including bathing e. R48 was admitted to the s of intellectual			C N A staff member #4 was re-educate by the Staff Development Coordinator/Designee on Foot Care an trimming of the resident nails.			
	up in his wheelchair, feet. All of R48's toen length of the toes. So	n., R48 was observed sitting and had no socks on his ails extended beyond the ome of the nails had erial underneath them.			Current Residents who require nailcare have the potential to be affected by this practice.			
	observed. All nails we	m., R48's toenails were ere beyond the length of the at toenail was between 1/2 and the end of the toe.			An audit was completed by the Unit Manager/Designee on resident Foot Cato review the need for nail care. Varian were addressed.			
	appointments revealed the facility podiatrist wand did not have a cupodiatrist.	/ documentation for podiatry ed R48 had not been seen by within the past four weeks, urrent appointment with the			The Staff Development Coordinator/Designee re-educated the Licensed Nursing Staff and C N A staff on Foot Care, and nail care.			
		e plan dated 4/20/23 ave an ADL Self Care I require 1 staff assist with			The DON/Designee will conduct an au			
	nurse) #7 was intervious toenail care includes and water, including valso involves applying stated the CNA(certif primarily responsible	m., LPN (licensed practical ewed. She stated basic washing the foot with soap washing between the toes. It g lotion to dry feet. She ied nursing assistant) is for the cleanliness of tates she has not provided			of 3 residents to validate foot care and nail care were provided. Variances wil 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	l be		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495272	B. WING _				C 16/2023	
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER		17	TREET ADDRESS, CITY, STATE, ZIP CODE 776 CAMBRIDGE DRIVE ICHMOND, VA 23238	, 00.	10/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 687	trimming the nails of diabetic. She stated (provide nail care to d managers maintain a diabetic nail care. On 8/10/23 at 3:26 p. interviewed. She stat have "good foot care. checking the feet for toes, and between th feet should be bather morning and evening fingernails and toena diabetic." On 8/14/23 at 4:01 p. staff member) #1, the regional risk consultate consultant, and ASM were informed of these A review of the facility revealed, in part: "Recare and treatment in and foot healthOve care and treatment or prevent foot complicates assisted in making aptransportation to and staff may provide rou example] toenail clips standards of practice complicating disease foot disorders or mediabetic.	ents. The CNAs are for residents who are not CNAs are not allowed to liabetics. She stated the unit list of residents who need m., CNA #5 was ed every resident should "She stated this includes concerns, massaging heels, et toes with lotion. She stated devery day as part of care. She stated: "We cut list if the resident is not m., ASM (administrative et administrator, ASM #4, the nt, ASM #8, the regional #7, the director of nursing, see concerns. If policy, "Foot Care," sidents receive appropriate to order to maintain mobility rall foot care includes the form specialists Trained tine foot care (e.g. [for bing within professional)	F	587	ongoing until compliance sustained.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495272	B. WING				C 16/2023
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER		17	REET ADDRESS, CITY, STATE, ZIP CODE 76 CAMBRIDGE DRIVE CHMOND, VA 23238	1 00/	10/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOUL			(X5) COMPLETION DATE
F 687	2. For Resident #34, provide foot care/pool Resident #34 had dia for assistance with prodid not have a diagnor on 8/08/23 at 11:55 made of Resident #3 toenail was 1/2 to 3/4 all toenails needed to toenail was 1/2 to 3/4 A review of the clinical physician's order data consult and treatment A review of the clinical evidence of when the On 8/9/23 at 3:05 PM a request for evidence care/toenail care for admission (11/1/22) provided of residents in June 2023. Resid No evidence was provided to the care/toenail care for admission (2011/1/22) provided of residents in June 2023. Resid No evidence was provided to the care/providence was providence was provi	n was provided prior to exit. the facility staff failed to liatry services. agnoses that included "need ersonal care." Resident #34 pois of diabetes. AM, an observation was 4's feet. The left foot big 4 inch long. On the right foot, to be trimmed. The great 4 inch long. all record revealed a ged 2/14/23 for "Podiatry at as needed." all record failed to reveal any to toenails were last trimmed. A and on 8/14/23 at 5:00 PM, are of all incidents of podiatry Resident #34 since was requested. A list was a who received podiatry care gent #34 was not on the list. A poided that Resident #34 had genail care/podiatry services.	F	687	DEFICIENCY)		
	revealed one dated (activities of daily livided) Deficit r/t (related to) Devices/Medical Equincluded an intervent	1/1/22 for "I have an ADL ng) Self Care Performance Disease Process, External lipment." This care plan ion dated 11/2/22 for NE: I am dependent on staff al hygiene."					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG	, ,	(X3) DATE SURVEY COMPLETED	
		495272	B. WING _			C 08/16/2023	
NAME OF P	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE		2011012020	
CANTERB	URY REHABILITATION A	AND HEALTHCARE CENTER		1776 CAMBRIDGE DRIVE			
				RICHMOND, VA 23238			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION SHOOD CORSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 687	Nurse). She stated the washing with soap and She stated that CNAs Assistant) will let her stated that bathing ind She stated that bathing ind She stated that she he the CNAs are supposed days if the resident is CNAs not allowed to the residents are mor stated the unit managed care and that she ask placed on the list and responsible for making seen. On 8/10/23 at 3:26 Ple conducted with CNAs care, the CNAs check stated that you don't we CNAs' put lotion on the heels, toes, and between CNAs need to make severy day. She state she bathes them. She fingernails and that the resident is not diabeting nurse if she can cut the CNAs' 24 All conducted with LPN 4 Nurse). She stated the VNAS She stated the stated the She She She Stated the She She She Stated the She She She Stated the She She She She She She She She She S	#7 (Licensed Practical nat basic foot care included of water, greasing / lotion. It is (Certified Nursing know any skin issues. She cluded in between the toes. It is were primarily responsible. It is asn't done the nail care, that is do to be doing it on shower not diabetic. She stated that diabetic foot care because the prone to wounds. She gers has a list for podiatry its for the resident to be at the unit manager is any sure those residents get. M, an interview was the want dry feet, and that in the mand massage it on the interview are not clean, the stated the staff cut the interview was the control of the control of the control of the want dry feet, and that if they are not clean, the stated the staff cut the interview was the control of th	F 6	· ·			
	should attempt to trim the nails are too thick try and file them. She	resident is not diabetic, staff in the nails. She stated that if it, that they might be able to be stated that they should wilt and be seen by podiatry					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495272	B. WING			1	C / 16/2023	
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238			10/2023	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	I	ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHO TAG CROSS-REFERENCED TO THE APPR DEFICIENCY)			(X5) COMPLETION DATE	
F 687	before they get too loo On 8/14/23 at 4:00 P ASM #1 (Administration, ASM) #7 ASM #8 the Regional aware of the findings provided by the end of 3. For Resident #144 toenail care. Observation on 8/8/2 #144's toenails, reversion and the left foot all trimmed. Resident #144 was a 3/27/23 with diagnost limited to: DM (diabet) Resident #144's most data set) assessment assessment, with an of 7/4/23, coded the resident #144 was used to the second trimmed. Resident #144's most data set) assessment with an of 7/4/23, coded the resident #144 was used to the second trimped. Resident #144 was used to the second tripped to the second tripped tr	M at an end-of-day meeting, ive Staff Member) the #4 the Regional Risk the Director of Nursing and I Consultant, were made. No further information was of the survey. The facility failed to provide at 1:23 AM, of Resident aled the following: right foot to be trimmed being they long, the second toenail anderneath of his big toe, I toenails needed to be dmitted to the facility on the set that include but are not the mellitus). It recent MDS (minimum that, a quarterly annual assessment reference date resident as scoring 03 out of finterview for mental status) resident was severely MDS Section G- Functional sident as total dependence thygiene and bathing.	F	587				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495272	B. WING				C 16/2023	
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER		17	REET ADDRESS, CITY, STATE, ZIP CODE 76 CAMBRIDGE DRIVE CHMOND, VA 23238	1 00	10/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 687	6/26/23, revealed, "T was no evidence of t 2023. An interview was cor PM, with LPN (licens asked who provides LPN #2 stated, if the thick toenails, podiat On 8/8/23 at 3:30 PN conducted with CNA #2. When asked wh #2 stated, "We look a getting bathed. If the toenails, we let the n podiatry list. If they a can trim them." An interview was cor AM, with OSM (other director of social sempodiatry appointmen are too many resider next visit and those redirector did not com	riew of the podiatry note for Toenails trim/care." There oenail care provided July adducted on 8/8/12 at 12:30 sed practical nurse) #2, when nail care for the residents, resident is diabetic or has ry cuts the toenails.	F	687	DEFICIENCY)			
	nurse) #7 was interv toenail care includes and water, including also involves applyin stated the CNA(certi primarily responsible residents' feet. She s	i.m., LPN (licensed practical liewed. She stated basic washing the foot with soap washing between the toes. It is lotion to dry feet. She fied nursing assistant) is for the cleanliness of states she has not provided lents. The CNAs are for						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		495272	B. WING _			1	C 1 6/2023
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER		1776	EET ADDRESS, CITY, STATE, ZIP CODE CAMBRIDGE DRIVE HMOND, VA 23238	1 00/	10/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOU			(X5) COMPLETION DATE
F 687	diabetic. She stated provide nail care to comanagers maintain a diabetic nail care. An interview was corp PM, with CNA #5. We care, CNA #5 stated We do not want dry fithem. Massage heel toes. We make sure do this every day. We toenails unless the consultanursing and ASM #8 made aware of the fill No further information. 4. For Resident #63 to provide podiatry complication (1). On the most recent Medical provides as a distribution of the fill of the complication (1).	residents who are not CNAs are not allowed to diabetics. She stated the unit a list of residents who need anducted on 8/15/23 at 3:26 //hen asked to describe foot we check everyone's feet. Seet, so we put lotion on states, toes and in between the they are nice and clean. We expected the fingernails and all ney are diabetic. M. ASM (administrative staff ministrator, ASM #4, the ant, ASM #7, the director of the regional consultant was	F	687			
		proximately 8:30 p.m. an toenails were conducted					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		` IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		495272	B. WING _			C 08/16	6/2023
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	' :	00/10	5/2525
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE
F 687	practitioner wound spreadescribe the condition stated that there were trimmed and should be revealed a consult not Group) dated May 12 documented, "Patient treated today, but wa Patient refused: veter pay for treatment." Frailed to evidence fur services to trim R63's On 8/10/23 at 2:19 p. nurse) #7 was intervit toenail care includes and water, including also involves applying stated the CNA(certif primarily responsible residents' feet. She shall care to any reside trimming the nails of diabetic. She stated (provide nail care to diabetic nail care. On 08/10/23 at approinterview was conductable to describe for stated that the CNAs and apply lotion to keemaking sure they are asked how often the	tive staff member) #2, nurse pecialist. When asked to an of R63's toenails she to long, needed to be be seen by a podiatrist. R (electronic health record) to the from (Name of Podiatry 2, 2022. The note to was scheduled to be so not treated. Reason: ran hosp [hospital] will not surther review of R63's EHR ther attempts to provide	F6	987			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
		495272	B. WING _			C 08/16/2023	
	ROVIDER OR SUPPLIER	N AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238		00/10/2020	
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 687	On 08/15/2023 at a (other staff membe services, provide a Services / Consulta Group) for R63. The "Podiatry. Other (ptrimming & (and) can asked if R63 receive trimming in June 20 on 08/14/2023 at a (administrative staff and ASM #4, region aware of the above No further information was obhttps://www.nlm.nih.001214.htm. 5. For Resident #1 failed to trim the too on the most recent quarterly assessment reference date) of 0 scored 8 (eight) our interview for mental	esident is not diabetic. approximately 10:24 a.m., OSM r) # 5, director of social form entitled "Request for ation" for (Name of Podiatry the form documented in part, alease specify): toenail are" dated 06/26/2023. When the Podiatry care and toenail 023 she stated no. approximately 9:50 a.m., ASM of member) #1, administrator that risk consultant, were made of findings. ion was provided prior to exit. see in which the body cannot that of sugar in the blood. This tained from the website: a.gov/medlineplus/ency/article/ 21 (R121), the facility staff the enails. a MDS (minimum data set), a cent with an ARD (assessment 05/18/2023, the resident that of 15 on the BIMS (brief I status), indicating the rately impaired of cognition for	F 6	87			
		oroximately 10:45 a.m. an 1's toenails were conducted					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULT IDENTIFICATION NUMBER: A. BUILDIN		LE CONSTRUCTION	COMF	(X3) DATE SURVEY COMPLETED C	
		495272	B. WING			/16/2023	
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	, 55		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 687	stated number three foot were approxima and needed to be tri R121's left foot LPN and four toe (1) on the approximately a quality to be trimmed. On 8/9/2023 at approximately a quality to be trimmed. On 8/9/2023 at approximately a quality to be trimmed. On 8/9/2023 at approximately a quality to be trimmed. When assistant) # providing toenail can that it was part of AI When asked if she the part of his ADL care R121 did not ask, at to trim his toenails. On 08/14/2023 at approximately to trim his toenails.	practical nurse) #1. She and four toe (1) on the left ately a quarter inch too long mmed. Upon observation of #1 stated number two, three he right foot were after inch too long and needed downward incompared to the residents of all pliving. The for the residents she stated obtained to the formulation of the foot were after inch too long and needed downward incompared to the residents she stated obtained to the for the residents she stated obtained to foot and the formulation of the foot and the	F 68				
F 688 SS=D	Increase/Prevent De CFR(s): 483.25(c)(1	ecrease in ROM/Mobility)-(3)	F 68	88		9/26/23	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		495272	B. WING _			C 08/16/2023		
	ROVIDER OR SUPPLIER	I AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	· ·	567 167 2025		
(X4) ID PREFIX TAG	(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFI) REGULATORY OR LSC IDENTIFYING INFORMATION) TAG		PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 688	resident who enters range of motion doe range of motion unlessed of motion is unavoid. §483.25(c)(2) A resident receives appropriate assistance to maint the maximum practice reduction in mobility. This REQUIREMEN by: Based on observate document review, a facility staff failed to contractures (1) for survey sample, Resident #5 provide a left hand contacted left hand. On the most recent	acility must ensure that a the facility without limited es not experience reduction in ess the resident's clinical ates that a reduction in range dable; and ident with limited range of propriate treatment and e range of motion and/or to rease in range of motion. ident with limited mobility e services, equipment, and ain or improve mobility with reable independence unless a v is demonstrably unavoidable. IT is not met as evidenced ion, staff interview, facility and clinical record review, the provide treatment for two of 57 residents in the sidents #5 and #48. EXECUTE: (R5), the facility staff failed to palm guard for the resident's	F6	,	a palm and. ving			
	reference date) of 7 being moderately co daily decisions. She	2/22/23, R5 was coded as ognitively impaired for making was coded as having of motion for both left and		Current residents that have a chave the potential to be affected practice. An audit was accompacurrent residents who have con	ed by this olished of			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495272	B. WING _			1	C 16/2023	
NAME OF PE	ROVIDER OR SUPPLIER	<u> </u>		STR	REET ADDRESS, CITY, STATE, ZIP CODE	1 00/	10/2023	
					6 CAMBRIDGE DRIVE			
CANTERB	URY REHABILITATION	AND HEALTHCARE CENTER			CHMOND, VA 23238			
0(1) 15	CLIMMADY C	TATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION		(V5)	
(X4) ID PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL SLSC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 688	Continued From page	ge 143	F 6	888				
	revealed, in part: "I r	e plan dated 12/8/22 equire assistive/adaptive wear Left palm protector at all			to validate care plan interventions such palm guards were implemented and to identify residents that need therapy screening/evaluation for contractures.			
	deviceresident to wear Left palm protector at all times, as tolerated with removal for hand hygiene and skin checks."				Variances were addressed and therapy screens were completed with residents picked up for service as indicated.			
	On the following dat observed in her bed in her left hand: 8/7/p.m.; 8/8/23 at 7:55 8/9/23 at 4:13 p.m., had a rolled washold observations, R5 ha of her left hand. On 8/14/23 at 9:16 a assistant) #11 was it should have "splints contractures. She st so we roll up a wash ever remember R5 h			The Staff Development Coordinator/Designee re-educated the Licensed Nursing and C N A staff on th need to follow the residents care plan t include but not limited to using palm guards as indicated to Increase/Prever Decrease in ROM/Mobility, and the process for notifying Therapy Services resident is noted with a need for screening/evaluation due to decrease in ROM due or contracture. Variances we addressed.	e o nt if a n			
	of rehab and an occinterviewed. She state OT screenings on all She stated: "These what we can see on stated if the therapis staff interviews identically evaluation would be was last screened, et al. (8/23 through 7/21/2) evaluated or treated stated the most receiver hands had been was documented as	a.m., OSM #12, the director upational therapist, was sted her staff does periodic I long term care residents. are only screenings, only a quick observation." She at observes a concern of if tify a concern, then a full OT performed. She stated R5 evaluated, and treated from 123. She stated R5 was not for hand contractures. She ent evaluation for the use of on 6/16/22, and the resident being independent for "That's our only baseline."			An audit will be conducted by the DON/Designee of 3 residents with contractures to validate interventions s as palm guards are implemented per p of care and that therapy referrals are made as indicated to increase/prevent decrease in ROM/Mobility. Variances 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	lan will e		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
		495272	B. WING _			1	C 16/2023
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER		177	REET ADDRESS, CITY, STATE, ZIP CODE 76 CAMBRIDGE DRIVE CHMOND, VA 23238	1 00	10/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	BY FULL PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 688	She provided an 8/14 therapy) evaluation for included, in part: "Left "A rolled up wash cloom on 8/14/23 at 1:20 pointerviewed. She stat palm guard as soon at the consultant of the state	ar R5. This evaluation of palm guard." She stated: th is not sufficient." m., OSM #12 was ed: "[R5] definitely needs a as possible." m., ASM (administrative e administrator, ASM #4, the ent, ASM #8, the regional #7, the director of nursing, se concerns. y policy, "Functional d, in part: As part of the ent, the physician will include enction as well as potential to ative services." y policy, "Resident Mobility ency," revealed, in part: and arange of motion will deservices to increase and/or rease in ROM (range of an will include specific	F 6	888	ongoing until compliance sustained.		
	improve motility and motionInterventions of necessary equipm No further information	s may includethe provision ent." n was provided prior to exit. velops when the normally					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		L IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG	, ,	(X3) DATE SURVEY COMPLETED		
		495272	B. WING			C 8/ 16/2023		
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238		10/10/2023		
(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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 688	normal movement." from the website https://medlineplus.g. 2. For Resident #48 to provide services f hand contractures. On the most recent I annual assessment reference date) of 6/being cognitively into having scored 13 ou interview for mental being impaired for ra and right upper extre the facility with a dia disability/autism. On the following date observed in his room R48's left and right there was no eviden contracture in either 8/8/23 at 7:29 a.m. a 3:45 p.m.	tch the area and prevents This information is taken gov/ency/article/003185.htm. (R48), the facility staff failed or the resident's left and right MDS (minimum data set), an with an ARD (assessment 9/23, R48 was coded as act for making daily decisions, t of 15 on the BIMS (brief status). He was coded as ange of motion in both left emities. R48 was admitted to	F 6	, , , , , , , , , , , , , , , , , , ,				
	assistant) #11 was in was not aware of an	a.m., CNA (certified nursing nterviewed. She stated she y devices available for R48's His hands have always been						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		495272	B. WING _			C / 16/2023	
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	1 00	10/2023	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 688	On 8/14/23 at 11:25 a of rehab and an occu interviewed. She state OT (occupational their term care residents. Someonings, only what observation." She state a concern of if staff in then a full OT evaluated She stated she was recontractures in his has on 8/14/23 at 1:20 p. interviewed. She stated and close his hands in can use his hands in can use his hands for stated he can grasp a because of his contratine motor skill tasks his phone. She stated but he needs assistant him all the time, but he from a resting hand sofurther contracture." On 8/14/23 at 4:01 p. staff member) #1, the regional risk consultant, and ASM were informed of these	a.m., OSM #12, the director pational therapist, was ed her staff does periodic rapy) screenings on all long She stated: "These are only to we can see on a quick ted if the therapist observes terviews identify a concern, ion would be performed. ot aware that R48 had nd, but would go and look. m., OSM #12 was ed R48 was able to open in a limited way, and that he gross motor skill tasks. She and hold his phone, but, ctures, he cannot perform like punching the buttons on it: "Overall he is functional, ince. I wouldn't put a splint on e would probably benefit plint at night to help prevent m., ASM (administrative administrator, ASM #4, the int, ASM #8, the regional #7, the director of nursing, see concerns.	F6	88			
F 689 SS=E	Free of Accident Haza CFR(s): 483.25(d)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)		F 6	89		9/26/23	

	OF DEFICIENCIES CORRECTION	RECTION IDENTIFICATION NUMBER: A. BUILDING COMPLET		OMPLETED		
		495272	B. WING _			C 08/16/2023
	ROVIDER OR SUPPLIER URY REHABILITATION	N AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP C 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 689	§483.25(d)(2)Each supervision and assaccidents. This REQUIREMEN by: Based on observative record review and fidetermined the facinesidents free of ac 57 residents, Residwings on Grove Untersidents included 1. For Resident #14 ensure fall mats we from falls. Observations of Re 08/07/23 at 11:40 A side of bed; 8/10/23 either side of bed; 8/10/23 either side of bed; 8/10/23 9:15 AM, no bed. Resident #144's modata set) assessment, with a	resident receives adequate sistance devices to prevent NT is not met as evidenced tions, staff interview, clinical acility document review, it was lity staff failed to keep cidents and hazards for one of ent #144, and one of three it, the west wing. E: 14, the facility staff failed to be in use to prevent injury sident #144 revealed: on a.M, no floor mats on either at 2:45 PM, no floor mats on 8/08/23 at 7:45 AM, no floor of bed; on 8/8/23 at 11:30 on either side of bed; and on either side of bed; and on floor mats on ei	F 6	F689 Free of Accident Hazards/Supervision/Device SS=E Resident #144 bilateral fall obtained and placed while in bed. Resident #144 □ C N A #2, LPN#1 were re-educated be Development Coordinator/Ekeeping residents Free of A Hazards/Supervision/Device maintaining the use of floor ordered/Care Planned to minjury. The chemical used for rend Grove Unit Bondo was rembuilding and will not be utility.	mats were the resident is RN #1, and y the Staff Designee on accident tes, to include mats as aninimize risk of evation on the accordent the coved from the zed and an	
	15 on the BIMS (bri score, indicating the cognitively impaired A review of the com	e resident as scoring 03 out of fer interview for mental status) e resident was severely d. herehensive care plan dated d 6/11/23, revealed, "FOCUS:		alternative product was pur Current Residents who resi Canterbury Rehabilitation a and utilize fall prevention de	ide at and Healthcare	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY IPLETED
		495272	B. WING			0.0	C 3/16/2023
NAME OF PI	ROVIDER OR SUPPLIER	1.002.12	<u> </u>	STR	REET ADDRESS, CITY, STATE, ZIP CODE	1 00	0/10/2023
				177	6 CAMBRIDGE DRIVE		
CANTERB	BURY REHABILITATION	AND HEALTHCARE CENTER		RIC	CHMOND, VA 23238		
(X4) ID PREFIX TAG	(EACH DEFICIENC	MARY STATEMENT OF DEFICIENCIES ID PREFIX ORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG		(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	Continued From pag	Continued From page 148					
	deconditioning/ weal	risk for falls related to confusion, g/ weakness, history of falls, poor nessINTERVENTIONS: Bilateral			potential to be affected by this proces	S.	
	revealed, "Floor mate shift." An interview was cor with CNA (certified n	cian order dated 4/27/23, s to both sides of bed every nducted on 8/7/23 at 2:00 PM ursing assistant) #2, when 44 had bilateral fall mats,			Current Resident who resided at Canterbury Rehabilitation and Health had the potential to be affected by this process. The chemical Bondo was removed from the facility and will not utilized.	S	
	An interview was cor PM, with RN (registe about the bilateral flo RN #1 stated, "He us	are not there now. He used nducted on 8/9/23 at 2:20 red nurse) #1. When asked for mats for Resident #144, sed to have fall mats. I m to give to another resident	t		An audit was conducted on current residents by the Unit Manager/Desigr on fall prevention devices to include from the to validate implementation per Fof Care. Variances were addressed.	all	
	An interview was cor PM, with LPN (licens When asked about th Resident #144, LPN fall mats and when h must not have gone	anducted on 8/14/23 at 2:15 and practical nurse) #1. and bilateral floor mats for #1 stated, he had bilateral ais room was changed, they with him. A review of sus sheet reveals Resident			An audit by the Regional Maintenance Director to validate Bondo product was longer utilized and removed from the building was conducted with no further variance noted.	as no	
	#144 was transferred 6/11/23. On 8/14/23 at 4:00 F member) #1, the adr regional risk consulta nursing and ASM #8 made aware of the fi	Mr. ASM (administrative staff ninistrator, ASM #4, the ant, ASM #7, the director of the regional consultant was			The Staff Development Coordinator/Designee completed re-education for the Licensed Nursing Staff, C N A staff, and Department He staff on residents Free of Accident Hazards/Supervision/Devices, to inclumaintaining the use of floor mats as ordered/Care Planned to minimize ris injury.	ead	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION 3	(X3) DATE SUR COMPLETE	
		495272	B. WING			C 08/16/2023
	ROVIDER OR SUPPLIER URY REHABILITATION	AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	'	33/13/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	MUST BE PRECEDED BY FULL PREFIX (EACH CORREC		SHOULD BE	(X5) COMPLETION DATE
F 689	Continued From pag	ge 149	F 68	39		
	used for renovations in a well ventilated a evacuation of reside of the ventilated at evacuation of reside of the ventilated of ventilated	ailed to ensure chemicals on the Grove Unit were used area which resulted in the ents on the west wing. Eximately 9:30 AM, the movest wing of Grove Unit, and floor. The double doors by area on Grove Unit were no chemical odors in the movest entering the west wing on louble doors, a strong burned surveyor's nose was and the chemical odor grew or progressed down the esident was sitting in a mately one third way down the A male resident was walking far end of the hall. Female		The Regional Maintenance Director/Designee will provide re-education to the constructio regarding appropriate products and what alternative products of utilized. The DON/Designee will comple of 5 residents at risk for falls to care plan interventions are imp to include use of floor mats as Variances will be addressed. The Administrator/Designee will an audit to validate chemicals	ete an audit validate elemented indicated.	
	were okay, with no a resident and the mato find his bed. LPN the unit manager, had ouble doors onto the what is that smell. Shall with LPN #1 who down the hall. Roor curtain over the doo workers inside. Who the chemical odor so was asked a second Zippered curtain was construction worker was causing the checonstruction worker	esident were asked if they answer from the female le resident stating, he wanted I (licensed practical nurse) #1, and entered through the closed ne west wing. LPN #1 stated, Surveyor walked to far end of o was coughing as we walked in 317 had a plastic zippered arway and there were two een asked what was causing mell, there was no reply. This is time without a reply. It is sopened and male was asked a third time what temical odor smell, the female was sanding in the closet preply. LPN #1 at that point		renovations on the Units are us according to manufacturer si in and do not pose a potential risk residents who reside within the Variances will be addressed. Both audits will be conducted weeks, then monthly x 2 month findings of the audits will be suthe Administrator/Designee to Committee for review and recommendation monthly for 3 ongoing until compliance sustain	nstructions, k for the e facility. weekly x 4 ns. The bmitted by the QAPI months or	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495272	B. WING			1	C 16/2023
NAME OF PROVIDER OR CANTERBURY REHA		AND HEALTHCARE CENTER		17	TREET ADDRESS, CITY, STATE, ZIP CODE 76 CAMBRIDGE DRIVE ICHMOND, VA 23238	1 00	10/2020
	CH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPROI DEFICIENCY)			(X5) COMPLETION DATE
went up to the whee opening of Thirteen in wing, and on the we satisfied odor, whis surveyor? 316 at the doors we assistant? care, and no chemically care, and no chemically care, and the can obtain the	Ichair out to doors to couresidents we a total of 20 est wing. Roor construction changes in the received as the resident was asked about a construction superfluid English. If the resident were moved as and ASM end arrived applicable to the resident were moved to the resident were moved to the source of the resident were moved to the source of the total and the resident were moved to the resident to the resident were moved to the source of the the resident were moved to the resident to the resident the resident to	the lobby. Surveyor began in the lobby. Surveyor began in residents on unit. The currently on the west in residents were assigned from 316 (room next to room on) had strong chemical furning sensation in the oresidents were in room majority of resident room in the company of the current of t	F	589			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		495272	B. WING _			08/1	; 6/2023	
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238		007.	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE		(X5) COMPLETION DATE	
F 689	opened the fire door opened the fire door opened the fire door outside. Exhaust fan air though the west w president of operation in construction in build 10:35 AM, residents froom area off of the we are going to check asked what criteria west wing, ASM #3 sopen up then, just choodor continued in room. On 8/10/23 11:35 AM sitting in front of closwing. CNA #12 state allowed back. Observing the hallway or room was no chemical odd around nurse station, room. The medical pand was in process of assessments on Gromedical practitioner of each resident's ability residents were identifias having adverse efforms which was observed by there was no chemical Unit. On 8/14/23 at 4:00 Pmember) #1, the admiregional risk consultations.	ows on the west wing, next to room 317 and on the first floor to the was placed in the hall to pull ving. ASM #3, the vice ns, stated that Bondo is used lding for metal doors. At were in the lobby or dining west wing. ASM #3 stated, k on this in an hour. When rould be used to open the stated, we are not going to leck on it. The chemical	F	589				

			DATE SURVEY COMPLETED			
		495272	B. WING _			C 08/16/2023
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238		00/10/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	((EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 689	made aware of the fire According to the facility Renovation-Role of the Designee" policy, "Purand employee exposing agents released into a construction, renovating demolition or related or designee(s) will essurveillance for airbour environmental disease the project to protect patients. The administy monitor construction a completion to ensure CDC/HICPAC (center infection control practing guidelines and state of A review of the Bondo BONDO dated 3/24/2 "Recommended use: Use with adequate version of the source of th	ity's "Construction and ne Administrator or prose: To reduce resident ure to potentially infectious the environment due to ion, remediation, repair and activities. The administrator tablish and maintain the and waterborne e (e.g., aspergillosis, e) as appropriate throughout immunocompromised strator or designee(s) will and renovation projects until adherence to current of disease control/healthcare cices advisory committee) or local requirements."	F6	589		
F 690 SS=E	nasal discharge, head nose/throat pain."	-(3)	F€	590		9/26/23
	§483.25(e)(1) The factoresident who is continuous	cility must ensure that nent of bladder and bowel on ervices and assistance to				

			ATE SURVEY OMPLETED			
		495272	B. WING _			C 08/16/2023
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238		<u>'</u>	00/10/2020
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F 690			F 6	90		
		unless his or her clinical les such that continence is ain.				
	ensure that- (i) A resident who entindwelling catheter is resident's clinical concatheterization was notinity in the context of the context o	on the resident's assment, the facility must an not catheterized unless the dition demonstrates that ecessary; ters the facility with an asubsequently receives one wal of the catheter as soon e resident's clinical condition theterization is necessary; incontinent of bladder treatment and services to nfections and to restore				
	ensure that a resident receives appropriate restore as much norm possible. This REQUIREMENT by: Based on observation interview, clinical recodument review, it wastaff failed to provide	on the resident's ssment, the facility must t who is incontinent of bowel treatment and services to hal bowel function as is not met as evidenced		F690 Bowel/Bladder Inconti Catheter, UTI SS=E	nence	
	urinary catheters; Re			Resident #144 was provided ca indwelling catheter by Licensed		

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SU (X3) DATE SU (X3) DATE SU (X4) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SU (X3) DATE SU (X4) MULTIPLE CONSTRUCTION (X3) DATE SU (X4) MULTIPLE CONSTRUCTION (X5) DATE SU (X5) DATE SU (X5) MULTIPLE CONSTRUCTION (X6) DATE SU (X6) DATE		PLETED				
		495272	B. WING _			1	C / 16/2023
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER		17	TREET ADDRESS, CITY, STATE, ZIP CODE 76 CAMBRIDGE DRIVE ICHMOND, VA 23238	1 00	10,2020
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F 690	Continued From pag	F 6	F 690 documentation to support provision care was entered into the MAR.				
	ensure care for an ir provided. Observations of Resrevealed the residen	4, the facility staff failed to adwelling urinary catheter was sident #144 during the survey t with a Foley (1) catheter on bag. Urinary catheter ed.			Resident #86 currently has a physiciar order for the use of an external urinary catheter and orders for catheter care puthe manufacturer secommendations	er	
	revealed, "Foley Our related to obstructive A review of the July (treatment administroutput documented evidence of urinary of the state	f the physician order dated 6/27/23, 'Foley Output every shift for Foley Cath obstructive and reflux uropathy." f the July and August 2023 TAR administration record) revealed urine sumented each shift. There was no of urinary catheter care documented for #144 for July and August 2023.			LPN #6 and C N A #6 were re-educate on Bowel/Blader Incontinence Cathete care and the process for documentation of care provided, and for the utilization external catheters the physician order requirement and care provision per the manufacturer secommendations by Staff Development Coordinator/Design	r on of e the	
	PM, with RN (register if a physician's order catheter care, RN # required. When asked care is documented, TAR. When asked if of urinary catheter country the care plan implements.				Current Residents who have an indwe catheter or external urinary catheter had the potential to be affected by this practice. An audit was accomplished by the Unit Manager/Designee of current residents who utilize indwelling catheter for evidence to support that documentation of urinary catheter care was provided each shift.	y ers	
	AM, with LPN (license When asked where documented, LPN # on the TAR. When a documentation of ur	nducted on 8/14/23 at 10:20 sed practical nurse) #13. urinary catheter care is 13 stated, it is documented asked if there is no inary catheter care, was the ed, LPN #13 stated, no, it is			An audit was accomplished by the Uni Manager/Designee of current residents who utilize external catheters for curre physician orders and orders for catheter care provision per the manufacturer secommendations.	s nt er	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495272	B. WING _			08/	16/2023
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	10/2020
CANTERB	SURY REHABILITATION	AND HEALTHCARE CENTER		1776 CAMBRIDGE DRIVE RICHMOND, VA 23238			
(X4) ID PREFIX TAG	(EACH DEFICIENC	JMMARY STATEMENT OF DEFICIENCIES ID DEFICIENCY MUST BE PRECEDED BY FULL PREFIX ATORY OR LSC IDENTIFYING INFORMATION) TAG		<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 690	Continued From page		Fθ	690			
F 690	not being implemented On 8/14/23 at 4:00 Pimember) #1, the admiregional risk consultation nursing and ASM #8, made aware of the firm. No policy regarding uprovided. No further inprior to exit. Reference: (1) A Foley catheter is indwelling catheter. It tube that is inserted in urine. https://medlineplus.gr. 2. For Resident #86 (to obtain physician's manufacturer's instruexternal urinary cather. On the most recent Manufacturery assessment reference date) of 7/10 out of 15 on the BIMS status), indicating the intact for making daily R86's clinical record in physician's orders for catheter. Further rev	M, ASM (administrative staff inistrator, ASM #4, the nt, ASM #7, the director of the regional consultant was adings. rinary catheter care was information was provided s a common type of has soft, plastic or rubber into the bladder to drain the ov/ency/article/003981.htm R86), the facility staff failed orders and provide care per ctions for the resident's eter. IDS (minimum data set), a with an ARD (assessment 7/23, the resident scored 15 b) (brief interview for mental in resident was cognitively of decisions. A review of failed to reveal any R86's external urinary itew of R86's clinical record structions for care of the	F6	690	Variances were addressed. The Staff Development Coordinator/Designee re-educated Licensed Nursing Staff and CNA st on Bowel/Blader Incontinence Cathete care and the process for documentatio of care provided, and the physician or requirement for the utilization of extern 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 utiliz an indwelling urinary catheter to valida catheter care was provided and documented documentation to support that documentation of urinary catheter care was provided each shift. In additi an audit will be accomplished by the DON/Designee of 3 residents who utiliz an external urinary catheter to validate physician order is in place and that ord are present and implemented for cathe 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	r n ler al ze te on, ze a ers	
	On 8/7/23 at 12:37 p. sitting upright in bed external urinary cathe	m., R86 was observed eating lunch. The resident's eter canister was observed e nightstand, and was			DON/Designee to the QAPI Committee for review and recommendation month for 3 months or ongoing until compliant sustained.	ly	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
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		495272	B. WING			08/	16/2023
	ROVIDER OR SUPPLIER BURY REHABILITATION	AND HEALTHCARE CENTER	•	17	TREET ADDRESS, CITY, STATE, ZIP CODE 776 CAMBRIDGE DRIVE ICHMOND, VA 23238		
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F 690	8/8/23 at 7:27 a.m., Fed. The resident's ecanister was observed nightstand, and was of urine. On 8/9/23 a observed lying in bedurinary catheter canisbed, on the nightstand one third full of urine. was conducted with Edaughter bought the facility staff were not timely manner. R86 care for the catheter care. R86 stated sincurrent hall, some of catheter system like them to rinse the wick day and change the wishe has a bowel move a.m., R86 was obserresident's external urobserved beside the was approximately of On 8/10/23 at 4:07 pconducted with CNA #6 (a CNA who cared the external urinary of CNA #6 stated she rethe tubing and canist the resident has a book on 8/11/23 at 8:14 acconducted with LPN LPN #6 stated R86 hcatheter for at least a	fourths full of urine. On R86 was observed lying in external urinary catheter ad beside the bed, on the approximately one tenth full at 4:18 p.m., R86 was d. The resident's external ster was observed beside the ad, and was approximately. At that time, an interview R86. R86 stated her catheter system because the changing the resident in a stated she did not personally but provided the supplies for ce she has resided on the the staff do not clean the they should but she tells k, tubing and canister once a wick once a day, or more if rement. On 8/10/23 at 7:50 wed lying in bed. The inary catheter canister was bed, on the nightstand, and he half full. I.m., an interview was (certified nursing assistant) of for R86). CNA #6 stated eatheter was new to her. Eplaces the wick and washes er per R86's request and if the adventure of the state of th	F	690			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		ONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495272	B. WING _				C 16/2023	
	ROVIDER OR SUPPLIER BURY REHABILITATION A	AND HEALTHCARE CENTER		177	EET ADDRESS, CITY, STATE, ZIP CODE 6 CAMBRIDGE DRIVE EHMOND, VA 23238			
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F 690	catheter, and it's been LPN #6 stated he look that staff had to empty did not obtain any phywas a device the resistance LPN #6 stated staff kill device because R86 to empty it and make infection control becautract infections. (Note treated with antibiotic infection). The external urinary constructions documen PureWick System (Troption to managing urincludes the PureWick External Catheter and Urine Collection System 2000cc (mL) before volume reached system 2000cc (mL) before volume reached. Is the PureWick (Trade System 2000cc (mL) before volume reached at least ever soiled with feces or biassessed to see if it's perineal care should be placement of a new with the canister and tubic 60 days, or sooner if degradation." This in the website:	n a learning experience. ked up the device and knew y it and clean it out, but he ysician's orders because it dent brought from home. hows how to care for the tells them and it's important sure the tubing is clean for use there is a risk for urinary e- on 6/6/23, R86 was therapy for a urinary tract catheter manufacturer's ted the following, "The ademark) is an innovative rinary incontinence. It k (Trademark) Female d the PureWick (Trademark) em. The System works raw urine away, helping mark) Urine Collection canister should be emptied es 1800cc (mL), or as demark) Female External No. The wick should be ry 8 to 12 hours or sooner if lood. Skin should be been compromised, and be performed prior to vick. ng should be replaced every	F	690				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	1 ` ′	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495272	B. WING		C 08/16/2023		
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	1 33/10/2020		
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F 690	staff member) #1 (the regional risk co the above concern.	ge 158 a.m., ASM (administrative ne administrator) and ASM #4 nsultant) were made aware of led, "PureWick Female	F 69	90			
F 002	External Catheter" I external catheter sh with feces or blood a more than every 12 canister and tubing week or as needed visibly soiled or dam	Documented, "2. The female ould be changed when soiled and at least once a shift, no hours. 3. Urine collection should be replaced once a if the tubing and canister are	F 69		9/26/23		
SS=D	CFR(s): 483.25(g)(4)-(5) En (Includes naso-gast both percutaneous en percutaneous enteral fluids). Base	e)(5) Interal Nutrition Interal Record of the second of	1 08		9/20/23		
	eat enough alone or enteral methods unl condition demonstra	dent who has been able to with assistance is not fed by ess the resident's clinical ates that enteral feeding was and consented to by the					
	means receives the services to restore, and to prevent comp including but not lim diarrhea, vomiting, of	dent who is fed by enteral appropriate treatment and if possible, oral eating skills blications of enteral feeding ited to aspiration pneumonia, dehydration, metabolic hasal-pharyngeal ulcers.					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER	•	STREET ADDRESS, CITY, STATE, ZIP CC 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	DDE	3.10.2020	
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F 693	by: Based on observation interview, clinical red document review, it staff failed to provide orders, for one of 16. The findings include For Resident #144, physician orders for On 8/7/23 at 2:30 Physician orders for On 8/7/23 with diagnos filling for a 3/27/23 with	ons, staff interview, resident cord review and facility was determined the facility at tube feeding per physician residents; Resident #144. The facility staff failed to follow tube feeding. M, Resident #144 was ran 1.5 calorie, 700 ml ng at the bedside and not g was labeled with a start AM. The Glucerna container admitted to the facility on sees that include but are not assessment reference date resident as scoring 03 out of a finterview for mental status) resident was severely MDS Section G- Functional sident as total dependence wor MDS Section utritional Status: coded the d symptoms of possible as: PEG (percutaneous	F	F693 Tube Feeding Mgmt/F Skills SS=D Resident #144 tube feeding reviewed by the clinical provinew recommendations or or new recommendations or or feeding at rate and time per bag and tubing are dated for and dating tubing with correstaff Development Coordinates. Current residents who receive feedings have the potential to by this practice. An audit was completed by Manager/Designee for currestamonary who receive tube feeding to administration rate and time physician orders and that the dated correctly. No further vinoted.	orders were vider with no orders. ecceiving tube order. The r current date. education on tube feedings of date by the ator/Designee. we tube to be affected Unit ent residents validate s are per e tubing is		
	A review of the comp	prehensive care plan dated					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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NAME OF PI	ROVIDER OR SUPPLIER			STREE	T ADDRESS, CITY, STATE, ZIP CODE	1 00/	10/2023		
				1776 C	CAMBRIDGE DRIVE				
CANTERE	BURY REHABILITATION	AND HEALTHCARE CENTER		RICHI	MOND, VA 23238				
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F 693	related to NPO (nothing dependence on enter encephalopathy, CKE failure, altered mental PEG (percutaneous explace. Resident requifeeding related to dysphagiaINTERVE nutrition as ordered. It as ordered for hydrat Administer tube feeding tube every shing the feeding tube every shing tube every shing tube every shing the feeding tube every shing tube every shi	as a nutritional problem and infusion, diagnosis of D, dysphagia, respiratory I status, DM, anemia, and endoscopic gastrostomy) in res require enteral tube ENTIONS:Provide enteral Provide flushes of free water ion and tube patency. In gas ordered" Cian's order dated 6/1/23, lucerna 1.5 Calorie liquid via nift, feeding pump set at 75 our) for 20 hours, total vides 2250 kcal, 124 protein, IP AT 1300 (1:00 PM), D AM), or until total volume es a day begin and end with flush of 200 mL free and tube patency AND every 3 e with 200 mL free water for atency." ducted on 8/7/23 at 3:30 red nurse) #1. When shown beding for Resident #144, left hanging, it should have then asked about the date, a wrong date and time. They ew feeding soon. When is were followed, RN #1	F6	Liure contul cont	censed Nursing staff members were educated by the staff development pordinator on following current orders be feedings and dating the tube with prect date. In audit was completed by Unit anager/Designee for current resident the receive tube feeding to validate diministration rate and times are per mysician orders and that the tubing is atted correctly Variances will be addressed. These audits will be conducted weekly x 4 weeks, then conthly x 2 months. The findings of the condition will be submitted by the ON/Designee to the QAPI Committee or review and recommendation month and its analysis.	the ts e e			
		M, ASM (administrative staff ninstrator, ASM #4, the							

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	IPLE CONST	RUCTION	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238			10/2023	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	Κ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE	
F 693	regional risk consultanursing and ASM #8, made aware of the find According to the facilipolicy, "The nursing resident for signs and nutrition, altered hydroperglycemia, and anursing staff and provesident for worsening resident for worsening resident at risk for the are scheduled to try independence whened during hours that do resident's ability to part the nurse confirms to nutrition are completed at the enteral nutrition placement); c. the specific (nasogastric, gastric, administration method intermittent); e. volume f. the volume/rate good advancement toward for flushing (solution, and 24-hour volume). No further information Reference:	ant, ASM #7, the director of the regional consultant was indings. Itity's "Enteral Nutrition" staff and provider monitor the disymptoms of inadequate ration, hypo- or altered electrolytes. The vider also monitor the electrolytes are provided to optimize resident ever possible (e.g., at night or not interfere with the articipate in facility activities). The complete orders include: In product; b. delivery site (tip recific enteral access device in product; b. delivery site (tip recific enteral ent		693	DEFICIENCY)			
	when you cannot eat This can happen if you trouble swallowing. E feeding can provide to also be used to remot types of tubes used i	way to provide nutrition or drink safely by mouth. ou are unconscious or have desides nutrition, tube fluids and medicines. It can eve stomach contents. The nclude the nasogastric tube ostomy tube (G-tube or						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	IPLE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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	ROVIDER OR SUPPLIER URY REHABILITATION A	AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	<u>, </u>	10/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 693	PEJ-tube). The NG tu nose and is used for a and J-tube are inserte the skin on the abdon use.	e 162 Ejunostomy tube (J-tube or libe is inserted through the la short time. The G-tube led through a small incision in liben and are for longer-term lov/ency/imagepages/19965.	Fθ	693		
F 695 SS=E	S 483.25(i) Respirator tracheostomy care ar The facility must ensure needs respiratory car care and tracheal succare, consistent with practice, the compreheare plan, the resider and 483.65 of this sul This REQUIREMENT	d tracheal suctioning. Ire that a resident who e, including tracheostomy tioning, is provided such professional standards of lensive person-centered tts' goals and preferences,	F €	395		9/26/23
	interview, facility docurecord review, the factor respiratory care and suprofessional standard the survey sample, R and #54. The findings include: 1. For Resident #360	n, resident interview, staff ument review and clinical cility staff failed to provide services consistent with s for four of 57 residents in esidents #360, #358, #106 (R360), the facility staff sician's order for the use of		F695: Respiratory/Tracheostomy Ca 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.	ne	
	an incentive spiromet incentive spirometer i	er and failed to store the		Resident #106 was discharged from the	ıe	

	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:		(2) MULTIPLE CONSTRUCTION . BUILDING			(X3) DATE SURVEY COMPLETED	
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		495272	B. WING _			0	8/16/2023	
NAME OF P	ROVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, STATE, ZIP CODE			
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CANTERE	OURT REHABILITATION	AND HEALTHCARE CENTER		R	ICHMOND, VA 23238			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 695	assessment was in I	ninimum data set (MDS) progress. An admission	F€	695	facility on 8/21/23.			
	assessment dated 7 was alert and oriente situation. Further re failed to reveal a phyincentive spirometer			Resident #54 oxygen orders were reviewed, and oxygen was adjusted by licensed nurse to the prescribed rate.	/ the			
	8/8/23 at 9:53 a.m., bed. An incentive sy the heating/air cond mouthpiece was in c 8/8/23 at 9:53 a.m., with R360. R360 sta spirometer a couple	o.m., 8/7/23 at 3:54 p.m., and R360 was observed lying in pirometer was observed on itioning unit and the contact with the unit. On an interview was conducted ated they use the incentive of times a day and has never ning to cover the device.			LPN #7, #13, and RN #1 were provide with re-education on receiving and following orders for incentive spirometer use and how to properly store when no use, review of oxygen administration proder, and monitoring of pulse oximeter as ordered.	er ot in er		
	On 8/10/23 at 2:19 p.m., an interview was conducted with LPN (licensed practical nu LPN #7 stated a resident should have a physician's order for an incentive spirome make sure it is used in a timely fashion, a incentive spirometer should be covered for infection control purposes.				Current residents who utilize respirator services have potential to be affected this practice. An audit of residents who utilize oxyge was conducted to validate oxygen is administered at a rate and method as	оу		
	staff member) #1 (th (the regional risk con the above concern. 2. For Resident #35	a.m., ASM (administrative ne administrator) and ASM #4 nsultant) were made aware of 8 (R358), the facility staff payygen at the physician to liters per minute.			ordered and pulse oximetry monitoring 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 maintained when not in use. No furthe variances were noted.	is		
	physician' order date	clinical record revealed a ed 8/7/23 for oxygen at two nasal cannula every shift.			Licensed Nursing staff members were re-educated on following physician ord	lers		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		495272	B. WING _			C 08/16/2023	
	ROVIDER OR SUPPLIER	N AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238		00/10/2020	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 695	observed lying in b cannula at one and evidenced by the r concentrator flown one-and-a-half-lite On 8/10/23 at 2:19	p.m. and 7:35 a.m., R358 was need receiving oxygen via nasal d a half liters per minute, as niddle of the ball in the oxygen neter positioned on the r line.	F 6	for oxygen administration, copulse oximetry as ordered, orders prior to the use of incospirometers, and sanitary stoincentive spirometers when its audit of 3 residents who is	btaining entive orage of not in use.		
	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.			will be conducted by Respira Director/Designee to validate administered at a rate and mordered and pulse oximetry reconducted as ordered. In adaudit of 3 residents that have spirometers will be complete an order is in place for use a sanitary manner is maintaine use. Variances will be addresudits will be conducted weeks, then monthly x 2 mor findings of the audits will be the DON/Designee to the QAC Committee for review and recommendation monthly for ongoing until compliance sus	etory e oxygen is ethod as monitoring is dition, an e incentive d to validate nd storge in a ed when not in essed. These ekly x 4 nths. The submitted by API		
	instructions docum the prescribed sett top of the flow met the line marking th The facility policy t documented, "1. V order for this proce orders or facility pr administration." 3. For Resident #1	ntrator manufacturer's nented, "5. Adjust the flow to ing by turning the knob on the er until the ball is centered on e specific flow rate." itled, "Oxygen Administration" erify that there is a physician's edure. Review the physician's otocol for oxygen 06, the facility staff failed to therapy as ordered. Resident					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495272	B. WING				C 16/2023	
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER	1	17	REET ADDRESS, CITY, STATE, ZIP CODE 76 CAMBRIDGE DRIVE CHMOND, VA 23238	1 00	10/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)			(X5) COMPLETION DATE	
F 695	nasal cannula at two consistent document via pulse oximetry (1) Resident #106 was a 10/10/22 with diagnol limited to: ASCVD (a disease), COPD (chr disease), OSA (obstr CHF (congestive heater the congestive heater the co	liters per minute without ed oxygen saturation levels). Idmitted to the facility on ses that include but are not therosclerotic cardiovascular onic obstructive pulmonary ructive sleep apnea), and art failure). It recent MDS (minimum t, a significant change assessment reference date resident as scoring 04 out rief interview for mental ing the resident was severely A review of MDS Section is: coded the resident as INTERVENTIONS: In facility protocol. 02 per MD signs, including pulse and clinically indicated" In cian orders dated 7/1/23, it 2-4 liters/minute via nasal on one of the code of the	F	695				
	obtained at least eve	oxygen saturations were ry 24 hours from 7/1/23 to ere were oxygen saturation						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495272	B. WING _			C 08/16	6/2023		
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	·E	00/10			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	-	(X5) COMPLETION DATE		
F 695	levels documented frunder the vital signs administration record. An interview was cor AM with LPN (license When asked if there SPO2 levels to deter levels of 2-4 liters, was ervices being provid stated, no, it is not. On 8/14/23 at 2:15 P conducted with RN (lasked where SPO2 lendered with RN (lasked where SPO2 lendered with RN (lasked where SPO2 lendered). When asked oximeter as ordered Resident #106's meditherapy services bein #1 stated, no, it is not. On 8/14/23 at 4:00 P member) #1, the adn regional risk consultanursing and ASM #8, made aware of the fill According to the facility policy, "Assessment: oxygen, and while tho oxygen therapy, assessings or symptoms of the skin and mucous symptoms of hypoxia pulse rate, restlessnessymptoms of oxygen	tab, TAR (treatment l) or progress notes. Iducted on 8/14/23 at 10:20 ad practical nurse) #13. Iducted on 8/14/23 at 10:20 ad practical nurse) #13. Iducted on 8/14/23 at 10:20 ad practical nurse) #13. Iducted on 8/14/23 at 10:20 ad practical nurse) #13. Iducted on 8/14/23 at 10:20 add practical nurse) #13. Iducted on 8/14/23 at 10:20 add practical nurse) #13. Iducted on 8/14/23 at 10:20	F	395					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		495272	B. WING _			C 08/16/2023	
	ROVIDER OR SUPPLIER	N AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP COI 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238)E		
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF CC X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 695	Arterial blood gase: applicable; and 7. ((hemoglobin, hemacount), if applicable completing the oxygfollowing information resident's medical in that the procedure and title of the indiverse procedure. 3. The interior rationale." No further information in the following information in the procedure of the indiverse procedure. 3. The interior information in the information i	al signs; 5. Lung sounds; 6. and oxygen saturation, if Other laboratory results atocrit, and complete blood and the Documentation: After gen setup or adjustment, the an should be recorded in the record: 1. The date and time was performed. 2. The name ridual who performed the rate of oxygen flow, route, and fon was provided prior to exit. For can also measure blood evels through a small clip that 'your finger or toe. An only indicates what percentage furated with oxygen, known as well as your heart rate. It 's a see way to check if someone 's is too low. It is also well as your heart rate. It is a see way to check if someone 's is too low. It is an at the rate ordered by the laboratory and the rate ordered by the laboratory and the rate ordered by the laboratory and the resident was oxygen in the facility.	F	695			
	observed in bed recannula via a conceper minute (3 lpm):	tes and times, R54 was beiving oxygen through a nasal entrator at a rate of three liters 8/7/23 at 12:10 p.m. and 4:18 8 a.m.; and 8/9/23 at 11:14					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	495272	B. WING _			C 08/16 /	/2023
NAME OF PROVIDER OR SUPPLIER CANTERBURY REHABILITATION AN	ID HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	E		
PREFIX (EACH DEFICIENCY!	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	-	(X5) COMPLETION DATE
order dated 5/23/23: "C sat [saturation] <90% (I A review of R54's Augu administration record) f that the resident's oxyg than 90% without the s therapy. A review of R54's care revealed, in part: "I hav statusAdminister oxyg. On 8/9/23 at 12:27 p.m nurse) #3 observed the administration on the od stated: "It's set on three On 8/9/23 at 4:11 p.m., assistant) #10 was ask R54 adjusting his own of she was not. She state resident was mobile en the concentrator and check the concentrator and check the concentrator should she stated the physicial stated if the oxygen is for the concentrator should she stated if the oxygen is for the concentrator should she stated if the oxygen is for the concentrator should she stated if the oxygen is for the concentrator should she stated if the oxygen is for the concentrator should stated if the oxygen is for the concentrator should she stated if the oxygen is for the concentrator should stated if the oxygen is for the concentrator should she stated if the oxygen is for the concentrator should she stated if the oxygen is for the concentrator should she stated if the oxygen is for the concentrator should she stated if the oxygen is for the concentrator should she stated if the oxygen is for the concentrator should she stated if the oxygen is for the concentrator should she stated if the oxygen is for the concentrator should she shall she should be concentrator should she stated if the oxygen is for the concentrator should she shall	rs revealed the following 22 (oxygen) at 2 lpm for O2 ess than 90%)." st 2023 MAR (medication failed to reveal evidence en saturation was less supplemental oxygen plan dated 5/31/23 e altered respirator gen as ordered." ., LPN (licensed practical rate of oxygen concentrator for R54. She e liters." CNA (certified nursing ed if she was aware of oxygen rate. She stated d she was not sure the ough to be able to get to hange the rate. ., LPN (licensed practical wed, she stated if a oxygen to be administered the center of the ball on d be on the two liter line. In orders the rate. She lowing at any other rate ered by the physician, the	F 6	95			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		495272	B. WING _			C 08/16/2023	
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP C 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	•		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	· ·	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 695	staff member) #1, th regional risk consult consultant, and ASM were informed of the No further information	e.m., ASM (administrative e administrator, ASM #4, the ant, ASM #8, the regional 1 #7, the director of nursing,		695			
F 697 SS=E	§483.25(k) Pain Mar The facility must ens provided to residents consistent with profe the comprehensive p and the residents' go This REQUIREMEN by: Based on staff inter and facility documer that the facility staff of complete pain mana 57 residents in the s and #133. The findings include	sure that pain management is so who require such services, essional standards of practice, person-centered care plan, pals and preferences. To is not met as evidenced eview, clinical record review at review, it was determined failed to implement a gement program for two of urvey sample, Residents #63 (R63), the facility staff failed macological interventions	F	F697: Pain Management SS=E Resident # 63 was discharged facility on 8/8/23. Resident # 133 pain management facility on 8/8/23.	gement orders lical provider	9/26/23	
	on the most recent l quarterly assessmer reference date) of 08 scored 15 out of 15	ration of a prn (as needed) cetaminophen (1) and failed ation of the pain. MDS (minimum data set), a at with an ARD (assessment 5/21/2023, the resident on the BIMS (brief interview dicating the resident was		with orders updated to include and/or pain characteristics, nonpharmacological interverse administration of unschedule. LPN # 16 was re-educated Development Coordinator/I	, and entions prior to iled analgesics. by Staff		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		495272	B. WING			C 08/16/2023		
NAME OF P	ROVIDER OR SUPPLIER	1002.12	<u> </u>	ST	REET ADDRESS, CITY, STATE, ZIP CODE	0	0/16/2023	
	10 112 11 011 001 1 21211				76 CAMBRIDGE DRIVE			
CANTERB	URY REHABILITATION	AND HEALTHCARE CENTER			CHMOND, VA 23238			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 697	Continued From pag	ne 170	F 6	97				
	The physician order "Acetaminophen Tab	•			regarding offering and documenting nonpharmacological interventions prio administering unscheduled analgesics			
	(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				LPN # 10 was re-educated by Staff Development Coordinator/Designee o documentation of pain management	n		
					program to include location and/or pai characteristics, and/or attempts at nonpharmacological interventions.	n		
	R63's pain on 07/03/ 07/08/2023, 07/13/20	nentation of the location of /2023, 07/06/2023, 023, 07/17/2023, 07/18/2023, 023, 07/24/2023 and on			Current residents on pain management therapy have the potential to be affect by this practice.			
	record) for R63 date the physician's order eMAR revealed that Acetaminophen with non-pharmacologica attempted nor docum	ne eMAR (electronic medication administration acord) for R63 dated August 2023 documented e physician's orders as stated above. The MAR revealed that R63 received 325 mgs of actaminophen with no evidence of an-pharmacological interventions being tempted nor documentation of the location of 63's pain on 08/01/2023 and 08/04/2023.			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 loca of pain and/or pain characteristics and attempting nonpharmacological interventions prior to administration of	ation		
	list above failed to ev non-pharmacologica	s notes for R63 for the dates vidence documentation of I interventions prior to the etaminophen and the location			unscheduled pain medications. Variar were addressed.			
	Review R63's compr 01/21/2023 failed to	rehensive care plan dated evidence documentation to and pain interventions.			Licensed Nursing staff members were re-educated on pain management program to include location and/or pai characteristics, and/or attempts at nonpharmacological interventions.			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` '	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER	700212		STREET ADDRESS, CITY, STATE, ZIP CODE	 	08/16/2023
				1776 CAMBRIDGE DRIVE		
CANTER	BURY REHABILITATION	AND HEALTHCARE CENTER		RICHMOND, VA 23238		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 697	F 697 Continued From page 171		F 69	7		
r 69/	On 08/10/2023 at appinterview was conducted practical nurse) #16. the procedure for adressess the resident's to ten with ten being resident where the papain without the med successful then admit When asked about donon-pharmacological the location of the resit would be document progress notes. After nursing progress notes. After nursing progress notes and completed, and note the completed, and note the nursing progress notes. On 08/14/2023 at appinterventions were noted. No further information was entirely used to relieve mediaches, muscle accolds and sore throat and reactions to vacoured the septiment of the septiment. 2. For Resident #133 implement a completed in the website in the septiment and the sep	proximately 2:15 p.m., an otted with LPN (licensed When asked to describe ministering as needed (prn) N #16 stated they would a pain level on a scale of zero their worse pain and ask the ain was, try to alleviate the ication and if that was not inister the pain medication. occumenting the linterventions attempted and sident's pain, she stated that ted on the MAR and in the reviewing R63's eMAR and es for the dates listed above a full pain assessment was con-pharmacological of attempted. proximately 9:50 a.m., ASM member) #1, administrator all risk consultant, were made indings. In was provided prior to exit. It was provided prior to exit.	F 69	An audit will be completed by Manager/Designee of 3 reside management therapy to validate management services is provimanner that is consistent with professional standards of practinclude but is not limited to do of location of pain and/or pain characteristics and attempts a nonpharmacological intervential administration of unscheduled medications were made. Variated addressed. These audits will be conducted weekly x 4 weeks, monthly x 2 months. The findinal audits will be submitted by the DON/Designee to the QAPI Cofor review and recommendation for 3 months or ongoing until constants.	ents on pain ate pain ded in a stice to cumentation t ons prior to pain ances will be be then ongs of the second monthly	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	•	30/10/2020	
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F 697	Continued From pag		F 6	97			
	non-pharmacological A review of the clinic physician's order da 5 mg (milligrams) or needed for moderate A review of the Augu Administration Reco was administered as 8/1/23 at 8:19 PM 8/2/23 at 1:22 AM at 8/3/23 at 5:29 AM 8/4/23 at 2:32 AM at 8/5/23 at 12:00 AM at 8/5/23 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	al interventions. cal record revealed a ted 8/1/23 for Oxycodone (1) ne capsule every six hours as e to severe pain. ust 2023 MAR (Medication ord) revealed the Oxycodone is follows: and 12:59 PM and 12:10 PM and 9:00 PM and 12:10 PM ce clinical record failed to rain location and/or pain or attempts at					
	A review of the clinic comprehensive care dated 7/6/23 for "I hpain." This care pla dated 5/1/23 for "Ennon-pharmacologica as applicable e.g. po	cal record revealed the e plan which included one ave pain and/or potential for n included the intervention courage me to try al interventions for pain relief ositioning, relaxation therapy, old application, muscle					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			1 ' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
	495272 B. WING		C 08/16/2023			
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	1 00/	10/2023
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 697	Practical Nurse) was given this resident's of non-pharmacological really be offered is a she stated the reside stated that the reside anything else. She scharacteristics and no interventions should be on 8/14/23 at 4:00 Pl ASM #1 (Administrator, ASM #7 to ASM #8 the Regional aware of the findings provided by the end of References:	PM, LPN #10 (Licensed interviewed. She stated that condition, the only interventions that could change in position, which not did not like to do. She not did not like to get up for tated that pain location and con-pharmacological conduction and consumented. M at an end-of-day meeting, we Staff Member) the #4 the Regional Risk the Director of Nursing and 1 Consultant, were made. No further information was of the survey.	F 69)7		
	severe pain. Information obtained https://medlineplus.gottml Dialysis CFR(s): 483.25(I) §483.25(I) Dialysis. The facility must ensurequire dialysis receiv with professional star comprehensive persot the residents' goals a This REQUIREMENT by: Based on staff interv	ov/druginfo/meds/a682132.h ure that residents who we such services, consistent adards of practice, the on-centered care plan, and	F 69	P698: Dialysis		9/26/23

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	(X3) DATE SURVEY COMPLETED		
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NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	00/10/2023
				1776 CAMBRIDGE DRIVE	
CANTERB	URY REHABILITATION	AND HEALTHCARE CENTER		RICHMOND, VA 23238	
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F 698	Continued From pag	e 174	F 698		
	dialysis care and ser residents receiving of #149. The findings include For Resident #149, 1 and maintain consist dialysis center by wa communication book 2023 A review of the clinic physician's order dat Tuesdays, Thursday A review of the dialyconducted. The folloresident was schedules.	e dialysis facility regarding rvices, for one of seven lialysis services; Resident che facility staff failed to utilize tent communication with the ay of the dialysis in June, July, and August of all record revealed a ted 6/16/23 for dialysis on		The licensed nurse obtained provide obtained an update from Resident # dialysis center on 9/8/23. The dialysis center coordinator was also made at of the need to provide updates utilizi communication form. Resident #149 provided dialysis communication bode each dialysis appointment. Current residents on dialysis have potential to be affected by this praction. An audit was completed by Unit Manager/Designee on residents recedialysis to validate dialysis communities sent and received for dialysis appointment. Variances were address	149 s ware ng the is ok for ce. eiving cation
	evidence that any concept between the facility and 17, 20, 24, 27, and 218, 22, 25, 27, and 218, 22, 25, 27, and 218, 22, 25, 27, and 218, 20, 20, 20, 20, 20, 20, 20, 20, 20, 20	ommunication occurred and the dialysis center: June 29 of 2023. July 6, 8, 11, 15, 29 of 2023. August 1, 3, 5, a.M., an interview was #1 (Licensed Practical that there should be amented every time they send and bring the book back at the dialysis center should every visit. She stated that		Licensed Nursing staff members were-educated on the need for resident who require dialysis to have ongoing communication and collaboration be the facility and the dialysis facility regarding dialysis care and services includes but is not limited to complet and maintaining the dialysis communication form sent and to be returned with the resident on each violation. The Unit Manager/designee will communication of 3 residents on dialysis to validate communication regarding care.	tween this ion sit.

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED	
		495272 B. WING		1	C 08/16/2023		
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00	10/2023	
CANTEDD	LIDV DELLA DIL ITATIONI A	AND HEALTHCARE CENTER		1776 CAMBRIDGE DRIVE			
CANTERD	ORT REHABILITATION A	AND HEALTHCARE CENTER		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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 698	698 Continued From page 175		F 69	98			
	should be something A review of a "Dialysis revealed the following the form to be filled in dialysis center: Vital and post dialysis weig comments, shunt site administered, tolerand of last food intake, admame, date. A policy for dialysis we provided, "Hemodialy Care Of" did not addrommunication with, something to the somethi	documented for every visit. s Communication Log" g information contained on by the facility and the signs, weight - including pre ght, labs drawn, dietician care, medications ce of dialysis treatment, time ditional comments, resident as requested. The policy sis Catheters - Access and ess the requirement for to and from, the facility and		and services that are being sent to received from the dialysis center fo dialysis appointment. Variances will addressed. These audits will be conducted weekly x 4 weeks, then monthly x 2 months. The findings of audits will be submitted by the DON/Designee to the QAPI Comm for review and recommendation mother for 3 months or ongoing until comp sustained.	r each I be of the ittee onthly		
F 700 SS=D	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 70	00		9/26/23	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495272	B. WING		C 08/16/2023	
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	1 00/10/2023	
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F 700	Continued From pag	e 176	F 700	0		
	bed rails with the res representative and o to installation. §483.25(n)(3) Ensure are appropriate for the second and maintaining bed This REQUIREMENty: Based on observation document review and facility staff failed to its representation of the second and the	e that the bed's dimensions the resident's size and weight. the manufacturers' d specifications for installing rails. is not met as evidenced on, staff interview, facility d clinical record review, the mplement bed rail		F700: Bedrails SS=D		
	survey sample, Resident The findings include:	e of 57 residents in the dents #359, #95 and #358. (R359), the facility staff		Resident #359, and #95, were reviewed for bed rails by the IDT to include documentation of clinical need, reviewed the risks and benefits of bed rails, physician order and informed consent	of	
	implemented bed rail recommended clinical risks and benefits of informed consent for On 8/7/23 at 12:17 p R359 was observed bar (bed rail) in the unit of the consent of th	s without a documented all need, failed to review the bed rails, and failed to obtain the use of bed rails. m. and 8/8/23 at 11:38 a.m., lying in bed with a left grab pright position.		the use of bed rails. Resident #358 was discharged from the facility on 8/30/23.		
	a physician's order for evidence that the risk were explained to the representative), and informed consent for	inical record failed to reveal by bed rails, failed to reveal as and benefits of bed rails be resident (or resident failed to reveal evidence that the use of bed rails was all evaluation section of an		Current residents who utilize bedrails have the potential to be affected by thi practice. An audit of current residents that utilize bed rails was conducted to validate documentation of assessment to include	9	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C 08/16/2023	
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NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00,	10/2020
				1	776 CAMBRIDGE DRIVE		
CANTERB	URY REHABILITATION	AND HEALTHCARE CENTER		R	RICHMOND, VA 23238		
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F 700 Continued From page			F 7	700	therapy evaluation as indicated, review	, of	
	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				risks and benefits, physician orders and informed consent is in place. Variances were addressed.	d	
	on 8/10/23 at 3:36 p. conducted with LPN regarding the use of residents must be ed benefits and a conse LPN #1 stated the fac	m., an interview was (licensed practical nurse) #1, bed rails. LPN #1 stated ucated about the risks and nt form has to be filled out. cility frowns on bed rails			Licensed Nursing staff members were re-educated on the process for the use bed rails which includes documentation clinical need, review of the risks and benefits of bed rails, physician order ar informed consent for the use of bed rail	n of nd	
	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.				A review of 3 residents that utilize bedre will be conducted by the DON/Designe validate documentation of assessment 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 weeks, then monthly x 2 months. The findings of the audits will be submitted the DON/Designee to the QAPI	te to to	
					Committee for review and recommendation monthly for 3 months ongoing until compliance sustained.	or	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	I AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	<u> </u>	00/10/2023
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F 700	Continued From page	ge 178	F 70	00		
		.m., and 8/8/23 at 7:34 a.m., lying in bed with bilateral grab position.				
	physician's order da to aide in positioning evaluation section of evaluation packet for documented, "1. Is 3. Does the residen bed mobility? No. 4 bed rail to assist with	the resident ambulatory? No. t use the bed rail to assist with l. Does the resident use the th transfers? No. and Care Planning: c. Bed				
	conducted with LPN regarding the use of facility frowns on be could get caught in if someone uses the if an evaluation docindicated then they On 8/14/23 at 4:06 staff member) #1 (the regional risk continuous conductions) with the staff member in the continuous conductions are conducted with the staff member in the conducted with the staff member in the conducted with LPN regional risk regional risk regional risk regional risk regional risk regional risk reg	p.m., an interview was I (licensed practical nurse) #1, If bed rails. LPN #1 stated the Index rails because someone Ithem, but they can be helpful Item for turning. LPN #1 stated Item for tu				
	On 8/15/23 at 1:24 conducted with LPN resident has an olderails, but then has a documents bed rails order should probab	p.m., an interview was I#14. LPN #14 stated that if a er physician's order for bed nursing assessment that s are not indicated then the oly be discontinued, and the rails should be addressed.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	FIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER BURY REHABILITATION	AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	ODE		
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F 700	failed to obtain a their there was a clinical in there was a clinical in On 8/7/23 at 12:21 p R358 was observed grab bars (bed rails) A review of R358's coal physician's order for evaluation section of evaluation packet for "1.1 Is the resident arresident use the bed mobility? No. 4. Doe rail to assist with transput Evaluation in of a physical therapy an occupational therapy an occupational therapidaled to document at rails. On 8/10/23 at 3:36 p conducted with LPN regarding the use of facility frowns on bed could get caught in the facility from the second get caught in the someone uses their that if a nursing asset therapy evaluation is should be involved.	g (R358), the facility staff rapy evaluation to determine leed for bed rails. I.m. and 8/8/23 at 7:30 a.m., lying in bed with bilateral in the upright position. Inical record failed to reveal or bed rails. The bed rail an admission/readmission m dated 8/5/23 documented, mbulatory? No. 3. Does the rail to assist with bed is the resident use the bed	F7	700	· /		
	conducted with OSM (the director of rehab not review the nursin	(other staff member) #12). OSM #12 stated she does g admission/readmission ms so if the nursing staff					

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
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F 742 SS=D	rails is needed, ther daily clinical meetin not made aware that a therapy evaluation. On 8/14/23 at 4:06 staff member) #1 (the regional risk codirector of nursing) above concern. Treatment/Srvcs McCFR(s): 483.40(b)(1) §483.40(b) Based of assessment of a resthat- §483.40(b)(1) A resident who disp mental disorder or predifficulty, or who has post-traumatic stress appropriate treatment assessed problem of practicable mental at This REQUIREMENT by: Based on staff intereview, and clinical failed to provide ser trauma-informed cat the survey sample, The findings include For Resident #37 (For Resident #37)	evaluation for the use of bed a she should be told during the g. OSM #12 stated she was at nursing staff recommended in for R358's bed rails. p.m., ASM (administrative the administrator), ASM #4 ansultant) and ASM #7 (the were made aware of the sental/Psychoscial Concerns 1) on the comprehensive sident, the facility must ensure stail adjustment is a history of trauma and/or is disorder, receives ant and services to correct the forto attain the highest and psychosocial well-being; in any solution in the facility document is not met as evidenced arview, facility document in the facility staff forces related to the facility staff for	F 74			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
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				1776 CAMBRIDGE DRIVE			
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F 742	On the most recent I	counseling services. MDS (minimum data set). an	F 74	Current residents who resid	nd Healthcare		
	reference date) of 5/ being moderately im decisions, having so BIMS (brief interview	with an ARD (assessment 21/23, R37 was coded as paired for making daily ored 11 out of 15 on the or mental status). He was a mood severity evaluation,		have potential to be affected practice.			
	indicating he had no dysfunction during th coded as having der during the look back	symptoms of mood ne look back period. He was nonstrated no behaviors period. R37 was admitted to noses including depression,		An audit was completed and with mental/psychosocial co- identified to validate counse are offered and provided as Variances were addressed.	oncerns were eling services s indicated.		
	progress note from a worker who was not facility, OSM (other was dated 7/19/22. In part: "The patient state that he had so	•		Social Work staff members by the Regional Social Serv Consultant on trauma informinclude but not limited to off referring utilization of couns for residents with mental/ps concerns.	vices med care to fering and seling services		
	that the patient will be familyThe psychot following weeks, cor rapportTreatment in psychotherapist will establishing coping a depressedThis psychotherapist in color and adjusting to the psychotherapist will mindfulness to reduce	Plan Progress/GoalsThis work with the patient on mechanisms to feel less /chotherapist will work to mbating emotional distress unit well. This		A review of 3 residents will I by the Administrator/Design residents with mental/psych concerns to validate counse are offered and provided as Variances will be addressed will be conducted weekly x a monthly x 2 months. The fin audits will be submitted by the Administrator/Designee to the Committee for review and recommendation monthly for ongoing until compliance submits.	nee of nosocial eling services s indicated. d. These audits 4 weeks, then ndings of the the he QAPI		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	N AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	· · · · · · · · · · · · · · · · · · ·			
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F 742	no evidence that R: counseling services 7/19/22. A review of R37's or revealed no informatinformed services for the services for the services, was role in trauma informating the asset the MDSs. She state about the resident's experienced any transpersion of the services	37's clinical record revealed 37 had received any since he was seen on are plan dated 11/27/22 ation related to trauma or R37. a.m., OSM #5, the director of sinterviewed. She stated her med care is limited to essments that are required for red: "We ask the questions a mood and if they have auma." She stated she does eveloping a care plan for re, and was not sure who is . She stated she was aware gnosis of PTSD, but did not reas receiving counseling at this e was not sure how R37 and nected." She stated no staff is about R37's mood or and she had not observed any ed she did not see any follow commendation, and that she had recommendation.	F 7	<u> </u>				
	staff member) #7, t interviewed. She st the facility for a whi employed by the fa facility staff was aw further counseling of	6 a.m., ASM (administrative he director of nursing, was lated OSM #17 had been with le, but no longer was cility. She stated none of the lare of the recommendation for lon OSM #17's progress note.						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	1 00/	10/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 742	poses a problem. Thi trauma informed care included in a resident with a history of PTSI annually by psychology. On 8/14/23 at 4:01 p. staff member) #1, the regional risk consultate consultant, and ASM were informed of these. A review of the facility and Culturally Compete address the needs of minimizing triggers are traumatizationperesidentsincorporate principlessafetytrusupportcollaboration choice." No further information NOTES (1) "Post-traumatic st disorder that develop experienced a shockie eventThose who coproblems may be diag who have PTSD may even when they are reinformation is taken fit	e medical record, and "that is one got lost." She stated should definitely be so care plan, and residents it is care plan, and residents it is care plan, and residents it is should be seen at least gical services. Im., ASM (administrative administrator, ASM #4, the ent, ASM #8, the regional effect of nursing, see concerns. If policy, "Trauma Informed stent CarePurposeto trauma survivors by end/or efform universal screening of the the following est and transparencypeer enempowerment, voice and enter was provided prior to exit. In was provided prior to exit. In was provided prior to exit. In some people who have eng, scary, or dangerous entinue to experience genosed with PTSD. People feel stressed or frightened, of in danger." This from the website gov/health/topics/post-traum	F 74	2		
	Provision of Medically	isd. Related Social Service	F 74	5		9/26/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
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F 745	Continued From page	ge 184	F 74	45	
	maintain the highes and psychosocial w This REQUIREMEN by: Based on staff interview, and clinical failed to provide me for one of 57 reside Resident #37. The findings include For Resident #37 (FPTSD (post-trauma facility social worker recommendation for On the most recent annual assessment reference date) of 5 being moderately in decisions, having so BIMS (brief interview scored a zero on the indicating he had not dysfunction during the coded as having deduring the look back the facility with diagochronic PTSD, and A review of R37's claprogress note from	cial services to attain or to practicable physical, mental cell-being of each resident. It is not met as evidenced review, facility document record review, the facility staff dically related social services atts in the survey sample, etc. 237), who had a diagnosis of the stress disorder) (1), the failed to follow up on a recounseling services. MDS (minimum data set). an with an ARD (assessment /21/23, R37 was coded as a paired for making daily cored 11 out of 15 on the for mental status). He was a mood severity evaluation, a symptoms of mood the look back period. He was monstrated no behaviors a period. R37 was admitted to moses including depression, visual hallucinations.		F745: Provision of Medically Relate Social Service SS=D Resident #37 was reviewed by the sworker on 8/31/23 and offered counservices for mental/psychosocial concerns. Current residents who reside at Canterbury Rehabilitation and Health have potential to be affected by this practice. An audit was completed and resident with mental/psychosocial concerns videntified to validate counseling servare offered and provided as indicate Variances were addressed. Social Work staff members re-educate by the Regional Social Service Conson trauma informed care to include the not limited to offering and referring and refe	ocial seling hcare hts were rices d.
	facility, OSM (other	longer employed at the staff member) #17. The note A review of the note revealed,		utilization of counseling services for residents with mental/psychosocial concerns.	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER BURY REHABILITATION	AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238		1 00/10/2023	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 745	in part: "The patient state that he had so familial issues, but of mood The psychold discussed focusing especially when it of that the patient will a family The psycholfollowing weeks, corapport Treatment psychotherapist will establishing coping depressed This psengage patient in coand adjusting to the psychotherapist will mindfulness to redubreathing exercises Weekly." Further review of R3 roundered and revidence that R3 counseling services 7/19/22. A review of R37's carevealed no informatinformed services for On 8/11/23 at 8:31 a social services, was role in trauma inform completing the asset the MDSs. She stat about the resident's experienced any train thave a role in detrauma informed care.	was doing well todayHe did me depression from his otherwise has been in a good herapist and patient on positive thinking, oncerns family. They resolved be mindful when talking to therapist will monitor over the intinuing to build Plan Progress/GoalsThis work with the patient on mechanisms to feel less ychotherapist will work to ombating emotional distress unit well. This encourage use of ce anxiety through deepPrescribed Frequency: 37's clinical record revealed 7 had received any since he was seen on	F 74!	A review of 3 residents will be comby the Administrator/Designee of residents with mental/psychoson concerns to validate counseling are offered and provided as indivariances will be addressed. The will be conducted weekly x 4 we monthly x 2 months. The finding audits will be submitted by the Administrator/Designee to the Committee for review and recommendation monthly for 3 rongoing until compliance sustain	of cial services cated. sees audits eeks, then as of the		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI			10/2020	
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CANTERD	OURT REHABILITATION A	AND HEALTHCARE CENTER		RICHMOND, VA 23238				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE	
F 745		e 186 osis of PTSD, but did not s receiving counseling at this	F 7	745				
	time. She stated she OSM #17 were "conn	was not sure how R37 and ected." She stated no staff						
		d she had not observed any she did not see any follow						
		ommendation, and that she						
	staff member) #1, the regional risk consulta consultant, and ASM	m., ASM (administrative administrator, ASM #4, the nt, ASM #8, the regional #7, the director of nursing,						
	staff member) #7, the	a.m., ASM (administrative director of nursing, was						
	the facility for a while by the facility. She sta	ed OSM #17 had been with , but no longer is employed ated none of the facility staff ommendation for further						
	counseling on OSM # #17 uploaded progres	t17's progress note. OSM ss notes directly into the edical record, and "that						
	poses a problem. This trauma informed care	s one got lost." She stated						
	with a history of PTSI annually by psycholog	D should be seen at least gical services. She stated						
		onsible for making sure g the services as						
	A review of the facility social services director "Develop and implem	's job description for the						

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '			(X3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER	A. BUILDING			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A	SHOULD BE	DATE
F 745	resident/families to a agencies when the C services or needs of settingDevelop a w resident that identified No further information NOTES (1) "Post-traumatic set disorder that develop experienced a shock eventThose who comproblems may be diated who have PTSD may even when they are a information is taken if https://www.nimh.nih.atic-stress-disorder-p. Pharmacy Srvcs/Pro CFR(s): 483.45(a)(b) §483.45 Pharmacy Strucs/Pro drugs and biologicals them under an agree §483.70(g). The facility must providing and provided the set of the se	s of the residentRefer ppropriate social service center does not provide the the resident in a private written plan of care for each is social problems/needs in was provided prior to exit. It is disorder (PTSD) is a position of the services or frightened, and in danger." This from the website a gov/health/topics/post-traum obtsd. Cedures/Pharmacist/Records of the services of the services or the services or the services of				9/26/23
	dispensing, and adm	inistering of all drugs and				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495272	B. WING _			C 08/16/2023
	ROVIDER OR SUPPLIER	I AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238		•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 755	must employ or obtance pharmacist who- §483.45(b)(1) Provious aspects of the provious the facility. §483.45(b)(2) Established preceipt and disposit sufficient detail to expression and sufficient detail to expression and sufficient detail to expression and that an axis maintained and provided provide	Consultation. The facility ain the services of a licensed des consultation on all sion of pharmacy services in olishes a system of records of ion of all controlled drugs in hable an accurate rmines that drug records are in ecount of all controlled drugs eriodically reconciled. It is not met as evidenced interview, staff interview, view and clinical record taff failed to provide pharmacy for residents in the survey #86, #115, #360, #95 and	F 7	· · · · · · · · · · · · · · · · · · ·	Unit ordered	
	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.			for administration. No further v were noted, and medications administered as prescribed by physician at this time.		
	physician's order da sodium 175 mcg (m day for hypothyroidi 2023 MAR (medicar revealed the same)	ical record revealed a sted 4/1/23 for levothyroxine icrograms)- one tablet once a sm. A review of R86's August tion administration record) ohysician's order for		Resident # 360 was discharge facility on 8/19/23.		
	levothyroxine sodiu	m. On 8/5/23 and 8/6/23, the		Resident #358 was discharged	from the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		495272	B. WING _			C 08/16/2023	
ME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	<u> </u>	00/10/2023	
				1776 CAMBRIDGE DRIVE			
ANIER	BURY REHABILITATIO	ON AND HEALTHCARE CENTER		RICHMOND, VA 23238			
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 755	Continued From page	age 189	F 7	55			
		the code, "5=Hold." Nurses' 3 and 8/6/23 documented, "Med		facility on 8/30/23.			
	the August 2023 M	review of nurses' notes and MAR failed to reveal					
		at levothyroxine sodium was 36 on 8/5/23 and 8/6/23.		Residents who have ordered medication administration have potential to be affected by this	ve the		
		ility backup medication supply nyroxine sodium was not ply.		review of residents receiving was completed by Unit Managto validate medications are or available for administration per	medications ger/Designee n hand and		
	conducted with LP LPN #7 stated nor	p.m., an interview was (N (licensed practical nurse) #7. n-narcotic medications should		orders. Variances were addre			
	pills remaining. LF not available for acting the backup medical	PN #7 stated if a medication is dministration, then she checks ation supply, and if the available there, she notifies the		Licensed Nursing staff memb re-educated by the Staff Deve Coordinator/Designee on the ordering medication, utilizing box and ordering stat medication, the pharmacy. This education	elopment process for back up drug tions from		
	staff member) #1 (a.m., ASM (administrative (the administrator) and ASM #4 consultant) were made aware of the consultant (the consultant) were made aware of the consultant (the consultant) were made aware of the consultant (the consultant)		the need to notify the physicial medication is not available or further instruction.	an if a		
	Treatment Orders' and biologicals that must be reordered less than three (3) being administered readily available." Reference: (1) "Levothyroxine (condition where the must be reordered."	itiled, "Medication and ' documented, "11. Drugs at are required to be refilled I from the issuing pharmacy not days prior to the last dosage d to ensure that refills are is used to treat hypothyroidism the thyroid gland does not aversid bormane)." This		The Unit Manager/designee versidents weekly for medication availability per physician order will be addressed. These audiconducted weekly x 4 weeks, monthly x 2 months. The finding audits will be submitted by the DON/Designee to the QAPI Construction and recommendation.	on ers. Variances lits will be then ings of the e Committee		
	conducted with LP LPN #7 stated nor be ordered from the pills remaining. LF not available for act the backup medication is not a pharmacy and documedication is not a pharmacy and being alministered readily available." Reference: (1) "Levothyroxine (condition where the produce enough the produce enough the produce and	n' (licensed practical nurse) #7. n-narcotic medications should be pharmacy when there are ten PN #7 stated if a medication is dministration, then she checks ation supply, and if the available there, she notifies the etor. Y a.m., ASM (administrative (the administrator) and ASM #4 consultant) were made aware of n. Titled, "Medication and documented, "11. Drugs at are required to be refilled from the issuing pharmacy not days prior to the last dosage d to ensure that refills are		Licensed Nursing staff memb re-educated by the Staff Deve Coordinator/Designee on the ordering medication, utilizing box and ordering stat medicathe pharmacy. This education the need to notify the physicial medication is not available or further instruction. The Unit Manager/designee was residents weekly for medication availability per physician orde will be addressed. These aud conducted weekly x 4 weeks, monthly x 2 months. The finding audits will be submitted by the	ers were elopment process for back up dru tions from included an if a in hand for ers. Variance its will be then ings of the e Committee on monthly	ag sees	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495272	B. WING _			1	C 16/2023	
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER	•	17	TREET ADDRESS, CITY, STATE, ZIP CODE 776 CAMBRIDGE DRIVE RICHMOND, VA 23238	, 55.		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 755	Continued From pag https://medlineplus.g tml.	ge 190 gov/druginfo/meds/a682461.h	F 7	755	sustained.			
	failed to ensure the predications lisinopri	5 (R115), the facility staff ohysician ordered I (1), allopurinol (2) and vailable and administered on						
	following physician's 4/1/23-lisinopril 40 m high blood pressure 4/1/23-allopurinol 30	ng (milligrams) once a day for 0 mg once a day for gout ng (milligrams) every eight						
	same physician's ord and diltiazem. On 7, the MAR documente Nurses' notes dated medications were or nurses' notes and th	d) for July 2023 revealed the ders for lisinopril, allopurinol /9/23 for the morning doses, ed the code, "5=Hold." 7/9/23 documented the order. Further review of e July 2023 MAR failed to in that the morning doses of and diltiazem were						
	Iist revealed lisinopri were not stocked in On 8/10/23 at 2:19 p conducted with LPN LPN #7 stated non-r be ordered from the pills remaining. LPN	ty backup medication supply I, allopurinol, and diltiazem the supply. b.m., an interview was (licensed practical nurse) #7. harcotic medications should pharmacy when there are ten I #7 stated if a medication is hinistration, then she checks						

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		495272	B. WING _			C 08/16/2023	
	ROVIDER OR SUPPLIER	I AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP COI 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	DE	00/10/2023	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 755	Continued From pa	ge 191	F 7	755			
		oion supply, and if the vailable there, she notifies the or.					
	staff member) #1 (tl	a.m., ASM (administrative ne administrator) and ASM #4 insultant) were made aware of					
	This information wa https://medlineplus.tml.	I to treat high blood pressure. s obtained from the website: gov/druginfo/meds/a692051.h ed to treat gout. This					
	information was obt https://medlineplus. tml. (3) Diltiazem is used This information wa	ained from the website: gov/druginfo/meds/a682673.h d to treat high blood pressure. s obtained from the website: gov/druginfo/meds/a684027.h					
	failed to ensure the	60 (R360), the facility staff as needed pain medication vailable for administration.					
	R360's admission n was in progress. A dated 7/31/23 docu	to the facility on 7/31/23. ninimum data set assessment admission assessment mented R360 was alert and place, time and situation.					
	physician's order da	clinical record revealed a ated 7/31/23 for Percocet as)- one tablet every four r pain.					
	On 8/10/23 at 9:50	a.m., an interview was					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG		OATE SURVEY OMPLETED
		495272	B. WING _			C 08/16/2023
	NAME OF PROVIDER OR SUPPLIER CANTERBURY REHABILITATION AND HEALTHCARE CENTER (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 755 Continued From page 192 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 on 8/9/23 until 6:00 a.m. on 8/10/23 but the nurse gave him Tylenol.		33, 13, 2323			
PRÉFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A	SHOULD BE	(X5) COMPLETION DATE
F 755	conducted with R36 concern that he ran medication on 8/9/2 not receive his pres about 2:00 p.m. on 8/10/23 but the nurs. A review of narcotic revealed R360 rece on 8/9/23 at 9:45 a. another dose until 8 On 8/10/23 at 10:35 conducted with LPN #11. LPN #11 state Percocet every four on 8/9/23, she gave Percocet in the mor new prescription an #11 stated Percoce medication supply a A review of the facil list revealed Percoce supply. On 8/10/23 at 2:19 conducted with LPN LPN #7 stated a ne medication should when there are seven LPN #7 stated if a radministration, then medication supply, available there, she doctor.	out of his prescribed pain 3. R360 further stated he did cribed pain medication from 8/9/23 until 6:00 a.m. on se gave him Tylenol. reconciliation sheets ived the last dose of Percocet m. and did not receive	F 7	55		

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X5) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X7) MULTIPLE CONSTRU			(X3) DATE SURVEY COMPLETED			
		495272	B. WING _			C 8/16/2023	
	ROVIDER OR SUPPLIER	N AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP (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 COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 755	Continued From pa	ge 193	F 7	55			
	, ,	he administrator) and ASM #4 onsultant) were made aware of					
	information was ob	d to treat pain. This tained from the website: .gov/druginfo/meds/a682132.h					
	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.						
		linical record revealed a ated 6/24/22 for Xtampza 18 ce a day for pain.					
	same physician's o evening dose on 6/ through 6/4/23, and the MAR document nurse's note dated would administer the from the pharmacy documented the management of the Murses' notes dated documented the numedication upon an	MAR (medication rd) for June 2023 revealed the rder for Xtampza. For the 1/23, both doses on 6/2/23 december the evening dose on 6/5/23, ted the code, "5=Hold." A 6/1/23 documented the nurse remedication upon arrival and A nurse's note dated 6/2/23 redication was on order. d 6/3/23 and 6/4/23 rese would administer the rival from the pharmacy.					
		p.m., an interview was N (licensed practical nurse) #7.					

	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION D PLAN		(X3) DATE SURVEY COMPLETED		
		495272	B. WING		08/16/2023
	ROVIDER OR SUPPLIER	N AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	1 00/10/2020
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE COMPLETION
F 755	medications should medication should when there are sev LPN #7 stated if a radministration, there medication supply, available there, she doctor. On 8/14/23 at 4:06 staff member) #1 (to the regional risk condirector of nursing) above concern. Reference: (1) Xtampza is used information was obto https://medlineplus.tml. 5. For Resident #35 failed to ensure the oxycodone (1) was 6/24/23. A review of R358's physician's order dooral solution five medical medi	w prescription for controlled be obtained, and the pe ordered from the pharmacy en or eight pills remaining. Inedication is not available for a she checks the backup and if the medication is not a notifies the pharmacy and p.m., ASM (administrative the administrator), ASM #4 posultant) and ASM #7 (the were made aware of the doubt to treat pain. This rained from the website: gov/druginfo/meds/a682132.h	F 75	5	

			(X3) DATE SURVEY COMPLETED		
		495272	B. WING		08/16/2023
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	1 00.1012020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED FICIENCY)	D BE COMPLETION
F 755	Continued From pag	e 195	F 75	5	
		y backup medication supply one oral solution was not v.			
	conducted with LPN LPN #7 stated a new medications should be when there are seven LPN #7 stated if a medication, then seven medication supply are	c.m., an interview was (licensed practical nurse) #7. It prescription for controlled be obtained and the electric or eight doses remaining. It is redication is not available for she checks the backup and if the medication is not motifies the pharmacy and			
	staff member) #1 (the (the regional risk con	.m., ASM (administrative e administrator), ASM #4 sultant) and ASM #7 (the vere made aware of the			
F 756 SS=D	https://medlineplus.g tml.	ined from the website: ov/druginfo/meds/a682132.h w, Report Irregular, Act On	F 75	6	9/26/23
		limen Review. ug regimen of each resident least once a month by a			
	§483.45(c)(2) This red	view must include a review ical chart.			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILD	NG		,	c l
		495272	B. WING				16/2023
	ROVIDER OR SUPPLIER BURY REHABILITATION	AND HEALTHCARE CENTER		177	REET ADDRESS, CITY, STATE, ZIP CODE 76 CAMBRIDGE DRIVE CHMOND, VA 23238		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 756	Continued From pag	e 196	F	756			
	irregularities to the a facility's medical dire and these reports mu (i) Irregularities includrug that meets the (d) of this section for (ii) Any irregularities during this review museparate, written repattending physician adirector and director minimum, the resider and the irregularity th (iii) The attending phresident's medical reirregularity has been action has been take be no change in the physician should doot the resident's medical should be shou	ride, but are not limited to, any criteria set forth in paragraph an unnecessary drug. noted by the pharmacist ust be documented on a cort that is sent to the and the facility's medical of nursing and lists, at a nt's name, the relevant drug, ne pharmacist identified. ysician must document in the cord that the identified reviewed and what, if any, on to address it. If there is to medication, the attending nument his or her rationale in all record. cility must develop and all procedures for the monthly that include, but are not not not set for the different steps in the pharmacist must take not not protect the resident. It is not met as evidenced wiew, facility document review wiew, it was determined the take action on a methe pharmacist for one of curvey sample, Resident #90.			F756: Drug Regimen Review, Report Irregular, Act on SS:D Resident #90 orders were reviewed by clinical provider with no new		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		495272	B. WING _			C 08/16/2023	
	ROVIDER OR SUPPLIER	ON AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238		00/10/2020	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 756	the physician/nurs a pharmacy recom 5/25/2023. The Medication Ref 5/25/2023, docum to utilize sliding so control. CMS [Cer Services] guideling long-term need for non-emergency or inadequate blood of finger sticks and patient discomfort without significant outcomes. Please resident's medicate eliminate the use of Therapy." Review of the phy insulin were dated the clinical record	the facility staff failed to have e practitioner, respond timely to amendation made on egimen Review dated, ented, "This resident continues ale insulin to manager glucose ters for Medicare & Medicaid es state that continued or sliding scale insulin for overage may indicate sugar control. Also, high rates dinsulin injections may add to and nursing time expenditures long-term benefit in patient e consider modifications to this ion therapy to minimize or of Sliding Scale Insulin	F 7	Current residents who are or have potential to be affected practice. An audit of residents who ha consultant reviews were completed pharmacy recommendations addressed by the clinical pro Variances were addressed. Licensed Nursing staff membeducated on the facility medi regimen review process to in reviewing pharmacy consultarecommendations with clinicatimely and validate that recording are addressed and document review is maintained.	d pharmacy pleted in the to validate were evider.		
	8/9/2023 at 5:37 p staff member) #7, asked the process pharmacy recomm pharmacist sends and sends it to ear practitioner to revi recommendations doctor/nurse pract	conducted, via phone, on .m. with ASM (administrative the director of nursing. When for responding to the monthly mendations, ASM #7 stated the her the report. She prints it out ch floor for the doctor or nurse ew and say, yes or no, to the .ASM #7 stated the itioner has 30 days to act on arse takes of any orders from		An audit of 10 pharmacy con medication reviews will be conthe Director of Nurses/design validate documentation is in supports pharmacy consultar recommendations are review addressed by the clinical pro Variances will be addressed will be conducted monthly at the findings of the audits will submitted by the DON/Design	onducted by nee to place that nt ved and ovider timely. These audits a months.		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495272	B. WING _				C 16/2023
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER		17	TREET ADDRESS, CITY, STATE, ZIP CODE 776 CAMBRIDGE DRIVE ICHMOND, VA 23238	1 00/	10/2023
(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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 756	Continued From page	÷ 198	F 7	756			
F 756	the recommendation, the clinical record. On 8/10/2023 at appr facility provided a coppharmacy recommendationer's review of practitioner disagreed term SSI (sliding scale A1C) (1) 6.8, will contour The facility policy, "Modern (MRR) and Reporting Resident - specific MI findings are document nursing care center at of the consultant phare recommendations is retrievable format to reare planning team we completion. 8. The notes that the consultant phare recommendation had been taken be acted upon within ASM (administrative stadministrator, ASM # consultant, and ASM case management, we above findings on 8/8 No further information (1) Hemoglobin A1C in blood glucose, or blood	oximately 10:00 a.m. the y of the 5/25/2023 dation with the nurse lated 8/10/2023. The nurse land documented "On long e insulin), A1C (hemoglobin inue to reassess." edication Regimen Review "documented in part, "6. RR recommendations and ted and acted upon by the ind/or physician. 7. A record macist's observations and made available in an easily nurses, physicians and the ithin 48 hours of MRR ursing care center follow upons to verify that appropriate in. Recommendations shall 30 days." staff member) #1, the 4, the regional risk #5, the regional director of ere made aware of the /2023 at 4:59 p.m. It was provided prior to exit.	F 7	756	QAPI Committee for review and recommendation monthly for 3 months ongoing until compliance sustained.	or	
	following website: https://medlineplus.go	ation was obtained from the					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		495272	B. WING _		08/16/2023
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	1 00/10/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE COMPLETION
F 757 F 757 SS=E	• •	e from Unnecessary Drugs	F 7		9/26/23
	_	eary Drugs-General. regimen must be free from An unnecessary drug is any			
	§483.45(d)(1) In exce duplicate drug therap	, -			
	§483.45(d)(2) For exc	cessive duration; or			
	§483.45(d)(3) Withou	t adequate monitoring; or			
	§483.45(d)(4) Withou use; or	t adequate indications for its			
	§483.45(d)(5) In the process which reduced or discontinu	indicate the dose should be			
	stated in paragraphs section.	mbinations of the reasons (d)(1) through (5) of this is not met as evidenced			
	by: Based on observatio document review, and	n, staff interview, facility d clinical record review, it acility staff failed to ensure		F757: Drug Regimen is Free fror Unnecessary Drugs	n
	five of 57 residents in free of unnecessary r	the survey sample were nedications, Resident #90,		SS=E	
	#11, #160, #149 and The findings include:	#133.		Resident #90 s medications were reviewed with the clinical provider orders updated to include monitor side effects of anticoagulant medi	with ing for
	to monitor the resider	R90), the facility staff failed nt for side effects (bleeding) nt medications, Eliquis (1).		therapy.	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	LTIPLE CONSTRUCTION (X3) DATE S COMPLI		IPLETED	
		495272	B. WING			0.5	C 3/ 16/2023
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00	J/ 10/2020
CANTEDE	NIDV PEHARII ITATION A	AND HEALTHCARE CENTER	1776 C		776 CAMBRIDGE DRIVE		
CANTERE	OURT REHABILITATION	AND HEALTHCARE CENTER		R	CICHMOND, VA 23238		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 757	Continued From page	≥ 200	F	757			
	were not limited to: a	ignoses that included but trial fibrillation, history of a status post left below the dated, 3/3/2023,			Resident #11 s clinical provider was made aware of cited occurrence, order were reviewed and clarified with medication on hand to reflect ordered dose.	rs	
	documented, "Apixab (milligram); Give 1 tal day for blood thinner. The July and August administration record order. The medication having been administ order. There was no of side effects for the The July and August administration record	pan Oral tablet 5 mg blet by mouth two times a " 2023 MAR (medication) documented the above in was documented as tered per the physician documentation of monitoring use of an anticoagulant. 2023 TAR (treatment) failed to evidence intoring of side effects for			Resident #160 s orders were reviewe with clinical provider and updated to include nonpharmacological interventic prior to administering unscheduled pair medication and to monitor for side effer of anticoagulant medication therapy. Resident #149 s medication was reviewed with the clinical provider and orders were updated to include monito for side effects and toxicity related to antipsychotic/antimanic medication therapy.	ons n cts	
	documented in part, 'anticoagulant therapy documented in part, '(as needed) s/sx (sig anticoagulant compliciblood in urine, black fred blood in stools, be headaches, nausea, lethargy, blurred visic breath), loss of appet mental status, signific vital signs. Report to of side effects includin urine, blood in stool	care plan dated, 3/13/2023, "Focus: I am on /." The "Interventions" "Monitor/record/report PRN ns and symptoms) of cations: blood tinges or frank tarry stools, dark or bright ruising, sudden severe vomiting, muscle joint pain, on, SOB (shortness of ite, sudden changes in cant or sudden changes in nurse PRN signs/symptoms ng bruising, bleeding, blood ol, black tarry stools, nausea, on, pain, shortness of breath,			Resident #133 s 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.	or	

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) D PLAN OF CORRECTION (X1) DENTIFICATION NUMBER: A. BUILDING			X3) DATE SURVEY COMPLETED		
		495272	B. WING _			C 8/ 16/2023
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	•	0/10/2023
				1776 CAMBRIDGE DRIVE		
CANTERB	URY REHABILITATION	AND HEALTHCARE CENTER		RICHMOND, VA 23238		
(V4) ID	SLIMMARYS	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG		ON SHOULD BE IE APPROPRIATE	COMPLETION DATE
F 757	Continued From page	ge 201	F 7	57		
	sudden changes in	mental status, weakness,		Residents who receive med	ication	
	lethargy."	,,,		administration by facility state		
				single dosing pack of Lokelr		
	An interview was co	onducted with LPN (licensed		anticoagulant therapy, unscl		
		on 8/8/2023 at 3:09 p.m.		medication or antimanic med		
	-	urses should be monitoring		potential to be affected by th		
		ent receiving anticoagulants,		The Unit Manager/designee	•	
		for bleeding and bruising.		audit of current residents red	•	
	LPN #9 was asked	where it is documented that		anticoagulant medication the	erapy, and	
	she monitored the re	esident, LPN #9 stated, there		antipsychotic/antimanic med	lication	
	is a place on the TA	R or progress notes for that.		therapy to validate monitoring	ng for side	
	LPN #9 looked at R	90's TAR and MAR and stated		effects is in place. An audit	was also	
	it was not there for t	this resident and it is on some		completed for residents with	th orders for	
		ts. When asked if she		non-scheduled pain medicat		
		urse's notes every shift she		nonpharmacological measur		
		itored the resident for side		attempted prior to use. In ad		
		anticoagulants, LPN #9		audit was completed for resi		
	stated, no.			Lokelma single dose packs		
	6 111 II	A .:		order clarification obtained a		
		Anticoagulation Management"		that the correct dosage is or		
		, "1. As part of the initial		administered. Variances we	re addressed.	
		ysician and staff will identify				
		currently anticoagulated; for				
		a recent history of deep vein		Licensed Nursing stoff mem	horo woro	
		or heart valve replacement, nose who have had recent		Licensed Nursing staff mem re-educated by the staff dev		
		urgery. a. Assess for any signs		coordinator on monitoring a		
		d to adverse drug reactions		documenting side effects for		
	• •	on alone or in combination		receiving anticoagulant med		
		ons5. The staff and		antipsychotic/antimanic med		
		or for possible complications		need to attempt nonpharma		
		re being anticoagulated and		measures prior to administe	•	
		problems. a. If an individual		unscheduled pain medicatio	•	
		herapy shows signs of		need to validate correct dos		
	•	hematuria, hemoptysis, or		administration of medication	•	
		eeding, the nurse will discuss				
		e physician before giving the				
		e of anticoagulant. b. The				
		measures to address any		The unit managers/designee	e will complete	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495272	B. WING		08/16/	2023
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/10/	2023
				1776 CAMBRIDGE DRIVE		
CANTERB	URY REHABILITATION A	AND HEALTHCARE CENTER		RICHMOND, VA 23238		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE C	(X5) OMPLETION DATE
F 757	the anticoagulant as i receiving anticoagula who have a markedly suffice to stop the ant PT/INR if the individu than minor bleeding, ithan 9. Once Vitamin the effects of warfarin resumption of anticoamore." ASM (administrative sadministrator, ASM #consultant, and ASM consultant, and ASM consultant, were mad on 8/9/2023 at 5:30 p No further information (1) Eliquis (Apixaban) prevent strokes or bleatrial fibrillation (a corbeats irregularly, increforming in the body at that is not caused by Apixaban is also used thrombosis (DVT; a band pulmonary embolung) in people who a or knee replacement used to treat DVT and after the initial treatmis in a class of medical inhibitors. It works by	ng holding or discontinuing ndicated. c. In individuals tion who are bleeding or elevated PT/INR, it may icoagulant and recheck the al is stable, there is no more and the INR is not more K is given to try to reverse I, it can hamper subsequent igulation for a week or staff member) #1, the 4, the regional risk #6, the clinical care e aware of the above finding Im. In was provided prior to exit. Apixaban is used help and clots in people who have indition in which the heart reasing the chance of clots and possibly causing strokes) heart valve disease. If to prevent deep vein lood clot, usually in the legical lism (PE; a blood clot in the re having hip replacement is used may be continued to the property. Apixaban is also if PE and may be continued to the property of the property in the legical property. Apixaban is also if PE and may be continued to the property of the property in the legical property. Apixaban is also if PE and may be continued to the property is completed. Apixaban is called factor Xa blocking the action of a	F 75	,	side ents es , two hat rill be ne e enly	
		nce that helps blood clots to n was obtained from the				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		NSTRUCTION		LETED
		495272	B. WING _				C 16/2023
	ROVIDER OR SUPPLIER BURY REHABILITATION	AND HEALTHCARE CENTER		1776	ET ADDRESS, CITY, STATE, ZIP CODE CAMBRIDGE DRIVE IMOND, VA 23238	1 00	10/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 757	tml 2. For Resident #11 to verify the dosage of Zirconium Cyclosilica administration on 8/8 receiving 10 grams rowas ordered by the properties of RN (register medications at the far preparing medication scheduled medication including a single do 10 gm (gram)" which dissolving the entire water and administer Review of the physic documented in part, Cyclosilicate Oral Pazirconium Cyclosilicate one time a day for hy 05/01/2023." The eMAR (electronic record) for R11 dated documented in part, Cyclosilicate Oral Pazirconium Cyclosilicate one time a day for hy 05/02/2023 0900 (9:0 documented RN #2 a scheduled for 9:00 a	(R11), the facility staff failed of Lokelma (Sodium ate) (1) prior to the 3/2023 resulting in them ather than the 5 grams that physician. a.m., an observation was red nurse) #2 administering acility. RN #2 was observed as for R11. RN #2 prepared as to administer to R11 sing pack labeled "Lokelma" she was observed packet contents into a cup of red to the resident. isian orders for R11 "Sodium Zirconium acket 5 GM (Sodium ate) Give 1 packet by mouth pyerkalemia. Order Date: "C medication administration at 8/1/2023-8/31/2023 "Sodium Zirconium acket 5 GM (Sodium ate) Give 1 packet by mouth pyerkalemia -Start Date-200 a.m.)." The eMAR administering the medication	F	757			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		ATE SURVEY OMPLETED
		495272	B. WING _			C 08/16/2023
	ROVIDER OR SUPPLIER	N AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODI 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	•	33.13.2023
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 757	sure they had the comedication, correct route and correct do reviewed the physic Sodium Zirconium of the 10 GM packets medication cart and checked the dosage was supposed to go 10 GM. The facility policy "Arevised April 2019, individual administe the label THREE (3 resident, right medication and right method (regiving the medication on 8/8/2023 at app (administrator, ASM consultant and ASM case management findings. No further information Reference: (1) Sodium zirconium hyperkalemia (high blood). Sodium zirconium for emergency treat hyperkalemia becau work. Sodium zirconium conference	tration they checked to make orrect person, correct dosage, correct time, correct ocumentation. RN #2 cian order for the 5 GM of Cyclosilicate Oral Packet and of the medications on the distated that they should have electoser because the resident et 5 GM and they had received Administering Medications documented in part, "The ering the medication checks by times to verify the right cation, right dosage, right time oute) of administration before on"	F7	257		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		ONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		495272	B. WING				C 16/2023
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER		1770	EET ADDRESS, CITY, STATE, ZIP CODE 6 CAMBRIDGE DRIVE CHMOND, VA 23238	1 00/	10/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 757	Continued From pag from the website: https://medlineplus.g tml 3. For Resident #160 failed to A) implemer interventions prior to pain medications and anticoagulant advers On the admission as 7/27/2023 the reside alert and oriented to assessment docume able to report pain, h with preferred pain repain relievers. The physician orders part, - "Hydrocodone-Aceta mouth every 4 hours to Pain, Unspecified - "Percocet Oral Table W/Acetaminophen) of hours as needed for 07/28/2023."	e 205 ov/druginfo/meds/a618035.h O (R160), the facility staff at non-pharmacological administration of as needed d B) evidence monitoring for se effects. sessment for R160 dated and the was assessed as being person, place and time. The anted R160 being cognitively aving pain less than weekly elief measures of narcotic as for R160 documented in taminophen Oral Tablet and taminophen Oral Tablet as needed for Pain related (). Order Date: 07/27/2023." et 5-325 MG (Oxycodone Sive 1 tablet by mouth every 6		757		ME.	
	(fibrillation). Order D. The eMAR (electronic record) for R160 date documented the Hydroxas administered on pain level of 8, at 5:2	times a day for atrial fib ate: 07/27/2023." or medication administration ed 7/1/2023-7/31/2023 drocodone-Acetaminophen 7/29/2023: at 1:36 a.m. for a 44 p.m. for a pain level of 7, n level of 7, on 7/30/2023: at					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495272	B. WING			1	C 16/2023
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER		1	TREET ADDRESS, CITY, STATE, ZIP CODE 776 CAMBRIDGE DRIVE RICHMOND, VA 23238	1 00	10/2020
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 757	pain level of 8, at 4:56 and on 7/31/2023: at 9. The eMAR further administered on 7/30 level of 6 and on 7/31 level of 0. The eMAR documentation of nor interventions attempte the as needed pain must be as n	evel of 8, at 9:45 a.m. for a 8 p.m. for a pain level of 7 9:41 a.m. for a pain level of documented the Percocet /2023 at 9:09 p.m. for a pain /2023 at 5:17 p.m. for a pain /2023 at failed to evidence on the diction of medication. The ed Apixaban administered ordered beginning on an of monitoring for effects. Edated 8/1/2023-8/31/2023 recodone-Acetaminophen /2023 at 11:37 a.m. for a pain /2023 at 1:37 a.m. for a pain /2023 at 1:36 a.m. for a pain level of 7, on an for a pain level of 7, on for a pain level of 4, on for a pain level of 4, on for a pain level of 8, at 4:48 of 4, on 8/3/2023: at 8:00 of 5, at 2:30 p.m. for a pain /2023 at 7:07 p.m. for a pain	F	757			
	the as needed pain m	ledication.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495272	B. WING		C 08/16/2023	
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	1 00/10/2023	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFICIENCY)	D BE COMPLÉTION	
F 757	Continued From page	e 207	F 75	7		
	The eMAR document administered to R160 and 5:00 p.m. The eM	ed Apixaban was as ordered at 9:00 a.m. MAR failed to evidence nitoring for anticoagulant				
	administration notes documentation of nor interventions attempt the as needed pain mabove with the excep p.m. where reposition administration. The p	failed to evidence				
	part; - "I have pain and/or to) being a dialysis pa 07/27/2023." Under " in part, "Encourage non-pharmacological as applicable e.g. pos bathing, heat and col stimulation, ultrasoun 07/27/2023" - "I am on anticoagula 07/28/2023." Under " in part, " Monitor/re needed) s/sx (signs/s complications: blood blood in urine, black to red blood in stools, bheadaches, nausea, lethargy, blurred visic breath), loss of appet	Interventions" it documented me to try interventions for pain relief sitioning, relaxation therapy, d application, muscle d. Date Initiated: ant therapy. Date Initiated: Interventions" it documented cord/report PRN (as ymptoms) of anticoagulant				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION UILDING			(X3) DATE SURVEY COMPLETED	
		495272	B. WING _			08/	C 16/2023	
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	=			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE	
F 757	nurse PRN signs/synincluding: bruising, blin stool, black tarry stiblurred vision, pain, schanges in mental st. Date Initiated: 07/28/On 8/8/2023 at 3:50 conducted with LPN LPN #7 stated that R to person, place and medication when the that they attempted minterventions like repmedications. She statempted each time medication and shoum edication and shoum edication administraticoagulant monito and was not sure where there was document the monito adocument the monito and was a document the monitors.	ated: 07/28/2023 Report to approve of side effects leeding, blood in urine, blood tools, nausea, vomiting, shortness of breath, sudden atus, weakness, lethargy. 2023." p.m., an interview was (licensed practical nurse) #7. 160 was alert and oriented time and requested pain y needed it. LPN #7 stated con-pharmacological ositioning prior to the ated that they did this to see ogical interventions would resident having to get pain ated that these were prior to administration of the ld be documented in the ation notes. She stated that ring was done every shift ere it was documented. LPN eMAR and stated that she agulant but she did not see umentation of monitoring for ere. She stated that n area on the eMAR to	F 7	/				
	conducted with LPN stated that the staff n anticoagulants for ble documented on the elements that R160 atrial fibrillation and r	#6, unit manager. LPN #6 nonitored residents on						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		495272	B. WING			C 8/16/2023	
	ROVIDER OR SUPPLIER	N AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238		00/10/2023	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 757	failed to evidence of non-pharmacologic needed pain medical The facility policy "Protocol" revised N part, " 5. The staff possible complication being anticoagulate problems. a. If an individual on shows signs of except hemoptysis, or other nurse will discuss the before giving the neanticoagulant. b. The physician with any complications, discontinuing the analycomplications, discontinuing the analycomplications, discontinuing the analycomplication with the policy of the physician with any complications, discontinuing the analycomplication with the policy of the physician with any complication with the policy of the physician with the policy of the physician with the	Administering Medications" guidance on sal interventions prior to assation administration. Anticoagulation- Clinical dovember 2018 documented in ff and physician will monitor for ons in individuals who are ed, and will manage related in anticoagulation therapy essive bruising, hematuria, er evidence of bleeding, the he situation with the physician ext scheduled dose of sill order measures to address including holding or inticoagulant as indicated" 7 p.m., ASM (administrative he administrator stated that my evidence of a interventions prior to e as needed pain medications of 2023 for R160 to provide. 0 p.m., ASM #1, the 1#4, the risk consultant and	F 75				
	ASM #6, the clinical aware of the concelling No further informat 4. For Resident #1 ensure daily monitors	l care consultant were made					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		` IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	` '	(X3) DATE SURVEY COMPLETED	
		495272	B. WING		C 08/16/2	2023	
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	00/10/2	2023	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE CO	(X5) DMPLETION DATE	
F 757	Continued From page		F 7	57			
		il record revealed an order ium Carbonate 150 mg ly for schizoaffective					
	order dated 6/30/23 fo	clinical record revealed an or Lithium Orotate 5 mg tabs mg in the morning and 30 bipolar disorder.					
		clinical record failed to the use of Lithium side					
	reveal any evidence t	rehensive care plan failed to hat the use, side effects, cicity of Lithium was care					
	Practical Nurse) was	PM, LPN #10 (Licensed interviewed. She stated that toring for the side effects					
		M, an interview was \$1. She stated that there for the side effects and					
	ASM #1 (Administratir Administrator, ASM # Consultant, ASM #7 t ASM #8 the Regional	t4 the Regional Risk he Director of Nursing and Consultant, were made No further information was					
	References:						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		COMPLETED
		495272	B. WING _			C 08/16/2023
	ROVIDER OR SUPPLIER URY REHABILITATION	I AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 757	Continued From page	ge 211	F 7	57		
	bipolar disorder and Information obtained					
	5. For Resident #13 monitor for the use medication.	3, the facility staff failed to of an anticoagulant				
	dated 7/7/23 for Api	cal record revealed an order xaban (1) 5 mg (milligrams) revention of blood clots.				
		e clinical record failed to onitoring for the use and side agulant medication.				
	Practical Nurse) wa the weekly skin che	PM, LPN #10 (Licensed s interviewed. She stated that cks would qualify as of bruising related to the use dication.				
	weekly skin check weekly skin checks indicate monitoring	cal record revealed that a vas completed on 6/22/23 and 8/10/23. There were no between these two dates to for the use of an cation from 6/2/23 to 8/10/23.				
	revealed one dated "Monitor/record/reportsigns and symptom complications: blood	ort PRN (as needed) s/sx				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION G	, ,	E SURVEY MPLETED
		495272	B. WING		0:	C 8/ 16/2023
	ROVIDER OR SUPPLIER BURY REHABILITATION	AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238		311312323
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 758 SS=D	nausea, vomiting, mediurred vision, SOB (appetite, sudden chasignificant or sudden) On 8/14/23 at 4:00 PASM #1 (Administrate, ASM Consultant, ASM #7 ASM #8 the Regional aware of the findings provided by the end	adden severe headaches, uscle joint pain, lethargy, shortness of breath), loss of inges in mental status, changes in vital signs." M at an end-of-day meeting, ive Staff Member) the #4 the Regional Risk the Director of Nursing and I Consultant, were made . No further information was of the survey. to prevent blood clots. from ov/druginfo/meds/a613032.h chotropic Meds/PRN Use (e)(1)-(5) pic Drugs. Shotropic drug is any drug that is associated with mental vior. These drugs include, drugs in the following	F 75			9/26/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495272	B. WING		C 08/16/2023		
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	1 00/10/2023		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)			
F 758	specific condition as in the clinical record; §483.45(e)(2) Reside drugs receive gradual behavioral interventic contraindicated, in an drugs; §483.45(e)(3) Reside psychotropic drugs punless that medication diagnosed specific coin the clinical record; §483.45(e)(4) PRN care limited to 14 days; §483.45(e)(5), if the prescribing practition appropriate for the P beyond 14 days, he rationale in the residindicate the duration §483.45(e)(5) PRN care limited to 12 renewed unless the apprescribing practition of the prescribing practition of the pres	ents who use psychotropic al dose reductions, and ons, unless clinically n effort to discontinue these ents do not receive ursuant to a PRN order on is necessary to treat a condition that is documented and erders for psychotropic drugs attending physician or er believes that it is RN order to be extended or she should document their ent's medical record and for the PRN order.	F 758				
	by: Based on clinical red and facility documen that the facility staff f of antipsychotic med	r is not met as evidenced cord review, staff interview t review it was determined ailed to evidence monitoring ication for one of 57 ey sample, Resident #160.		F758: free from Unnec. Psychotropic Meds/PRN Use SS=D Resident #160 orders were reviewed with orders revised.	vith		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495272	B. WING			C 8/16/2023	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		70/10/2023	
				1776 CAMBRIDGE DRIVE			
CANTERB	URY REHABILITATION	AND HEALTHCARE CENTER		RICHMOND, VA 23238			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 758	Continued From pag	e 214	F 75	58			
	to monitor behaviors antipsychotic medica (1). R160 was admitted to that included but well depressive disorder. On the admission as 7/27/2023 the reside alert and oriented to resident was assess cognitive condition, to having a pertinent diagonalic brain syndrometric and the companion of the	R160), the facility staff failed and adverse effects of the ation Quetiapine Fumarate to the facility with diagnoses re not limited to major and pain, unspecified. Seessment for R160 dated ent was assessed as being person, place and time. The ed as having a psychiatric or aking an antidepressant, and agnosis of Dementia, OBS ome), Alzheimer's, Delusions, ety disorder, Depression,		include behavior and side effect monitoring related to antipsych medication use. Residents who are prescribed antipsychotic medication have be affected by this practice. An current residents receiving antimedications was completed by Manager/designee to validate rof behaviors and side effects had completed and documented. We were addressed. Licensed Nursing staff member re-educated by the staff develor	potential to n audit of ipsychotic the Unit monitoring ad been 'ariances		
	part, - "Quetiapine Fumar	s for R160 documented in ate Tablet 50 MG (milligram) ith two times a day for Bipolar		coordinator/designee on the far regarding psychotropic medica include monitoring and docume effects of antipsychotic therapy	cility policy ation use to enting side		
	record) for R160 date documented the Queen day as ordered 8/3/2023. The eMAR monitoring for behave anti-psychotic medic The progress notes or "8/3/2023 15:43 (3: Note Text: Psychiatr Complaint: Patient set	iors or adverse effects of the ation.		An audit will be conducted by the Manager/Designee of 3 resider receiving antipsychotic medical validate monitoring of behavior documentation of side effects in completed. Variance will be active audits will be conducted weeks, then monthly x 2 months findings of the audits will be surthe DON/Designee to the QAP Committee for review and recommendation monthly for 3 ongoing until compliance sustain	nts tions to rs and had been ddressed. I weekly x 4 s. The bmitted by I		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE S COMPL	ETED
		495272	B. WING _			08/1	6/2023
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	DE	, , ,	·
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIA	I	(X5) COMPLETION DATE
F 758	to assess for anxiety She stated she has a hospitalization for bip mentioned that she hallucinations while shospital recently W [Quetiapine] 50mg Bl depression Primary 'Depressed' Moderate Recommendations. F Reviewed SE and Ris Supportive therapy p Medication: After care benefits of anti-psych patient outweigh the dyskinesia ' hypergly in modifying the behapossible while the pa The baseline care plapart, "I use anti-depreto] depression. Date On 8/8/2023 at 3:50 pconducted with LPN #7 stated that the they monitored reside medications for that we MAR every shift. SI the ordinary was reported to the antipsychology of the antipsychology on 8/9/2023 at 12:47 conducted with LPN stated that staff documents and the st	lested for a new admission and episodes of crying I history of past psychiatric olar depression. She also ad both auditory and visual he was admitted in the e agreed to add Seroquel D [twice a day] for bipolar or Diagnosis: Bipolar Disorder e - F31.32. Treatment Plan / Plan: Supportive care, sk/Benefits analysis, rovided. Antipsychotic eful consideration ' the notic medications in this potential risks of tardive cemia and stroke. They help avior such that normal care is tient is in the nursing facility." In for R160 documented in essant medication r/t [related Initiated: 07/27/2023." Jo.m., an interview was (licensed practical nurse) #7. Here were specific behaviors ents taking antipsychotic were documented on the ne stated that anything out of orted to the physician. She AR and stated that she did nitoring behaviors or adverse	F	758			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	, , ,	(X3) DATE SURVEY COMPLETED	
		495272	B. WING			C 8/16/2023	
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238		0/10/2023	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 758	conducted with LPN monitored residents medications for beh stated that they mor and documented the She stated that they effects from antipsy and some staff documented routine observed but she will documented routine. The facility policy "A revised July 2022, distaff will observe, do attending physician effectiveness of any antipsychotic medic monitor for and reported the standard standar	p.m., an interview was #5. LPN #5 stated that they taking antipsychotic aviors and vital signs. She hitored for behavior changes em in the medical record. It monitored for adverse chotic medications every shift mented in their medication It that no adverse effects were as not sure if it was hy. Intipsychotic Medication Use" ocumented in part, "17. The ocument, and report to the information regarding the interventions, including ations. 18. Nursing staff shall ort any of the following side consequences of ations to the attending hergic: constipation, blurred rinary retention, sedation; rthostatic hypotension, se in total des, unstable or poorly	F 75				

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		E SURVEY PLETED
		495272	B. WING		08	C / 16/2023
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	1 35	110/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 758	consultant were mad No further information Reference: (1) Quetiapine tablets (long-acting) tablets a symptoms of schizopicauses disturbed or uninterest in life, and st emotions). Quetiapininextended-release table with other medication (frenzied, abnormally	e aware of the concern. n was provided prior to exit. s and extended-release are used to treat the ohrenia (a mental illness that unusual thinking, loss of rong or inappropriate e tablets and olets are also used alone or as to treat episodes of mania of excited or irritated mood) or	F 7	58		
F 761	(manic depressive di causes episodes of comania, and other abriquetiapine tablets an are used with other nepisodes of mania or bipolar disorder. Que tablets are also used medications to treat of tablets may be used program to treat biposchizophrenia in child Quetiapine is in a claratypical antipsychotic activity of certain nat This information was https://medlineplus.gtml Label/Store Drugs ar	depression. Quetiapine as part of a treatment lar disorder and dren and teenagers. ss of medications called es. It works by changing the ural substances in the brain. obtained from the website: ov/druginfo/meds/a698019.h	F 70	51		9/26/23
SS=D	CFR(s): 483.45(g)(h) §483.45(g) Labeling					

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		495272	B. WING _			C 08/16/2023
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	ı	35/10/2020
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		RECTION SHOULD BE PPROPRIATE	(X5) COMPLETION DATE
F 761	professional principle appropriate accessor instructions, and the applicable. §483.45(h) Storage §483.45(h)(1) In accessor in the second personnel and the second personnel to have a	ce with currently accepted es, and include the ory and cautionary expiration date when of Drugs and Biologicals cordance with State and cility must store all drugs and compartments under proper s, and permit only authorized	F 7	F761: Label/Store Drugs and E	Biologicals	
	The findings include Observation was may of the Tuckahoe unity had left her medicate room 115 and enterside of the hallway. within her sight. On			SS=D No specific residents were iden RN #2 was provided with re-ed Staff Development Coordinator on keeping the medication cart locked when not in use and line Current residents have potentia	ucation by /Designee closed and e of sight.	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495272	B. WING_			1	16/2023
NAME OF PR	ROVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	16/2023
CANTEDD	LIDV DELIABILITATION A	AND HEATTHCARE CENTER		17	776 CAMBRIDGE DRIVE		
CANTERD	URT REHABILITATION A	AND HEALTHCARE CENTER		R	ICHMOND, VA 23238		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 761	spoon sticking out of her medication cart, so the plastic cup that wows a resident's med to get into her all mor orange color is comin was mixed in it. When be left on the top of a not at her cart, RN #2 lock it up. RN #2 was left on the medication replied, no. The "Administering M April 2019 documents administration of medication nurse or a doorway of the reside drawers facing inward No medications are k cart must be clearly vadministering medica must be inaccessible passing by" ASM (administrative sadministrator, ASM # consultant, and ASM case management, wabove findings on 8/8	it. When RN #2 returned to the was asked what was in as orange, RN #2 stated it ideation that she's been trying ning. RN #2 stated the g from the multivitamin that in asked if medications are to medication cart when she is a stated she had forgotten to asked if medications can be cart unattended, RN #2 edications" policy revised and in part, "19. During dications, the medication cart sked when out of sight of hide. It may be kept in the int's room, with open if and all other sides closed. The isible to the personnel tions, and all outward sides to residents or others staff member) #1, the 4, the regional director of ere made aware of the	F	761	affected by this practice. Walking round were completed by the Unit Manager/Designee on each nursing un at different times of the day to validate that the medication cart was closed and locked when out of sight of the medication rounds. No further variances were noted to the cart closed and locked when not in use and out of sight of the medication rounds 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 or 3 months or ongoing until compliance sustained.	it d ion d.	
F 773 SS=D		Order/Notify of Results	F7	773			9/26/23
	§483.50(a)(2) The fac	cility must-					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		495272	B. WING _		30	C 8/16/2023	
	ROVIDER OR SUPPLIER URY REHABILITATION	I AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	·	, 10, 2020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 773	ordered by a physic practitioner or clinic accordance with Stapractice laws. (ii) Promptly notify t physician assistant, nurse specialist of leaves notification of a pracephysician's orders. This REQUIREMENTS assed on staff intereview, the facility services in a timely residents in the sum. The findings included to obtain STAT (impanel) (1) and CBC laboratory tests, per 8/3/23. A review of R360's nurse practitioner's that documented, "A Nausea and vomitin diarrhea. Regular benign. Ordered Zonausea and vomitin mouth every) 6 hou vomiting x3d (times)	laboratory services only when ian; physician assistant; nurse al nurse specialist in ate law, including scope of the ordering physician, nurse practitioner, or clinical aboratory results that fall afference ranges in accordance and procedures for citioner or per the ordering that is not met as evidenced tryiew and clinical record taff failed to provide laboratory manner for one of 57 yey sample, Resident #360.	F 7	F773 (D) Lab Services Physi Order/Notify of Results Resident # 360 was discharge facility on 8/19/23. LPN #1 and LPN # 11 were reby the DON/Designee on the service process for STAT test and arranging for tests in a time. Current residents requiring Shave the potential to be affect of residents ordered to have shave the last 7 days was conducted timeliness of lab draw per MD further variances were noted. Licensed Nursing Staff were reby the Staff Development Coordinator/Designee on the service process for STAT test and arranging for tests in a time.	ed from the e-educated laboratory requisitions mely manner. TAT labs ted. An audit STAT labs in d validating order. No re-educated laboratory requisitions		
		fluid intake, we can do IV		The DON/Designee will condu	uct an audit		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	495272	B. WING		00/4	6/2023	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	•	0/2023	
			1776 CAMBRIDGE DRIVE			
CANTERBURY REHABILITAT	ION AND HEALTHCARE CENTER		RICHMOND, VA 23238			
PREFIX (EACH DEFIC	RY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
Further review of a physician's ord and CBC for nau note dated 8/3/2 stat CBC and BN specimen, stated will send someor ordered labs tod: 8/3/23 document stated they do not today to attempt in AM with routin BMP and CBC laspecimens were On 8/10/23 at 10 conducted with L #11. LPN #11 st outside company labs. LPN #11 s comes from the of for Sundays. LP do not routinely could if someone available and prestated that on 8/3 R360 so she call someone came of labs and asked L let them know. L company then the	dis if necessary, ordered clear 24 hours. Discussed with nurse." If R360's clinical record revealed der dated 8/3/23 for a STAT BMP usea and vomiting. A nurse's 3 documented, "Lab out to draw MP, but unable to obtain defect the discussion of the select of attempt to draw ay." Another nurse's note dated ted, "Lab called back to facility of have anyone to come back out the blood draw, lab to be drawn to elab orders." A review of the ab results revealed the lab collected on 8/4/23 at 2:00 p.m. In the facility to obtain the discussion of the selection of the facility to obtain the selection of the facility. LPN #11 stated nurses at the facility draw blood but she guessed they be who knew how to do it was the sesent in the facility. LPN #11 along the facility. LPN #11 along the company, but, said she couldn't obtain the LPN #11 to call the company and LPN #11 stated she called the levy called back to someone elsed as aid no one could come out that	F 77		orders to ed in a timely I provider was of completed. I. These audits 4 weeks, then adings of the the Committee ation monthly		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		495272	B. WING			C 8/16/2023	
	ROVIDER OR SUPPLIER URY REHABILITATION	AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	ET ADDRESS, CITY, STATE, ZIP CODE CAMBRIDGE DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 773	Continued From pag labs should be obtain	e 222 ned within an hour of being	F 7	73			
	staff member) #1 (the (the regional risk conthe above concern. References: (1) "A basic metaboli measures eight differ blood. It provides impour body's chemical Metabolism is the profood and energy. A Efollowing: Glucose, a body's main source of the body's most import essential for proper for muscles, and heart. dioxide, and chloride electrically charged ramount of fluids and bases in your body. BUN (blood urea nitr products removed frokidneys." This inform website: https://medlineplus.gpanel-bmp/ (2) "Your blood contains."	e administrator) and ASM #4 sultant) were made aware of companies panel (BMP) is a test that rent substances in your cortant information about a balance and metabolism. Society of sugar and your of energy. Calcium, one of cortant minerals. Calcium is functioning of your nerves, Sodium, potassium, carbon. These are electrolytes, minerals that help control the the balance of acids and cogen) and creatinine, waste om your blood by your nation was obtained from the cov/lab-tests/basic-metabolic-lins red blood cells (RBC), and platelets. Blood					
F 804 SS=D	count tests (CBC) mo of cells in your blood obtained from the we https://medlineplus.g Nutritive Value/Appe	easure the number and types " This information was bsite: ov/bloodcounttests.html ar, Palatable/Prefer Temp	F 8	04		9/26/23	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	IPLE CONSTRUCTION IG		ATE SURVEY DMPLETED
		495272	B. WING _			C 08/16/2023
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238		1 00/10/2023	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 804	Continued From page	e 223	F8	004		
	§483.60(d) Food and Each resident receive	drink es and the facility provides-				
		repared by methods that ue, flavor, and appearance;				
	attractive, and at a sa temperature.	and drink that is palatable, afe and appetizing is not met as evidenced				
	Based on observation interview, clinical record document review, it was a second contract of the contract of t	n, resident interview, staff ord review, and facility was determined that the		F804 (D) Nutritive Value/Appear Palatable/Prefer Temp		
	temperature. The findings include:	provide food at a palatable		Resident # 48 was reviewed with adverse effects related to cited occurrence with palatable tempe during the lunch meal.		
	The facility staff failed	d to provide food at a e during lunch on 8/8/2023.		Resident # 160 was reviewed wit adverse effects related to cited occurrence with palatable tempe		
	(minimum data set), a	848) most recent MDS an annual assessment with a reference date) of 6/9/2023,		during the lunch meal. OSM #2 and OSM #7 were re-ec		
	the resident scored 1 (brief interview for me indicating the resider	3 out of 15 on the BIMS ental status) assessment, it was cognitively intact. On n., R48 was interviewed.		by the facility administrator on va meals are served at a palatable temperature per the facility policy	llidating	
	stated, "It is cold and			Current residents have the poten affected. A resident council meet be held by 9/25/23 with review of	ing will f dining	
		R160) admission 27/2023, the resident was ert and oriented to person,		services to include palatability to reviewed. Findings will be address		
	place and time. On 8 was sitting up in her l	8/8/2023 at 10:14 a.m., R160 bed eating breakfast. She terrible." When asked if the		The Dining Service Manager and staff were re-educated by the fac administrator on the proper	-	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
				_			С	
		495272	B. WING _			(08/16/2023	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
CANTEDE	LIDY DELIABILITATION A	AND LIEALTHOADE CENTED		17	776 CAMBRIDGE DRIVE			
CANTERB	ORY REHABILITATION	AND HEALTHCARE CENTER		R	CICHMOND, VA 23238			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 804	Continued From page	e 224	F 8	304				
	food she was served it's usually kind of col	was warm, she stated, "No, d."			process/procedure to maintain palatab food temperatures per policy and procedure.	le		
	Review of the resider	nt council minutes dated			•			
	6/29/2023 documente	ed concerns for cold food			The Dining Service Manager/Designee	;		
	served on the units.	The resident council minutes			will audit 3 test trays to validate food			
	dated 7/19/2023 docu	umented concerns regarding			temps are maintained per policy and			
	undercooked meats a	and vegetables.			procedures. Variances will be address. These audits will be conducted weekly			
	On 8/8/2023 at 11:00	a.m., the holding			weeks, then monthly x 2 months. The			
	temperatures of lunch	n were obtained from the			findings of the audits will be submitted	by		
	service line in the kito	chen and were as follows:			the Administrator/Designee to the QAF	P		
	Pureed ham- 176 deg	grees Fahrenheit			Committee for review and			
	Pureed sweet potatoe	es- 149 degrees Fahrenheit			recommendation monthly for 3 months	or		
	Pureed peas- 163 de	grees Fahrenheit			ongoing until compliance sustained.			
		· 138 degrees Fahrenheit						
		es- 155 degrees Fahrenheit						
	Regular peas- 177 de							
	Regular ham- 165 de	grees Fahrenheit						
		peratures were obtained, plated, covered with a lid,						
	-	and taken to the units. On						
	-	n., a test tray was plated and						
		yay of the Tuckahoe unit with						
		n 8/8/2023 at 1:04 p.m.,						
	when the final meal w	vas served on the west						
	hallway of the Tuckah	noe unit, the temperatures of						
	the food on the test tr	ay were obtained by OSM						
	(other staff member)	#2, the dietary manager.						
	The temperatures we							
	Pureed ham- 94.5 de	_						
	Pureed sweet potatoe	es- 119.5 degrees						
	Fahrenheit							
	Pureed peas- 117.1 c							
		- 123.3 degrees Fahrenheit						
	Regular sweet potato	es- 133.8 degrees						
	Fahrenheit							
	Regular peas- 121.6	degrees Fahrenheit						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495272	B. WING _			C / 16/2023
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238		110/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 804	surveyors who detern pureed peas were no appetizing temperatu manager confirmed th items could be warme	ray was sampled by two nined the pureed ham and t warm enough to be an re. OSM #7, the district nis and stated these food	F 8	04		
	dated October 2017, Statement. Each residence nourishing, palatable, meets his or her daily dietary needs, taking preferences of each runner of the state of the	documented in part, "Policy dent is provided with a well-balanced diet that nutritional and special into consideration the esident" ximately 5:00 p.m., ASM nember) #1, the 4, the risk consultant and				
F 812 SS=D	Food Procurement, St CFR(s): 483.60(i)(1)(2)(3)(4)(4)(4)(5)(4)(5)(5)(5)(6)(6)(6)(6)(6)(6)(6)(6)(6)(6)(6)(6)(6)	ore/Prepare/Serve-Sanitary 2) y requirements. re food from sources ed satisfactory by federal, es. bod items obtained directly subject to applicable State	F8	12		9/26/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		, ,	(X3) DATE SURVEY COMPLETED	
		495272	B. WING			C 8/16/2023	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	, ,		
				1776 CAMBRIDGE DRIVE			
CANTERB	URY REHABILITATION	AND HEALTHCARE CENTER		RICHMOND, VA 23238			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 812	Continued From page	e 226	F 8	12			
	safe growing and foo (iii) This provision do	ompliance with applicable d-handling practices. es not preclude residents s not procured by the facility.					
	serve food in accorda standards for food se	prepare, distribute and ance with professional ervice safety. Γ is not met as evidenced					
	Based on observation facility document revithe facility staff failed	ons, staff interview, and ew, it was determined that to store food in a sanitary		F812 (D) Food Procurement, Store/Prepare/Serve-Sanitary			
	manner in one of one kitchen, in one of three nourishment rooms in the facility and during meal service.			The two-pound bag of brown su observed in the dry goods stora was removed from the inventory discarded without adverse effect	ge area y and		
	The findings include:			cited occurrence.	is to the		
	conducted of the kitcl member) #2, dietary the dry goods storage bag of brown sugar a	20 a.m., an observation was hen with OSM (other staff manager. Observation of e area revealed a two pound approximately three-quarters wrap. The package was		The ground coarse yellow subsidentified as cornmeal, observe goods storage area was remove the inventory without adverse e related to the cited occurrence.	d in the dry ed from		
	observed to not have stated that the staff's opened so that they l discarded. She state	an opened date. OSM #2 hould date the product when knew when it needed to be det that she was going to the was unable to identify		OSM # 2 was re-educated by fa administrator on validating that in the dry goods storage room a and labeled per facility policy.	items kept		
	approximately four quyellow substance tha cornmeal. The plasti			The fans observed in the kitche removed with no adverse effect to the cited occurrence. Facility updated to reflect guidance for maintaining dust free fans. OSM #2 was re-educated by the	s related policy		
	the bin contained cor	nmeal and it should have sed when the cornmeal was		administrator to ensure that who	en utilizing		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
						(
		495272	B. WING _			08/	16/2023
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CANTEDE	LIDY DELIA DIL ITATIONI	AND LIEALTHOADE CENTED		17	776 CAMBRIDGE DRIVE		
CANTERE	URY REHABILITATION A	AND HEALTHCARE CENTER		R	ICHMOND, VA 23238		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 812	Continued From page	e 227	F	812			
	poured into the bin fo	r storage and a use by date.			dust and not blowing on the dish ware.		
	portable fans in use. sitting on top of a rolli metal rack containing including serving scorcontainers. The meta observed with visible When asked about the they had been having conditioning in the kit been working on it bukitchen so they had be cooler. She stated the blowing up towards the clean uter visible dust on the mestated that she was near for cleaning of the far have dust on it. She	chen and maintenance had It it had been very hot in the een using the fans to keep at the fans should be ne ceiling and not blowing ensils. OSM #2 viewed the etal cage of the fan and ot sure who was responsible ns but the fan should not stated that the dietary staff			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 trays and replaced with covered cake who 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	er e o	
	a large dry goods sto dated 7/8, use by 9/8 paper cup was observed of the sugar. When a #2 stated that the cup and nothing should be product. On 8/7/2023 at 2:45 products at 2:45 products at 2:45 products at 2:45 products with LPN (A stand up refrigerate items was observed to with a receipt dated 7/8/8/2023 at 2:45 products with a receipt dated 7/8/2023 at 2:45 products with LPN (A stand up refrigerate items was observed to with a receipt dated 7/8/2023 at 2:45 products with a receipt date	of the kitchen area revealed rage bin labeled sugar, Inside of the bin, a single wed inside of the bin on top asked about the cup, OSM o should not be in the bin to inside the bin touching the co.m., an observation of the the facility Grove unit was dicensed practical nurse) #8. For/freezer for resident food to contain a white paper bag and the receipt or bag.			professional standards for food service safety. Current residents have the potential to affected. An audit of dry storage room, kitchen and Grove unit pantry was conducted by Dietary Manager/Designe to ensure variances were addressed. Dietary staff were re-educated by the Dietary Manager/Designee on storing fin 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 fans in the kitchen.	be ee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		IPLE CONSTRUCTION IG	, ,	(X3) DATE SURVEY COMPLETED	
		495272	B. WING			С	
		495272	B. WING _			08/16/2023	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI	E		
CANTERE	BURY REHABILITATION	N AND HEALTHCARE CENTER		1776 CAMBRIDGE DRIVE			
G/ ((11 E) (E		1, 11, 11, 12, 11, 11, 11, 11, 11, 11, 1		RICHMOND, VA 23238			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 812	·	ge 228 PN #8 revealed a container	F 8	112			
	with food contents to identified with a rest with no identifying robserved in the refrinterview was conducted that the night refrigerator each night.	that were not labeled, dated or ident name. A fast food box esident name or date was rigerator. At this time an ucted with LPN #8. LPN #8 t shift staff checked the ght for temperatures and		Licensed Nursing staff and CN re-educated by the DON/Desi proper labeling and storage of items in the nourishment room An audit of the nourishment roon conducted 4x a week for 4 we times a week with the Distriction of the	gnee on the f residents ns. nooms will be teks, then 2		
	discard anything the stated that the refrictionly and the items is been dated and lab and room number be who they belonged	andated items and should at was past three days. She gerator was for resident use in the refrigerator should have eled with the residents name because they could not identify to or when they came in.		times a week x 4 weeks by Di manager/Designee validating storage of residents□ food ite of the Dry food storage area v conducted 4 x week for 4 wee times a week for 4 weeks by t Manager/Designee validating storing of food.	the proper ms. An audit vill be ks, then 2 he Dietary		
	conducted with ASI member) #3, the vio ASM #3 stated that kitchen normally an process for cleaning dietary staff would praintenance to have	M (administrative staff ce president of operations. fans would be avoided in the d they were not sure of the g of the fans but thought that but a request in for them cleaned. ASM #3 uld not want the fans blowing		A random audit of 10 meal tra conducted weekly x 8 weeks I DON/Designee validating that meal trays are served in acco professional standards. The fi the audit will be submitted by DON/Designee to QAPI month months or ongoing until comp sustained.	oy i items on rdance with ndings of the hly for 3		
	"Perishable foods containers with tigh Containers are labe the item and the "us will discard perishaby" date" The facility policy "S	dated, documented in part, are stored in re-sealable tly fitting lids in a refrigerator. eled with the resident's name, se by" date. The nursing staff ble foods on or before the "use					
	September 2021, fa	ailed to evidence guidance for ee fans or use of fans in the					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495272	B. WING _				C 16/2023
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	DDE	1 001	10/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BI HE APPROPRIA		(X5) COMPLETION DATE
F 812	kitchen area. The facility policy "Forevised 9/2017, docustatement. All dry gostored will be appropaccordance with the administration) Food be neat, arranged for marked as appropriate administrator, AS consultant and ASM case management with findings. No further information 2. The facility staff secon plates with no covour on 8/7/23 at 11:57 as was observed on the Westham unit. Five of individual pieces of disaucers. Each of the uncovered. On 8/7/23 at 12:02 pinurse) #6, the unit minurovered cake. Whistated: "Yes, they actiding the cake pieces and the cake pieces and the cake pieces."	pod Storage: Dry Goods" Imented in part, "Policy Imented in part, "Policy Imented in part, "Policy Imented in part, "Policy Index will be appropriately Index in part, in part	F	312			

I 2 1 1 1 1 2 1 1 1 1 1 1 1 1 1 1 1 1 1	C 1 16/2023
I ABBLIZ I D. WING I NO!	
NAME OF PROVIDER OR SUPPLIER CANTERBURY REHABILITATION AND HEALTHCARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	16/2023
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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 842 SS=E CFR(s): 483.20(f)(5), 483.70(l)(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	9/26/23

		IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495272	B. WING _			C 08/16/2023	
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 842	regardless of the forr records, except where (i) To the individual, or representative where (ii) Required by Law; (iii) For treatment, para operations, as permit with 45 CFR 164.506 (iv) For public health neglect, or domestic activities, judicial and law enforcement purp purposes, research produced examiners, for a serious threat to he by and in compliance \$483.70(i)(3) The fact record information again authorized use. §483.70(i)(4) Medical for- (i) The period of time (ii) Five years from the there is no requirement (iii) For a minor, 3 yelegal age under State \$483.70(i)(5) The medical supposition of the result of the result of the result of the comprehension of the result of the comprehension of the result of the resul	ned in the resident's records, in or storage method of the in release isport their resident is permitted by applicable law; yment, or health care sted by and in compliance is; activities, reporting of abuse, violence, health oversight if administrative proceedings, posses, organ donation purposes, or to coroners, uneral directors, and to avert ealth or safety as permitted is with 45 CFR 164.512. It records must be retained in state law; or the date of discharge when the ent in State law; or the area after a resident reaches in a safety is assessments; is assessments; ive plan of care and services in y preadmission screening evaluations and	F8	42			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495272	B. WING) n	C 8/ 16/2023	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	•	0/10/2020	
				1776 CAMBRIDGE DRIVE			
CANTERE	BURY REHABILITATIO	N AND HEALTHCARE CENTER		RICHMOND, VA 23238			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)	
PRÉFIX TAG	,	ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	IE APPROPRIATE	COMPLETION DATE	
F 842	Continued From pa	age 232	F 84	12			
		rse's, and other licensed					
	professional's prog						
		liology and other diagnostic					
		required under §483.50.					
		NT is not met as evidenced					
	by:	t interview, staff interview,		F842 (E) Resident Records	Idontifiable		
		eview and clinical record		Information	- Identiliable		
		staff failed to maintain an		Information			
		cord for four of 57 residents in		Resident # 86 continues to r	eside in the		
		, Residents #86, #361, #144		facility with no adverse effect			
	and #63.			cited occurrence.			
	The findings includ	le:		CNA 6 was re-educated by t			
	1. For Resident #8	6 (R86), the facility staff failed		and the importance of docur			
		ment the resident's ADLs		correct information in the pa			
	(activities of daily li	iving). On 8/8/23 and 8/9/23,					
		cumented R86 was assisted		Resident #361 no longer res	sides in the		
	_	ut the resident was not out of		facility.			
	bed.						
				LPN 10 was re-educated by			
		t MDS (minimum data set), a		DON/Designee on nursing d			
		ent with an ARD (assessment 7/17/23, the resident scored 15		and the importance of docur correct information in the pa	-		
		MS (brief interview for mental		Correct information in the pa	tientus Chart.		
		the resident was cognitively		Resident # 144 continues to	reside in the		
	intact for making d	•		facility with no adverse effect			
		•		cited occurrence.			
	On 8/8/23 at 7:27 a	a.m., 8/8/23 at 10:43 a.m.,					
		., 8/9/23 4:12 p.m., 8/10/23 at		RN # 1 was re-educated by			
		0/23 at 2:02 p.m., R86 was		DON/Designee on nursing d			
	, , ,	ped. On 8/10/23 at 2:02 p.m.,		and the importance of docur	•		
		onducted with R86. R86 stated		correct information in the pa	tient⊡s chart.		
		een out of bed all week. A		Decident # 62 no longer	idee in the		
		DL records for August 2023		Resident # 63 no longer resi	aes in the		
		tation that the resident was with physical assistance of two		facility.			
		ransferring during the evening					
	i oi illoio stall Willi l		1	1		1	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION UILDING			(X3) DATE SURVEY COMPLETED	
		495272	B. WING _				C 1 16/2023	
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	10/2020	
CANTEDE	LIDY DELIABILITATION	AND HEALTHCARE CENTER		17	776 CAMBRIDGE DRIVE			
CANTERE	OURY REHABILITATION	AND HEALTHCARE CENTER		R	CICHMOND, VA 23238			
(X4) ID PREFIX TAG			ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 842	Continued From page	e 233	F 8	342				
F 842	shift on 8/8/23 and 8/shift on 8/8/23 and 8/6 (a CNA who docur transferring on 8/8/23 stated R86 rarely get she mistakenly docur with transferring and documented the code On 8/11/23 at 9:57 a. staff member) #1 (the regional risk con the above concern. The facility policy title Documentation" docuprovided to the reside plan goals, or any chemedical, physical, fur condition, shall be domedical record. The reacilitate communicatinterdisciplinary team condition and respon 2. For Resident #361 failed to accurately desischial pressure injury	9/23, and during the day 10/23. m., an interview was (certified nursing assistant) mented assisting R86 with and 8/9/23). CNA #6 sout of bed. CNA #6 stated mented she assisted R86 stated she should have a NA [not applicable]. m., ASM (administrative administrator) and ASM #4 sultant) were made aware of add, Charting and amented, "All services ent, progress toward the care anges in the resident's actional or psychosocial acumented in the resident's medical record should ion between the aregarding the resident's se to care." (R361), the facility staff ocument the location of an y. A skin assessment dated	F &	342	Current residents have the potential to affected. A seven-day review of POC charting, of residents charts/nursing notes was conducted by the DON/Designee. Follow up was comple as indicated. CNAs were re-educated by the Staff Development Coordinator/Designee to accurately document the resident shall accurately document the resident shall accordance with nursing standards. An audit of 3 residents will be completed related to POC charting to validate completion and accuracy. Variances we 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 month for 3 months or ongoing until compliant sustained.	ted ted iill		
	ischium, but the press the left ischium. A review of R361's sk 1/26/23 documented	a pressure injury on the right sure injury was located on kin assessment dated multiple pressure injuries injury on the right ischium.						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495272	B. WING _			1	C 16/2023
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER		1776	EET ADDRESS, CITY, STATE, ZIP CODE CAMBRIDGE DRIVE HMOND, VA 23238	1 00/	10/2020
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFII TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 842	progress reports dat documentation for a ischium but no docupressure injury on the On 8/14/23 at 1:56 pconducted with LPN #10. LPN #10 stated assessment on 1/26 mistakenly document R361's right ischium left ischium. On 8/14/23 at 4:06 pstaff member) #1 (the regional risk condirector of nursing) vabove concern. 3. For Resident #144 evidence complete a for bilateral fall mats Observations of Res 11:40 AM, no floor m8/10/23 at 2:45 PM, of bed, 8/08/23 at 7: either side of bed, or mats on either side of no floor mats on either side of no	1/31/23 and weekly wound ed 2/1/23 revealed pressure injury on the left mentation regarding a e right ischium. 1.m., am interview was (licensed practical nurse) dishe completed R361's skin /23. LPN #10 stated she ted a pressure injury on but the wound was on the 1.m., ASM (administrative e administrator), ASM #4 insultant) and ASM #7 (the were made aware of the 1.m. the facility staff failed to and accurate documentation in ident #144 on 08/07/23 at instantiation in 1.m. identification in 1.m. identi	F	342	DEFICIENCY)		
	revealed, "Floor mat shift." A review of the Augu administration record both sides of bed ev	ician order dated 4/27/23, s to both sides of bed every est 2023 TAR (treatment d) revealed, "Floor mats to ery shift" and documented as /23 day shift through 8/10/23					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		495272	B. WING _			C 08/16/2023	
	ROVIDER OR SUPPLIER	N AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODI 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	E	33/13/2023	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF COI ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 842	PM, with RN (regist about the bilateral f RN #1 stated, he us they took them to g was more active. V documentation on t administration record to both sides of bed that they were pres #1 stated, it was an When asked if there is the medical record #1 stated, no, it is not not a manager of the No further information of the No further inf	onducted on 8/9/23 at 2:20 pered nurse) #1. When asked floor mats for Resident #144, sed to have fall mats. I believe five to another resident who when asked about the floor mats for Resident who when asked about the floor mats floor floo	F	342			
		ician's orders for R63 dated ugh January 2023 failed to or offloading boots.					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		495272	B. WING			C 8/16/2023	
	ROVIDER OR SUPPLIER	N AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238		0/10/2023	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 842	R63 was provided to offloading boots. Review of the R63's dated of 10/15/2020 offloading boots. On 08/08/2023 at a (administrative staff consultant, stated Forder for offloading) On 08/10/2023 at a (registered nurse) #R63's comprehensi use and/or refusal for At approximately 1: surveyor that there comprehensive care	ogress notes dated 1 01/31/2023 failed to evidence with and/or refused the use of 2 comprehensive care plan 3 failed to evidence the use of 2 pproximately 2:57 p.m., ASM 3 member) #4, regional risk 3 did not have a physician's	F 84	,			
	#1, administrator, in there was document of offloading boots. On 08/16/2023 at an interview was condursing. She provided document entitled "03/02/2022. Under documented in part When asked about was part of her risk When asked to interview of order of the transport of the trans	pproximately 9:18 a.m., ASM aformed the surveyor that station of R63 refusing the use pproximately 9.30 a.m., an acted with ASM #7, director of ded the surveyor with a Clinical Stand Down" dated the heading "Resident" it , "(Name of R63) - ® HLSB." the document she stated it management documents. rpret "® HLSB" she stated it Heel Lift Suppression Boots"					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495272	B. WING		C 08/16/2023
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	1 33.10.222
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 842	the offloading boots	on that R63 refused to wear . When asked if the "Clinical nent was part of R63's clinical	F 84	2	
F 880 SS=D	No further information Infection Prevention CFR(s): 483.80(a)(1		F 88	0	9/26/23
	infection prevention designed to provide comfortable environ	ablish and maintain an and control program a safe, sanitary and ment and to help prevent the ansmission of communicable			
	program. The facility must est	prevention and control ablish an infection prevention (IPCP) that must include, at wing elements:			
	reporting, investigati and communicable of staff, volunteers, vis providing services u arrangement based	upon the facility assessment g to §483.70(e) and following			
	procedures for the p but are not limited to (i) A system of surve possible communication	eillance designed to identify			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED C 08/16/2023	
		495272	B. WING				
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238	, ,	3110/2020	
(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 CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 880	communicable diseate reported; (iii) Standard and tratto be followed to pre (iv)When and how is resident; including b (A) The type and du depending upon the involved, and (B) A requirement th least restrictive possicircumstances. (v) The circumstance must prohibit employ disease or infected scontact with residen contact will transmit (vi)The hand hygien by staff involved in contact with residen contact will transmit (vi)The hand hygien by staff involved in contact with residen contact will transmit (vi)The hand hygien by staff involved in contact with residen contact will transmit (vi)The hand hygien by staff involved in contact with residen contact will transmit (vi)The hand hygien by staff involved in contact with resident contact with	om possible incidents of ase or infections should be ansmission-based precautions event spread of infections; solation should be used for a ut not limited to: ration of the isolation, infectious agent or organism at the isolation should be the sible for the resident under the es under which the facility yees with a communicable skin lesions from direct the disease; and e procedures to be followed direct resident contact. Item for recording incidents facility's IPCP and the ken by the facility. In the disease, and the store, process, and the store, process, and the store, process, and the store prevent the spread of	F 88				
	The facility will cond IPCP and update the This REQUIREMEN by: Based on observati document review, it	uct an annual review of its eir program, as necessary. T is not met as evidenced on, staff interview and facility was determined the facility in effective infection control		F880 (D) Infection Prevention &			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		(2) MULTIPLE CONSTRUCTION . BUILDING			(X3) DATE SURVEY COMPLETED	
		495272	B. WING _				C 1 16/2023	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	, 00/	10/2023	
				17	776 CAMBRIDGE DRIVE			
CANTERB	URY REHABILITATION	AND HEALTHCARE CENTER		R	CICHMOND, VA 23238			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 880	residents in the Tuck. 8/7/2023 at 11:32 a.m. #10, the activity assis resident's orders for the drinks to the resident OSM #10 was observed the gloves on between #10 continued to pass 11:53 a.m. OSM #10 sanitizer with his glove changed gloves. An interview was consolved at 12:00 p.m. hand sanitizer with his stated, "To make sure well." An interview was consolved at 1:49 p.m. When as should use hand san have gloves on, RN # that either." RN #4 we should who are service the dining room have gloves, RN #4 stated is going from residen hygiene practice should the they should they are going table resident, then they should resident, then they should who are services and they are going table resident, then they should who are services and they are going table resident, then they should who are services and they are going table resident, then they should who are services and they are going table resident, then they should who are services and they are going table resident, then they should who are services and they are going table resident, then they should was a should was	de of the staff serving the ahoe dining room on n. OSM (other staff member) stant, was helping getting their lunch and passing out s. OSM #10 had gloves on. Wed using hand sanitizer with an serving residents. OSM s plates to residents. At was observed using hand wes on, again. He never adducted with OSM #10 on n. When asked why he used s gloves on, OSM #10 e my hands are disinfected and ducted with RN (registered on preventionist, on 8/8/2023 sked if a staff member itizer on the gloves when you was asked what the staffing food to the residents in on, should they be wearing , no. When asked if the staff to resident, what hand all did they follow, RN #4 stated	F	380	OSM # 10 was re-educated on the han hygiene process per facility protocol who passing out food trays. Current residents have the potential to affected. The DON/Designee conducter review of meals to validate hand hygien was being used appropriately. No furth variances were noted. The facility staff will be re-educated on correct hand hygiene protocol for passiout meal trays to residents by the DON/Designee. A random audit of 5 staff members per week x 4 weeks, then 3 staff members week x 4 weeks will be conducted by the DON/Designee validating the correct hygiene protocol is being utilized. The findings of the audit will be submitted be the DON/Designee to QAPI monthly for months or ongoing until compliance is sustained.	be d a ne er the ing a ne and		
	The facility policy, "P	reventing Foodborne Illness -						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495272	B. WING		C 08/16/2023	
	ME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238			1 00/10/2020		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE	
F 880 F 921 SS=D	documented in part, when distributing foo tables or when assist touching ready-to-ear ASM (administrative administrator, ASM # consultant, and ASM case management, vabove findings on 8/8 No further informatio Safe/Functional/Sani CFR(s): 483.90(i) \$483.90(i) Other Environment of the facility must provide the same street of the control of the same street of the control of the con	nd Sanitary Practices," "13. Gloves are not required ds to residents at the dining ring residents to eat, unless t food." staff member) #1, the 4, the regional risk #5, the regional director of were made aware of the 3/2023 at 4:59 p.m. In was provided prior to exit. tary/Comfortable Environ ironmental Conditions vide a safe, functional,	F 88		9/26/23	
	by: Based on observation document review and was determined that provide a safe and fur of 12 resident rooms. The findings include: The facility staff failed functional environme rooms, for Resident resident screening or room 316 revealed a dispenser partially to	ne public. T is not met as evidenced ons, staff interview, facility d clinical record review, it the facility staff failed to unctional environment for one (for Resident #129). d to provide a safe and nt for one of 12 resident #129. During the initial in 8/7/23 at 2:59 PM, resident wall mounted hand sanitizer rn off the wall above and to int's sink, a section of		F921 Safe/Functional/Sanitary/Comfortable Environment 1. Resident #129 Hand sanitizer wall mount, dry wall, missing flooring, peele wallpaper, and cove base was repaired resident room. 2. Residents who reside at Canterbury Rehabilitation and Healthcare Center have the potential to be affected by thi practice. An audit was conducted by the	d in	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495272	B. WING _				C / 16/2023
NAME OF PROVIDER OR SUPPLIER			<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	710/2023
					776 CAMBRIDGE DRIVE		
CANTERE	URY REHABILITATION	AND HEALTHCARE CENTER					
				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				(X5) COMPLETION DATE
F 921	Continued From page 241		FS	921			
	approximately six inc			Administrator/Designee of resident roo	ms		
	the resident's sink, m				to ensure a safe, functional, sanitary, a		
	doorway between the	-			comfortable environment for residents,		
		ately 12 inches of cove base			staff, and the public. Variances were		
		additional tearing of the dry			addressed.		
	wall between the head of the residents beds and						
	an approximate 12 in			3. Weekly audit of 5% of resident room	ıs		
	off the wall to the left side the heating/air				and common areas will be conducted by		
	conditioning unit at the far side of the room.				the Administrator/Designee to monitor		
					rooms and environment to ensure they		
	On 8/8/23 at 3:30 PM, an interview was				are presenting in a safe, sanitary,		
	conducted with CNA (certified nursing assistant)				functioning, and comfortable manner.		
	#2. When shown Resident #129's room with the						
	broken dry wall, peeled wallpaper and no tiles in				a. The Staff Development		
	doorway between resident room/ bathroom, and				Coordinator/Designee will provide		
	asked if this was a sa			education to all departments within the			
	CNA #2 stated, no, this is not sanitary. When				center on the importance of a clean an		
		environment, CNA #2			homelike environment. Education on the		
	stated, no it is not.				utilization of tels system to identify nee	ded	
				work orders for repair or needing			
	On 8/9/23 at 10:15 AM, an interview was				addressed.		
		(other staff member) #3, the			4 TI D: 4 C		
	maintenance director. When shown Resident				4. The Director of		
	#129's room with broken dry wall, peeled				Maintenance/Housekeeping and/or		
	wallpaper and no tiles in doorway between				Designee will conduct a weekly roundi	•	
	resident room/bathroom and asked if this was a				of the facility to ensure a safe, function sanitary, and comfortable environment		
	safe, sanitary environment, OSM #3 stated, no, it is not.				residents, staff and the public.	101	
	15 1101.				residents, stan and the public.		
	On 8/14/23 at 4:00 P	M, ASM (administrative staff			Findings from the audit will be submitte	ed	
	member) #1, the administrator, ASM #4, the				to the QAPI committee for review and	-	
	, .	ant, ASM #7, the director of			recommendation monthly.		
	_	the regional consultant was					
	made aware of the fi						
		lity's "Construction and					
	Renovation-Role of t						
		urpose: To reduce resident ure to potentially infectious					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		495272	B. WING_			C 08/16/2023	
NAME OF PROVIDER OR SUPPLIER CANTERBURY REHABILITATION AND HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1776 CAMBRIDGE DRIVE RICHMOND, VA 23238			00/16/2023	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 921	construction, renovati demolition or related or designee(s) will es surveillance for airbor environmental diseas Legionnaire's disease the project to protect patients. The adminismonitor construction completion to ensure CDC/HICPAC (center infection control practiguidelines and state of	the environment due to ion, remediation, repair and activities. The administrator tablish and maintain rne and waterborne	FS	021			