STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495272	A. Building B. Wing	12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Canterbury Rehabilitation and Healthcare Center	1776 Cambridge Drive Richmond, VA 23238

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews facility document review and clinical record review, it was determined the facility staff failed to develop a baseline care plan for one of six residents in the survey sample, Resident #1 (R1). The findings include: The facility failed to develop a baseline care plan to include diabetes and monitoring of blood sugars for R1. R1 was admitted to the facility on [DATE] with diagnosis that included diabetes, acute/chronic respiratory failure and trach (tracheostomy).The most recent MDS (minimum data set) assessment, a Medicare 5-day assessment, with an ARD (assessment reference date) of 11/18/25, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as being dependent for mobility/transfers, dressing, hygiene toileting and set up for eating. A review of the baseline care plan dated 11/13/25 revealed, FOCUS: Resident is a new admission with discharge potential. Stay projected to be short in duration. INTERVENTIONS: Discuss with rehab (rehabilitation) any special equipment needs and facilitate obtaining prior to discharge. Encourage patient and family to be involved in planning of care and discharge planning. Make referrals to other community agencies as deemed appropriate. Social work and Care Navigator to visit with patient and/or family to discuss any concerns regarding potential discharge.A review of the physician order dates 11/17/25 revealed Blood sugar checks AC and HS before meals and at bedtime for blood sugar check.There is no evidence of the baseline care plan including any focus or interventions related to diabetes or blood sugar monitoring until 11/20/25.On 12/30/25 at 8:00 an interview was conducted with LPN (licensed practical nurse) #2. Asked what the baseline care plan should include, LPN #2 stated, it should include the initial plan of care for the resident. When asked if a resident with diabetes should have it on the baseline care plan, LPN #2 stated, yes, that should go on the baseline care plan. The blood sugars will pop on the MAR (medication administration record), and you document it there.On 12/30/25 at 2:30 PM, ASM (administrative staff member) #2, the interim director of nursing and ASM #3 the regional director of operations was made aware of the findings. No further information was provided prior to exit.

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495272	A. Building B. Wing	12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Canterbury Rehabilitation and Healthcare Center	1776 Cambridge Drive Richmond, VA 23238

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495272	A. Building B. Wing	12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to provide care and services to promote a resident's highest level of wellbeing for three of six residents, Resident #1, #2 and #6. The findings include: 1. The facility failed to monitor blood sugar as ordered for Resident #1 (R1). R1 was admitted to the facility on [DATE] with diagnosis that included diabetes, acute/chronic respiratory failure and trach(tracheostomy).The most recent MDS (minimum data set) assessment, a Medicare 5-day assessment, with an ARD (assessment reference date) of 11/18/25, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as being dependent for mobility/transfers, dressing, hygiene toileting and set up for eating. A review of the baseline care plan dated 11/13/25 revealed, FOCUS: Resident is a new admission with discharge potential. Stay projected to be short in duration. INTERVENTIONS: Discuss with rehab any special equipment needs and facilitate obtaining prior to discharge. Encourage patient and family to be involved in planning of care and discharge planning. Make referrals to other community agencies as deemed appropriate. Social work and Care Navigator to visit with patient and/or family to discuss any concerns regarding potential discharge.A review of the physician order dates 11/17/25 revealed Blood sugar checks AC and HS before meals and at bedtime for blood sugar check.A review of the November 2025 MAR (medication administration record) revealed missing evidence of blood sugar checks for 9:00 PM on 11/17, 11/18 and 11/19.On 12/30/25 at 8:00 an interview was conducted with LPN (licensed practical nurse) #2. Asked where blood sugars are documented, LPN #2 stated, the blood sugars will pop on the MAR (medication administration record), and you document it there. Asked if there is no documentation of blood sugar checks, is there evidence that they were done? LPN #2 stated, no, there is no evidence, if it is not documented, it was not done.On 12/30/25 at 2:30 PM, ASM (administrative staff member) #2, the interim director of nursing and ASM #3 the regional director of operations was made aware of the findings. A review of the facility's Obtaining a Fingerstick Glucose Level policy revealed, 'The purpose of this procedure is to obtain a blood sample to determine the resident's blood glucose level. Verify that there is a physician's order for this procedure. No further information was provided prior to exit. 2. The facility failed to monitor neuro checks post fall for Resident #2 (R2). R2 was admitted to the facility on [DATE] with diagnosis that included CVA (cerebrovascular accident), Atrial fibrillation and NSTEMI (non ST elevation myocardial infarction).The most recent MDS (minimum data set) assessment, a discharge return anticipated assessment, with an ARD (assessment reference date) of 4/24/25, the resident was not coded on the BIMS (brief interview for mental status) score. A review of the MDS Section GG-functional abilities and goals coded the resident as being dependent for dressing, hygiene toileting and supervision for bed mobility, transfers and walking 10 feet. A review of the baseline care plan dated 4/23/24 revealed, FOCUS: Resident is at risk for falls related to CVA. I am on anticoagulation therapy related to atrial fibrillation. INTERVENTIONS: Assist and/ or remind me to change position and get up from sitting or lying slowly due to orthostatic blood pressure problems (dizziness/fainting with position changes). Be sure call light is within reach and provide reminders to use call for assistance as needed. Monitor/record/report PRN(as needed) signs/symptoms of anticoagulant complications: blood tinged or frank blood in urine, black tarry stools, dark or bright red blood in stools, bruising, sudden severe headaches, nausea, vomiting, muscle joint pain, lethargy, blurred vision, SOB(short of breath) loss of appetite, sudden changes in mental status, significant or sudden changes in vital signs.A review of the progress note dated 4/24/24 at 5:54 PM revealed, At approximately 1720, this nurse went to find resident to give him his medication. Resident was found in room [ROOM NUMBER] on the floor. There was blood covering a large portion of the floor and resident was laying in between the two beds in the room. There were no other residents or staff around as this was during mealtime. Resident was unable to say what happen. I immediately went to get my fellow nurse and a nurse aide to get the resident up off of the floor and further assess resident. Resident had a gash/ laceration on the bridge of his nose and a small abrasion in between his eyes and was bleeding from the back right side of his head. Resident also had a brush burn on his left knee. This nurse and fellow nurse cleaned resident to the best of our ability and called emergency services after MD said to send him out since the event was unwitnessed. VS (vital signs) were taken 139/103, pulse 119, oxygen saturation 98%, respirations 22 and calls were made to the unit manager, ADON