STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495272	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/29/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on staff interview, facility document review and clinical record review, the facility staff failed to implement the comprehensive care plan for one of six residents in the survey sample, Resident #5. The findings include: For Resident #5, the facility staff failed to implement the comprehensive care plan for the administration of the medication, Midodrine (used to treat orthostatic hypotension, a sudden fall in blood pressure that occurs when a person assumes a standing position) (1) per the physician orders. The comprehensive care plan dated 11/3/2025 documented in part, Focus: I have hypotension related to ESRD (end stage renal disease). Interventions: Give medications as ordered. Monitor vital signs as ordered and as clinically indicated.An interview was conducted with LPN (licensed practical nurse) #4 on 1/29/2026 at 7:45 a.m. LPN #4 stated the care plan is a guide for the staff on how to care for the residents and their individual needs. The facility policy, Care Plans; Comprehensive Person-Centered documented in part, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident. Administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing and ASM #5, the regional director of operations, were made aware of the above findings on 1/29/2026 at approximately 4:45 p.m. No further information was provided prior to exit. (1) this information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a616030.html

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

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to clarify physician orders for one of six residents in the survey sample, Resident #5. The findings include: For Resident #5 (R5), the facility staff failed to clarify the physician orders for Midodrine (used to treat orthostatic hypotension, a sudden fall in blood pressure that occurs when a person assumes a standing position) (1) and Clonidine (used to treat high blood pressure) (2). The physician order dated, 1/14/2026 documented, Midodrine HCL (hydrochloride) Oral Tablet 10 MG (milligrams); Give 10 MG via Peg - tube (a feeding tube inserted in the stomach) (3) every 8 hours as needed for orthostatic hypotension. Give for SBP (systolic blood pressure) under 100 mmHg (millimeters of mercury). A second physician order dated 1/14/2026 documented, Clonidine HCL Oral Tablet; Give 1 tablet by mouth every 8 hours as needed for HTN (hypertension) for 30 days; Give for SBP over 170 mmHg. Review of the clinical record failed to evidence that the resident's blood pressure was taken every eight hours to determine if they needed one of the as needed medications. An interview was conducted with LPN (licensed practical nurse) #4, on 1/29/2026 at 7:45 a.m. LPN #4 stated that when there is a medication that requires a blood pressure, the nurse should take the blood pressure and administer or hold the medication per the physician's order.An interview was conducted with administrative staff member (ASM) #4, the regional director of clinical services, on 1/29/2026 at 11:46 a.m. ASM #4 stated orders for Midodrine, the facility was cited on a previous survey, and they had addressed it with the physicians to change the orders from PRN (as needed) to a scheduled dose with parameters to hold it when indicated. ASM #4 stated it was unusual to have a PRN order for Clonidine. She further stated these orders need to be clarified. Administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing and ASM #5, the regional director of operations, were made aware of the above findings on 1/29/2026 at approximately 4:45 p.m. No further information was provided prior to exit. (1) this information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a616030.html(2) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a682243.html

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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 - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, facility document review and clinical record review, the facility staff failed to administer medications per the physician orders for one of six residents in the survey sample, Resident #5. The findings include: For Resident #5, the facility staff failed to administer Midodrine (used to treat orthostatic hypotension, a sudden fall in blood pressure that occurs when a person assumes a standing position) (1) per the physician orders. The physician order dated, 11/4/2025 documented, Midodrine HCL (hydrochloride) [NAME] tablet 10 MG (milligrams); Give 10 MG via PEG-Tube (feeding tube) every 8 hours related to dependence on dialysis. Give for SBP (systolic blood pressure) under 100 mmHG (millimeters of mercury). The medication administration record (MAR) for January 2026 documented the above order. On 1/1/2026 at 8:00 a.m. the resident's blood pressures were documented on the following dates and times and the Midodrine was documented as administered:1/1/2026 at 8:00 a.m. - 126/801/2/2026 at 2:00 p.m. - 122/761/6/2026 at 2:00 p.m. - 126/861/8/2026 at 10:00 p.m. - 148/801/10/2026 at 2:00 p.m. - 125/781/11/2026 at 8:00 a.m. - 117/83. On each of these occasions the resident's systolic blood pressure was not below 100. The comprehensive care plan dated 11/3/2025 documented in part, Focus: I have hypotension related to ESRD (end stage renal disease). Interventions: Give medications as ordered. Monitor vital signs as ordered and as clinically indicated.An interview was conducted with LPN (licensed practical nurse) #4, on 1/29/2026 at 7:45 a.m. LPN #4 stated that when there is a medication that requires a blood pressure, the nurse should take the blood pressure and administer or hold the medication per the physician's order. The above MAR was reviewed with LPN #4. She stated that the medication should not have been administered. The facility policy, Administering Medications, documented in part, 12. When indicated, validate physician ordered parameters prior to medication administration. Administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing and ASM #5, the regional director of operations, were made aware of the above findings on 1/29/2026 at approximately 4:45 p.m. No further information was provided prior to exit. (1) this information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a616030.html