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	07/02/2026

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on observation, staff interviews, clinical record review, and review of facility documents, the facility staff failed to prevent abuse for 1 of 8 residents (Resident #2), in the survey sample which resulted in the identification of Immediate Jeopardy.The findings included: Based on observation, staff interviews, clinical record review, and review of facility documents, the facility staff failed to prevent abuse for 1 of 8 residents (Resident #2), in the survey sample which resulted in the identification of Immediate Jeopardy.The findings included: The facility staff failed to prevent Resident #1 from abusing Resident #2 by pushing him out of a chair and onto the floor as well as attempting to hit Resident #2 with a chair while Resident #3 stood in close proximity to the incident. 1. Resident #1 was originally admitted to the facility 2/21/26. The diagnoses included unspecified dementia with other behavioral disturbance, chronic obstructive pulmonary disease, muscle weakness, and major depressive disorder.The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 5/30/26 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 03 out of a possible 15. This indicated Resident #1's cognitive abilities for daily decision making were severely impaired.A review of nursing progress notes dated 6/24/26 at 3:40 PM read: Resident is on constant supervision. Resident was in a resident on resident altercation. at 3:40pm. Writer was counting out/giving report at the nurse's station. A noise was heard of a chair flipping over and a thud on the ground down hallway one. As we came around the nurse's station, a resident was on the floor sitting. Between the resident and writer was (resident name retracted). He proceeded to pick up the chair and directed it towards the resident that was sitting on the floor. A thud was heard after that happened. Staff immediately removed the chair from the resident's possession and the resident on the floor was brought to the nurses station for evaluation. MD has been notified. RP was called and a message left to call back for an update. UM, DON and Administrator were immediately notified and came to evaluate. Statements have been collected. Resident remains on 1:1 supervision.The comprehensive care plan dated 4/7/2026, documented in part, Focus: I have a behavior problem of becoming aggressive during care at times. Interventions: Educate caregivers on successful coping and interaction strategies such as allowing resident time to de-escalate and reapproach at later time. Explain all procedures to the resident before starting and allow the resident to adjust to changes. Dated 5/11/2026 - Resident placed on 1:1 supervision. The care plan further documented, Focus: I am/have the potential to demonstrate physician behaviors related to Dementia, hx (history) of resident-to-resident altercations, I pushed another resident. Interventions: 1:1 supervision (6/24/26). Assess and address for contributing sensory deficits. Close monitoring (5/14/26). 2. Resident #2 was originally admitted to the facility 1/29/26. The diagnoses included Alzheimer's Disease with early onset, unspecified dementia without behavioral disturbance, essential hypertension, and muscle wasting and atrophy.The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 6/12/26 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 03 out of a possible 15. This indicated Resident #2's cognitive abilities for daily decision making were severely impaired.A review of nursing progress notes dated 6/24/26 at 5:19 PM read: At 3:40pm, Writer was informed about a (continued on next page)

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
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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	resident-to-resident altercation and noted resident sitting on the floor. Staff immediately check on the resident. Writer assess resident skin, ROM and Vital signs taken. No injuries noted. Resident was helped to the nurses' station for evaluation. UM, DON and Administrator were immediately notified and came to evaluate. Statements have been collected. Resident placed on 1:1 supervision. MD made aware and ordered to send resident out for further evaluation and CT scan. Wife is here at this time and is aware of incident. 911 was called.A review of Resident #2's Hospital Emergency Department documentation dated 6/24/26 read: You have a head injury. It doesn't appear serious at this time. But symptoms of a more serious problem, such as a mild brain injury (concussion) or bruising or bleeding in the brain, may appear later. For this reason, you or someone caring for you will need to watch for the symptoms listed below. Once you're home, also be sure to follow any care directions you're given.On 7/1/26 at 2:35 PM an interview was conducted with Licensed Practical Nurse (LPN) #1. LPN #1 stated while giving a recount of the event that occurred on 6/24/26 between Resident #1 and Resident #2 that he was in the process of counting medications and heard a thud. LPN #2 also stated that he observed Resident #2 laying on the ground and Resident #1 picking up a chair and directing the head of the chair towards Resident #2. LPN #1 further stated that an Activities Aide 1:1 was assigned to Resident #1 and observed this incident as well. LPN #1 lastly stated that the Activities Aide 1:1 was just watching and should have intervened quicker than she did. On 7/1/26 at 2:53 PM an interview was conducted with the Director of Nursing (DON). The DON stated that Resident #1 was on constant observation for a prior incident that took place regarding another resident. The DON also stated that Resident #1 has a history of displaying aggressiveness. The DON further stated that regarding the incident that took place between Resident #1 and Resident #2, the staff member should have intervened quickly, much quicker than she did.On 7/1/26 at 3:45 PM an interview was conducted with the Leadership Development Manager. The Leadership Development Manager presented a video of the incident that took place between Resident #1 and Resident #2. The video showed Resident #1 standing in front of Resident #2 and pushing him over onto the floor while he was sitting in a chair in the hallway. OSM #6 was sitting in a chair nearby and observed the entire incident. OSM #6 did not intervene until after Resident #2 was pushed by Resident #1 and fell to the floor. The video further revealed that Resident #1 picked up the chair with Resident #3 in close proximity and attempted to strike Resident #2 with the chair, however OSM #6 intervened and put her hand on the chair to stop Resident #1 from hitting Resident #2 with the chair.On 7/1/26 at 4:10 PM an interview was conducted with LPN #2. LPN #2 stated that the incident should not have occurred due to Resident #2 being on constant observation. LPN #2 also stated that the Activities Aide 1:1 was observing the confrontation and should have intervened to prevent Resident #2 from being pushed out of the chair and onto the floor by Resident #1.On 7/1/26 at 4:35 PM an interview was conducted with Activities Aide 1:1. The Activities Aide 1:1 stated, I did not feel like it was typical protocol to intervene. I did not feel like he would take it the physical part. That was my first day taking care of him. I did not think he would physically get him out of the chair. We are told who we are taking care of when we get to work. We are just told they have to be watched. I did not know what the constant observation was for regarding the resident. The facility's Memory Care Unit Policy with an effective date of 5/13/26 read: Phase 2 - Constant Observation/Monitoring Requirements: Staff shall remain within close proximity to intervene immediately if necessary. The facility's Abuse, Neglect, Exploitation and Misappropriation Prevention Program Policy with a revision date of 04/2021 read: Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms.On 7/2/26 at 11:32 AM the facility's Administrator, Director of Nursing, [NAME] President of Operations, Regional Director of Operations, Regional Nursing Consultant, and Leadership Development Manager were informed of the non-compliance which constituted Immediate Jeopardy at Past Non-Compliance, identified in F-600 Free from Abuse and Neglect at a Scope and Severity Level 4, isolated. The (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Immediate Jeopardy start date is 6/24/26 due to this being the day the resident-to-resident altercation occurred between Resident #1 and Resident #2. A copy of the Immediate Jeopardy template was reviewed and the facility was provided a copy.The facility provided a copy of their Ad Hoc meeting minutes dated 6/24/2026. The meeting minutes documented: Identified Issue: the facility experienced a resident-to-resident altercation that did not result in injury.Goal: Resident will not sustain serious injurySummary Report: Resident to Resident events reviewed in addition to the plan of correction from survey ending 4/9/26. The plan in place at the time of the event was sufficient to address the escalation of behavior and as a result kept all residents free from harm. The facility has successfully implemented a system for observing resident identified as potential victims or resident with potential for behaviors affecting others. The levels of supervision are determined by a number of factors including but not limited to historical events, assessment by social services, psychiatry consultation recommendations, review of monitoring documentation and input from medical director, staff and families. The success of the system is measured and validated by substantial decrease in incidents, also noting that this was an isolated event and the only time since the date of compliance. Upon debriefing with the team members present at the time, additional educational opportunities were identified. Resident companions received additional training on methods to de-escalate situations and early identification of triggers that can cause an increase in resident behaviors resulting in altercations. The committee will continue to monitor and address educational needs as they are identified. A training session with (name of local police officer) is schedule for August 6, 2026 from 2:00 p.m. to 3:30 p.m. to teach additional methods of protecting resident and staff from potentially aggressive behaviors. Cards provided to Recreational Sitters.Definitions of Levels of Monitoring:1:1 Monitoring: I can see you and touch you. Constant Supervision: I can always see you. Q (every) 15-minute checks: I put my eyes on you every 15 minutes to make sure you are safe.Documentation for all the above: I sign my initial every 15 minutes to document your activity and SAFETY. The survey team entered the facility on 7/1/2026 at 10:30 a.m. Observations were made of the memory care unit. The staff currently assigned to the five residents with enhanced monitoring (15 minute checks, 1:1 and constant observation) were interviewed regarding their understanding of their responsibility. The staff was interviewed at that time and verified immediate educations of 100% of all staff regarding the facility's abuse policy. The Facility's Final/Accepted Removal Plan dated 7/2/26 at 2:28 PM:Upon escalation of behavior of resident # 1 resulting in resident # 2 being pushed to the floor, staff immediately intervened and removed resident # 1 from the area and placed him on 1:1 supervision. Resident # 2 was assessed by licensed staff and verified as having no injuries. Relocation plans were immediately initiated for Resident # 1 and the resident discharged from the facility on June 25, 2026.All residents have the potential to be affected. Full body skin assessments were completed by licensed nurses for all residents residing on the unit with no additional findings. The resident present at the time of the incident was immediately removed from the area.Resident companions were re-educated by department heads on methods to de-escalate situations and early identification of triggers that can cause an increase in behaviors. All staff were re-educated by department heads on identifying and preventing abuse.The facility's final Immediacy Removal Plan was validated through:1. Verified skin assessments on 100% of all residents residing on the memory care unit.2. Verified immediate education of 100% of all staff regarding the facility's abuse policy.3. Verified that 100% of all Resident Companions were re-educated by department heads on methods to de-escalate situations and early identification of triggers that can cause an increase in behaviors.Following the removal of Immediate Jeopardy on 6/25/26 at 5:00 PM, the scope and severity was lowered to a level three, isolated harm.No additional information was provided to the conclusion of the survey.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record reviews and staff interview the facility failed to report the results of a facility reported incident investigation within 5 working days of the incident.The findings included: The facility staff failed to report the results of a facility reported incident investigation within 5 working days regarding Resident #1 abusing Resident #2 by pushing him out of a chair and onto the floor as well as attempting to hit Resident #2 with a chair while Resident #3 stood in close proximity to the incident. On 7/1/26 at 4:55 PM an interview was conducted with the Administrator. The Administrator stated that she had 5 (five) minutes to send the final investigation to the State Agency or she would be in violation of not reporting in the required amount of time. The Administrator also stated that the State Agency was informed of the initial Facility Reported Incident on 6/24/26. The Administrator further stated that she did not know that the reporting requirements under this regulation are based on real (clock) time, not business hours.A review of the Facility Reported Incident dated 6/24/26 read: Staff reported (resident name redacted) pushed (resident name redacted) out of chair causing resident to fall. Both residents were immediately separated. Investigation implemented.On 7/2/26 at 5:30 PM a final interview was conducted with the facility's Administrator, Director of Nursing, [NAME] President of Operations, Regional Director of Operations, Regional Nursing Consultant, Leadership Development Manager, and [NAME] President of Quality. An opportunity was offered to the facility's staff to present additional information. They had no further comments and voiced no concerns regarding the above information.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, staff interviews, clinical record review, and review of facility documents, the facility staff failed to provide adequate supervision to prevent accidents for 1 of 8 residents (Resident #2), in the survey sample.The findings included: The facility staff failed to provide supervision to prevent Resident #1 from pushing Resident #2 out of a chair and onto the floor as well as attempting to hit Resident #2 with a chair. 1. Resident #1 was originally admitted to the facility 2/21/26. The diagnoses included unspecified dementia with other behavioral disturbance, chronic obstructive pulmonary disease, muscle weakness, and major depressive disorder.The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 5/30/26 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 03 out of a possible 15. This indicated Resident #1's cognitive abilities for daily decision making were severely impaired.A review of nursing progress notes dated 6/24/26 at 3:40 PM read: Resident is on constant supervision. Resident was in a resident on resident altercation. at 3:40pm. Writer was counting out/giving report at the nurse's station. A noise was heard of a chair flipping over and a thud on the ground down hallway one. As we came around the nurse's station, a resident was on the floor sitting. Between the resident and writer was (resident name retracted). He proceeded to pick up the chair and directed it towards the resident that was sitting on the floor. A thud was heard after that happened. Staff immediately removed the chair from the resident's possession and the resident on the floor was brought to the nurses station for evaluation. MD has been notified. RP was called and a message left to call back for an update. UM, DON and Administrator were immediately notified and came to evaluate. Statements have been collected. Resident remains on 1:1 supervision.The comprehensive care plan dated 4/7/2026, documented in part,Focus: I have a behavior problem of becoming aggressive during care at times. Interventions: Educate caregivers on successful coping and interaction strategies such as allowing resident time to de-escalate and reapproach at later time. Explain all procedures to the resident before starting and allow the resident to adjust to changes. Dated 5/11/2026 - Resident placed on 1:1 supervision. The care plan further documented, Focus: I am/have the potential to demonstrate physician behaviors related to Dementia, hx (history) of resident-to-resident altercations, I pushed another resident. Interventions: 1:1 supervision (6/24/26). Assess and address for contributing sensory deficits. Close monitoring (5/14/26). 2. Resident #2 was originally admitted to the facility 1/29/26. The diagnoses included Alzheimer's Disease with early onset, unspecified dementia without behavioral disturbance, essential hypertension, and muscle wasting and atrophy.The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 6/12/26 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 03 out of a possible 15. This indicated Resident #2's cognitive abilities for daily decision making were severely impaired.A review of nursing progress notes dated 6/24/26 at 5:19 PM read: At 3:40pm, Writer was informed about a resident-to-resident altercation and noted resident sitting on the floor. Staff immediately check on the resident. Writer assess resident skin, ROM and Vital signs taken. No injuries noted. Resident was helped to the nurses' station for evaluation. UM, DON and Administrator were immediately notified and came to evaluate. Statements have been collected. Resident placed on 1:1 supervision. MD made aware and ordered to send resident out for further evaluation and CT scan. Wife is here at this time and is aware of incident. 911 was called.A review of Resident #2's Hospital Emergency Department documentation dated 6/24/26 read: You have a head injury. It doesn't appear serious at this time. But symptoms of a more serious problem, such as a mild brain injury (concussion) or bruising or bleeding in the brain, may appear later. For this reason, you or someone caring for you will need to watch for the symptoms listed below. Once you're home, also be sure to follow any care directions you're given.On 7/1/26 at 2:35 PM an interview was conducted with Licensed Practical Nurse (LPN) #1. LPN #1 stated while giving a recount of the event that (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	occurred on 6/24/26 between Resident #1 and Resident #2 that he was in the process of counting medications and heard a thud. LPN #2 also stated that he observed Resident #2 laying on the ground and Resident #1 picking up a chair and directing the head of the chair towards Resident #2. LPN #1 further stated that an Activities Aide 1:1 was assigned to Resident #1 and observed this incident as well. LPN #1 lastly stated that the Activities Aide 1:1 was just watching and should have intervened quicker than she did. On 7/1/26 at 2:53 PM an interview was conducted with the Director of Nursing (DON). The DON stated that Resident #1 was on constant observation for a prior incident that took place regarding another resident. The DON also stated that Resident #1 has a history of displaying aggressiveness. The DON further stated that regarding the incident that took place between Resident #1 and Resident #2, the staff member should have intervened quickly, much quicker than she did.On 7/1/26 at 3:45 PM an interview was conducted with the Leadership Development Manager. The Leadership Development Manager presented a video of the incident that took place between Resident #1 and Resident #2. The video showed Resident #1 standing in front of Resident #2 and pushing him over onto the floor while he was sitting in a chair in the hallway. OSM #6 was sitting in a chair nearby and observed the entire incident. OSM #6 did not intervene until after Resident #2 was pushed by Resident #1 and fell to the floor. The video further revealed that Resident #1 picked up the chair with Resident #3 in close proximity and attempted to strike Resident #2 with the chair, however OSM #6 intervened and put her hand on the chair to stop Resident #1 from hitting Resident #2 with the chair.On 7/1/26 at 4:10 PM an interview was conducted with LPN #2. LPN #2 stated that the incident should not have occurred due to Resident #2 being on constant observation. LPN #2 also stated that the Activities Aide 1:1 was observing the confrontation and should have intervened to prevent Resident #2 from being pushed out of the chair and onto the floor by Resident #1.On 7/1/26 at 4:35 PM an interview was conducted with Activities Aide 1:1. The Activities Aide 1:1 stated, I did not feel like it was typical protocol to intervene. I did not feel like he would take it the physical part. That was my first day taking care of him. I did not think he would physically get him out of the chair. We are told who we are taking care of when we get to work. We are just told they have to be watched. I did not know what the constant observation was for regarding the resident. The facility's Memory Care Unit Policy with an effective date of 5/13/26 read: Phase 2 - Constant Observation/Monitoring Requirements: Staff shall remain within close proximity to intervene immediately if necessary. The facility provided a copy of their Ad Hoc meeting minutes dated 6/24/2026. The meeting minutes documented:Identified Issue: the facility experienced a resident-to-resident altercation that did not result in injury.Goal: Resident will not sustain serious injurySummary Report: Resident to Resident events reviewed in addition to the plan of correction from survey ending 4/9/26. The plan in place at the time of the event was sufficient to address the escalation of behavior and as a result kept all residents free from harm. The facility has successfully implemented a system for observing resident identified as potential victims or resident with potential for behaviors affecting others. The levels of supervision are determined by a number of factors including but not limited to historical events, assessment by social services, psychiatry consultation recommendations, review of monitoring documentation and input from medical director, staff and families. The success of the system is measured and validated by substantial decrease in incidents, also noting that this was an isolated event and the only time since the date of compliance.Upon debriefing with the team members present at the time, additional educational opportunities were identified. Resident companions received additional training on methods to de-escalate situations and early identification of triggers that can cause an increase in resident behaviors resulting in altercations. The committee will continue to monitor and address educational needs as they are identified. A training session with (name of local police officer) is schedule for August 6, 2026 from 2:00 p.m. to 3:30 p.m. to teach additional methods of protecting resident and staff from potentially aggressive behaviors.Cards provided to Recreational Sitters.Definitions of Levels of Monitoring:1:1 Monitoring: I can see you and touch you. Constant Supervision: I can always see you.Q (every) 15-minute checks: I put my eyes on you every 15 minutes (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to make sure you are safe.Documentation for all the above: I sign my initial every 15 minutes to document your activity and SAFETY.The survey team entered the facility on 7/1/2026 at 10:30 a.m. Observations were made of the memory care unit. The staff currently assigned to the five residents with enhanced monitoring (15 minute checks, 1:1 and constant observation) were interviewed regarding their understanding of their responsibility. The staff was interviewed at that time and verified immediate educations of 100% of all staff regarding the facility's abuse policy.Plan of Correction:Upon escalation of behavior of resident # 1 resulting in resident # 2 being pushed to the floor, staff immediately intervened and removed resident # 1 from the area and placed him on 1:1 supervision. Resident # 2 was assessed by licensed staff and verified as having no injuries. Relocation plans were immediately initiated for Resident # 1 and the resident discharged from the facility on June 25, 2026.All residents have the potential to be affected. Full body skin assessments were completed by licensed nurses for all residents residing on the unit with no additional findings. The resident present at the time of the incident was immediately removed from the area.Resident companions were re-educated by department heads on methods to de-escalate situations and early identification of triggers that can cause an increase in behaviors. All staff were re-educated by department heads on identifying and preventing abuse.Verified skin assessments on 100% of all residents residing on the memory care unit.5. Verified immediate education of 100% of all staff regarding the facility's abuse policy.6. Verified that 100% of all Resident Companions were re-educated by department heads on methods to de-escalate situations and early identification of triggers that can cause an increase in behaviors.Compliance was obtained on 6/25/26 at 5:00 PMNo additional information was provided to the conclusion of the survey.