DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 09/11/18 through 09/13/18. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
E 006 SS=C	Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed and updated at least annually. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* *[For LTC facilities at §483.73(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. *[For ICF/IIDs at §483.475(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a)(2):] (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care.	E 006	E 006 Plan Based on All Hazards Risk Assessment 1. Brookside Rehab's geographic all-hazard facility risk assessment was reviewed and updated by facility QA committee and community emergency personnel on or before 10/28/18 and included, but not limited to, local empirical data for the community-based assessment, current and comprehensive policies and procedures and updated facility-specific all-hazards risk assessment. Missing Residents Policy and Procedure reviewed and updated by facility QA committee on or before 10/28/18 and submitted into the Emergency Preparedness Manual. 2. Facility determined that all residents are potentially affected by deficient practice. 3. Staff educated on or before 10/28/18 by Administrator or designee regarding updated all-hazard risk assessments and facility Policy and Procedure outlining Missing Resident protocol.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Dawn Dyer LNHA	Administrator	10/10/18

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.

RECEIVED
OCT 11 2018
VDH/OLC

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 006	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to develop a complete facility risk assessment based on an all-hazards approach specific to the geographic location of the facility and that encompasses potential hazards. The findings include: On 09/13/18 at 3:15 p.m. a review of the facility's emergency preparedness plan and interview was conducted with ASM (administration staff member) # 1, administrator. Review of the facility's emergency preparedness plan failed to evidence documentation that the facility's risk assessment was based on an all-hazards approach specific to the geographic location of the facility and that encompassed potential hazards. ASM # 1 stated, "We don't have the documentation." On 09/13/18 at approximately 5:55 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings. No further information was provided prior to exit.	E 006	E 006 Plan Based on All Hazards Risk Assessment continued from page 1 4. After completion of initial staff education on the all hazards approach and Missing Residents, the Administrator or designee will monitor the effectiveness of the Emergency Preparedness Manual plan through staff interview and provide outcomes to the QA committee monthly. Additional education will be provided monthly and as necessary and plan to be updated as indicated. Emergency Preparedness plan will be reviewed and updated at least annually. Auditing for compliance will occur weekly x 3 months, October, November and December; and compliance reported monthly at the QA meetings. Random audits will be conducted for 3 additional months to March 2019. 5. The facility dutifully alleges compliance of these tasks on or before 10/28/18.	
E 007 SS=C	EP Program Patient Population CFR(s): 483.73(a)(3) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan	E 007		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 007	Continued From page 2 that must be reviewed, and updated at least annually. The plan must do the following:] (3) Address patient/client population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.** *Note: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC, FQHC, or ESRD facilities.] This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to evidence that the facility's emergency plan included documentation of the services the facility would be able to provide during an emergency and documentation of how the facility would plan to continue operations during an emergency. The findings include: On 09/13/18 at 3:15 p.m. a review of the facility's emergency preparedness plan and interview was conducted with ASM (administration staff member) # 1, administrator. Review of the facility's emergency preparedness plan failed to evidence that the facility's emergency plan included documentation of the services the facility would be able to provide during an emergency and documentation of how the facility would plan to continue operations during an emergency.	E 007	E 007 EP Program Patient Population 1. Brookside Rehab's Emergency Preparedness plan reviewed and updated by facility QA committee and community emergency personnel on or before 10/28/18 and included, but not limited to persons-at-risk, the types of services Brookside can provide during emergencies; and continuity of operations, including delegations of authority and succession plans. Additional inclusions reviewed and updated by the QA committee on or before 10/28/18: Current and comprehensive policies and procedures and the documented, updated means by which to provide continued operations during an emergency. 2. Facility determined that all residents are potentially affected by deficient practice. 3. Staff educated on or before 10/28/18 by Administrator or designee regarding facility's resident population including persons at risk, staff succession planning, and the facility's ability to provide care and services in an emergency.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 007	Continued From page 3 ASM # 1 stated, "We don't have the documentation." On 09/13/18 at approximately 5:55 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings. No further information was provided prior to exit.	E 007	E 007 EP Program Patient Population continued from page 3 4. Upon completion of initial staff education, the Administrator or designee will monitor the effectiveness of the Emergency Preparedness Manual plan through staff interview and provide outcomes to the QA committee monthly. Additional education will be provided monthly and as necessary and plan to be updated as indicated. Emergency Preparedness plan will be reviewed and updated at least annually. Auditing for compliance will occur weekly x 3 months, October, November and December; and compliance reported monthly at the QA meetings. Random audits will be conducted for 3 additional months to March 2019. 5. The facility dutifully alleges compliance of these tasks on or before 10/28/18.	
E 013 SS=C	Development of EP Policies and Procedures CFR(s): 483.73(b) (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures	E 013		

			E 013 Development of EP Policies and Procedures 1. Brookside Rehab's Emergency Preparedness plan reviewed and updated on or before 10/28/18 by facility QA committee and community emergency personnel and to include, but not limited to documented, updated current and comprehensive site-specific policies and procedures for all areas of the facility all-hazards risk assessment and communications plan. 2. Facility determined that all residents are potentially affected by deficient practice. 3. Staff educated on or before 10/28/18 by Administrator or designee regarding facility's updated Emergency Preparedness policies per the facility all-hazards risk assessment and Emergency Preparedness communications plan.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 013	Continued From page 4 must be reviewed and updated at least annually. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to evidence documentation that the facility's policy and procedures were developed based on the facility-and-community based risk assessment and communication plan, utilizing an all-hazards approach and failed to evidence the policies and procedures were reviewed and updated on an annual basis. The findings include: On 09/13/18 at 3:15 p.m. a review of the facility's emergency preparedness plan and interview was conducted with ASM (administration staff member) # 1, administrator. Review of the facility's emergency preparedness plan failed staff failed to evidence documentation that the facility's	E 013	E 013 Development of EP Policies and Procedures continued from page 5 4. Upon completion of initial staff education, the Administrator or designee will monitor the effectiveness of the Emergency Preparedness Manual plan through staff interview and provide outcomes to the QA committee monthly. Additional education will be provided monthly and as necessary and plan to be updated as indicated. Emergency Preparedness plan will be reviewed and updated at least annually. Auditing for compliance will occur weekly x 3 months, October, November and December; and compliance reported monthly at the QA meetings. Random audits will be conducted for 3 additional months to March 2019. 5. The facility dutifully alleges compliance of these tasks on or before 10/28/18.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 013	Continued From page 5 policy and procedures were developed based on the facility-and-community based risk assessment and communication plan, utilizing an all-hazards approach and failed to evidence the policies and procedures were reviewed and updated on an annual basis. ASM # 1 stated, "We don't have the documentation." On 09/13/18 at approximately 5:55 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings. No further information was provided prior to exit.	E 013		
E 015 SS=C	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.	E 015	E 015 Subsistence Needs for Staff and Patients 1. Brookside Rehab's Emergency Preparedness plan reviewed and updated on or before 10/28/18 by facility QA committee and community emergency personnel. Emergency Preparedness plan to include, but not limited to documented, updated current and comprehensive site-specific policies and procedures to include the provision of subsistence needs for staff and residents/patients when sheltering in place; including, but not limited to water storage; food, water, medical and pharmaceutical supplies, alternate sources of energy to maintain the following: Temperatures to protect patient health and safety, the safe and sanitary storage of provisions; emergency lighting, fire detection, extinguishing, and alarm systems, sewage and waste disposal.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 015	Continued From page 6 (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to provide documentation that the emergency plan included policies and procedures for sewage and waste disposal. The findings include:	E 015	E 015 Subsistence Needs for Staff and Patients continued from page 7 2. Facility determined that all residents are potentially affected by deficient practice. 3. Staff educated on or before 10/28/18 by Administrator or designee regarding facility's updated Emergency Preparedness policies and procedures on the provision of subsistence needs which also includes, but not limited to alternate energy sources and sewage/waste disposal. 4. Upon completion of initial staff education, the Administrator of designee will monitor the effectiveness of the Emergency Preparedness Manual plan through staff interview and provide outcomes to the QA committee monthly. Additional education will be provided monthly and as necessary and plan to be updated as indicated. Emergency Preparedness plan will be reviewed and updated at least annually. Auditing for compliance will occur weekly x 3 months, October, November and December; and compliance reported monthly at the QA meetings. Random audits will be conducted for 3 additional months to March 2019.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 015	Continued From page 7 On 09/13/18 at 3:15 p.m. a review of the facility's emergency preparedness plan and interview was conducted with ASM (administration staff member) # 1, administrator. Review of the facility's emergency preparedness plan failed staff failed to evidence documentation that the emergency plan included policies and procedures for sewage and waste disposal. ASM # 1 stated, "We don't have the documentation." On 09/13/18 at approximately 5:55 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings. No further information was provided prior to exit.	E 015	E 015 Subsistence Needs for Staff and Patients continued from page 8 5. The facility dutifully alleges compliance of these tasks on or before 10/28/18.	
E 022 SS=C	Policies/Procedures for Sheltering in Place CFR(s): 483.73(b)(4) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (4) A means to shelter in place for patients, staff, and volunteers who remain in the [facility]. [(4) or (2),(3),(5),(6)] A means to shelter in place for patients, staff, and volunteers who remain in the [facility]. *[For Inpatient Hospices at §418.113(b):] Policies and procedures.	E 022	E 022 Policies/Procedures for Sheltering in Place 1. Brookside Rehab's Emergency Preparedness plan reviewed and updated on or before 10/28/18 by facility QA committee and community emergency personnel and includes, but not limited to documented, updated current and comprehensive policies and procedures regarding the means to shelter in place the facility staff, volunteers and residents/patients who remain in the facility. 2. Facility determined that all residents are potentially affected by deficient practice.	

			E 022 Policies and Procedures for Sheltering in Place continued from page 9 3. Staff educated on or before 10/28/18 by Administrator or designee regarding facility's updated Emergency Preparedness policies and procedures; how those policy and procedures are aligned with the facility's Emergency Preparedness plan and management. 4. Upon completion of initial staff education, the Administrator or designee will monitor the effectiveness of the Emergency Preparedness Manual plan through staff interview and provide outcomes to the QA committee monthly. Additional education will be provided monthly and as necessary and plan to be updated as indicated. Emergency Preparedness plan will be reviewed and updated at least annually. Auditing for compliance will occur weekly x 3 months, October, November and December; and compliance reported monthly at the QA meetings. Random audits will be conducted for 3 additional months to March 2019.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 022	Continued From page 8 (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (i) A means to shelter in place for patients, hospice employees who remain in the hospice. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to develop policies and procedures of how the facility will provide a means to shelter in place for patients, staff and volunteers who remain in the facility and how those policies and procedures are aligned with the facility's emergency plan and risk management. The findings include: On 09/13/18 at 3:15 p.m. a review of the facility's emergency preparedness plan and interview was conducted with ASM (administration staff member) # 1, administrator. Review of the facility's emergency preparedness plan failed staff failed to evidence documentation of policies and procedures of how the facility will provide a means to shelter in place for patients, staff and volunteers who remain in the facility and how those policies and procedures are aligned with the facility's emergency plan and risk management. ASM # 1 stated, "We don't have the documentation." On 09/13/18 at approximately 5:55 p.m., ASM (administrative staff member) # 1, the	E 022	E 022 Policies/Procedures for Sheltering in Place continued from page 10 5. The facility dutifully alleges compliance of these tasks on or before 10/28/18.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 022	Continued From page 9 administrator and ASM # 2, director of nursing were made aware of the findings. No further information was provided prior to exit.	E 022	E 023 Policies/Procedures for Medical Documentation 1. Brookside Rehab's Emergency Preparedness plan reviewed and updated on or before 10/28/18 by facility QA committee and community emergency personnel and includes, but not limited to documented, updated current and comprehensive policies and procedures regarding a system of medical documentation, protects patient information confidentiality; secures and maintains the availability of records. 2. Facility determined that all residents are potentially affected by deficient practice. 3. Staff educated on or before 10/28/18 by Administrator or designee regarding facility's updated Emergency Preparedness plan policies and procedures on preserving patient information, protecting patient health information confidentially, how the facility secures and maintains the availability of patient/protected records.	
E 023 SS=C	Policies/Procedures for Medical Documentation CFR(s): 483.73(b)(5) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (5) A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. [(5) or (3),(4),(6)] A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. *[For RNHCIs at §403.748(b):] Policies and procedures. (5) A system of care documentation that does the following: (i) Preserves patient information. (ii) Protects confidentiality of patient information. (iii) Secures and maintains the availability of records. *[For OPOs at §486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual	E 023		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 023	Continued From page 10 donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to develop policies and procedures of how the facility plans to preserve patient information, protect confidentiality of patient information, how it secures and maintains the availability of records. The findings include: On 09/13/18 at 3:15 p.m. a review of the facility's emergency preparedness plan and interview was conducted with ASM (administration staff member) # 1, administrator. Review of the facility's emergency preparedness plan failed staff failed to evidence documentation of policies and procedures of how the facility plans to preserves patient information protect the confidentiality of patient information, how it secures and maintains the availability of records. ASM # 1 stated, " We don't ave the documentation." On 09/13/18 at approximately 5:55 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings. No further information was provided prior to exit.	E 023	E 023 Policies/Procedures for Medical Documentation continued from page 12 4. Upon completion of initial staff education, the Administrator or designee will monitor the effectiveness of the Emergency Preparedness Manual plan through staff interview and provide outcomes to the QA committee monthly. Additional education will be provided monthly and as necessary and plan to be updated as indicated. Emergency Preparedness plan will be reviewed and updated at least annually. Auditing for compliance will occur weekly x 3 months, October, November and December; and compliance reported monthly at the QA meetings. Random audits will be conducted for 3 additional months to March 2019. 5. The facility dutifully alleges compliance of these tasks on or before 10/28/18.	
E 024	Policies/Procedures-Volunteers and Staffing	E 024		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 024 SS=C	Continued From page 11 CFR(s): 483.73(b)(6) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to develop policies and procedures for the use of volunteers and other staffing strategies are in the emergency plan . The findings include: On 09/13/18 at 3:15 p.m. a review of the facility's	E 024	E 024 Policies/Procedures-Volunteers and Staffing 1. Brookside Rehab's Emergency Preparedness plan reviewed and updated on or before 10/28/18 by facility QA committee and community emergency personnel and includes, but not limited to documented, updated and site-specific current and comprehensive policies and procedures regarding the facility's response to surge capacity needs, the use of volunteers, role integration of designated Federal and State healthcare professionals; and other emergency staffing strategies addressing surge needs. 2. Facility determined that all residents are potentially affected by deficient practice. 3. Staff educated on or before 10/28/18 by Administrator or designee regarding facility's updated Emergency Preparedness plan policies and procedures relevant to facility response to surge capacity needs and requirements of the facility.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 024	Continued From page 12 emergency preparedness plan and interview was conducted with ASM (administration staff member) # 1, administrator. Review of the facility's emergency preparedness plan failed to evidence documentation of policies and procedures for the use of volunteers and other staffing strategies are in the emergency plan . ASM # 1 stated, "We don't have the documentation." On 09/13/18 at approximately 5:55 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings. No further information was provided prior to exit.	E 024	E 024 Policies/Procedures-Volunteers and Staffing continued from page 14 4. Upon completion of initial staff education, the Administrator or designee will monitor the effectiveness of the Emergency Preparedness Manual plan through staff interview and provide outcomes to the QA committee monthly. Additional education will be provided monthly and as necessary and plan to be updated as indicated. Emergency Preparedness plan will be reviewed and updated at least annually. Auditing for compliance will occur weekly x 3 months, October, November and December; and compliance reported monthly at the QA meetings. Random audits will be conducted for 3 additional months to March 2019. 5. The facility dutifully alleges compliance of these tasks on or before 10/28/18.	
E 026 SS=C	Roles Under a Waiver Declared by Secretary CFR(s): 483.73(b)(8) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. *[For RNHCIs at §403.748(b):] Policies and	E 026		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 026	Continued From page 13 procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to develop policies and procedures in the emergency plan that describe the facility's role in providing care and treatment at altered care sites under an 1135 waiver. The findings include: On 09/13/18 at 3:15 p.m. a review of the facility's emergency preparedness plan and interview was conducted with ASM (administration staff member) # 1, administrator. Review of the facility's emergency preparedness plan failed to evidence documentation of policies and procedures in the emergency plan that describe the facility's role in providing care and treatment at altered care sites under an 1135 waiver. ASM # 1 stated, "We don't have the documentation." On 09/13/18 at approximately 5:55 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings. No further information was provided prior to exit..	E 026	E 026 Roles Under a Waiver Declared by Secretary 1. Brookside Rehab's Emergency Preparedness plan reviewed and updated on or before 10/28/18 by facility QA committee and community emergency personnel and includes, but not limited to documented, updated and site-specific current and comprehensive policies and procedures regarding the facility's role and responsibilities-provision of care and treatment at an alternate care site-established by the 1135 section of the declared waiver by the Secretary. 2. Facility determined that all residents are potentially affected by deficient practice. 3. Staff educated on or before 10/28/18 by Administrator or designee regarding facility's updated Emergency Preparedness plan policies and procedures concerning the facility role and responsibilities under 1135 waiver.	
E 029 SS=C	Development of Communication Plan CFR(s): 483.73(c)	E 029		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 029	Continued From page 14 (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to develop a communication plan. The findings include: On 09/13/18 at 3:15 p.m. a review of the facility's emergency preparedness plan and interview was conducted with ASM (administration staff member) # 1, administrator. Review of the facility's emergency preparedness plan failed to evidence documentation of a communication plan. ASM # 1 stated, "We don't have the documentation." On 09/13/18 at approximately 5:55 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings. No further information was provided prior to exit.	E 029	E 026 Roles Under a Waiver Declared by Secretary continued from page 16 4. Upon completion of initial staff education, the Administrator or designee will monitor the effectiveness of the Emergency Preparedness Manual plan through staff interview and provide outcomes to the QA committee monthly. Additional education will be provided monthly and as necessary and plan to be updated as indicated. Emergency Preparedness plan will be reviewed and updated at least annually. Auditing for compliance will occur weekly x 3 months, October, November and December; and compliance reported monthly at the QA meetings. Random audits will be conducted for 3 additional months to March 2019. 5. The facility dutifully alleges compliance of these tasks on or before 10/28/18.	
E 033 SS=C	Methods for Sharing Information CFR(s): 483.73(c)(4)-(6) [(c) The [facility] must develop and maintain an emergency preparedness communication plan	E 033		

			E 029 Development of Communication Plan 1. Brookside Rehab's Emergency Preparedness plan reviewed and updated on or before 10/28/18 by facility QA committee and community emergency personnel and includes, but not limited to documented, updated and site-specific current and comprehensive policies and procedures to encompass an emergency preparedness communications plan. 2. Facility determined that all residents are potentially affected by deficient practice. 3. Staff educated on or before 10/28/18 by Administrator or designee regarding facility's updated Emergency Preparedness plan policies and procedures concerning the facility communications and disclosure plan during an emergency. 4. Upon completion of initial staff education, the Administrator or designee will monitor the effectiveness of the Emergency Preparedness Manual plan through staff interview and provide outcomes to the QA committee monthly. Additional education will be provided monthly and as necessary and plan to be updated as indicated. Emergency Preparedness plan will be reviewed and updated at least annually.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 033	Continued From page 15 that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (4) A method for sharing information and medical documentation for patients under the [facility's] care, as necessary, with other health providers to maintain the continuity of care. (5) A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii). [This provision is not required for HHAs under §484.22(c), CORFs under §485.68(c), and RHCs/FQHCs under §491.12(c).] (6) [(4) or (5)]A means of providing information about the general condition and location of patients under the [facility's] care as permitted under 45 CFR 164.510(b)(4). *[For RNHCIs at §403.748(c):] (4) A method for sharing information and care documentation for patients under the RNHCI's care, as necessary, with care providers to maintain the continuity of care, based on the written election statement made by the patient or his or her legal representative. *[For RHCs/FQHCs at §491.12(c):] (4) A means of providing information about the general condition and location of patients under the facility's care as permitted under 45 CFR 164.510(b)(4). This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff	E 033	E 029 Development of Communication Plan continued from page 18 Auditing for compliance will occur weekly x 3 months, October, November and December; and compliance reported monthly at the QA meetings. Random audits will be conducted for 3 additional months to March 2019. 5. The facility dutifully alleges compliance of these tasks on or before 10/28/18. E 033 Methods for Sharing Information 1. Brookside Rehab's Emergency Preparedness plan reviewed and updated on or before 10/28/18 by facility QA committee and community emergency personnel and includes, but not limited to documented, updated and site-specific current and comprehensive policies and procedures regarding methods of sharing information and medical documentation with other health care providers. Including, in	

			E 033 Methods for Sharing Information continued from page 19 the event of an evacuation the release of patient information as well as general condition, transfer location of patients under the facility's care to maintain continuity of care. 2. Facility determined that all residents are potentially affected by deficient practice. 3. Staff educated on or before 10/28/18 by Administrator or designee regarding facility's updated Emergency Preparedness plan policies and procedures concerning the facility's sharing of patient information along with patient condition, location and the methods of sharing information with other health care providers as indicated. 4. Upon completion of initial staff education, the Administrator or designee will monitor the effectiveness of the Emergency Preparedness Manual plan through staff interview and provide outcomes to the QA committee monthly. Additional education will be provided monthly and as necessary and plan to be updated as indicated. Emergency Preparedness plan will be reviewed and updated at least annually.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 033	Continued From page 16 failed to have a complete emergency preparedness plan. The facility staff failed to provide documented evidence that the communication plan includes a method for sharing information and medical documentation for patients under the facility's care, as necessary, with other health providers to maintain the continuity of care by reviewing the communication plan. The staff also failed to provide documentation that the facility has developed policies and procedures that address the means the facility will use to release patient information to include the general condition and location of patients by reviewing the communication plan. The findings include: On 09/13/18 at 3:15 p.m. a review of the facility's emergency preparedness plan and interview was conducted with ASM (administration staff member) # 1, administrator. Review of the facility's emergency preparedness plan failed to evidence documentation that the communication plan includes a method for sharing information and medical documentation for patients under the facility's care, as necessary, with other health providers to maintain the continuity of care by reviewing the communication plan. In addition, failed to evidence documentation that the facility has developed policies and procedures that address the means the facility will use to release patient information to include the general condition and location of patients by reviewing the communication plan. ASM # 1 stated, "We don't have the documentation." On 09/13/18 at approximately 5:55 p.m., ASM	E 033	Methods for Sharing Information continued from page 20 Auditing for compliance will occur weekly x 3 months, October, November and December; and compliance reported monthly at the QA meetings. Random audits will be conducted for 3 additional months to March 2019. 5. The facility dutifully alleges compliance of these tasks on or before 10/28/18.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 033	Continued From page 17 (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings. No further information was provided prior to exit.	E 033		
E 035 SS=C	LTC and ICF/IID Sharing Plan with Patients CFR(s): 483.73(c)(8) [(c) The [LTC facility and ICF/IID] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to provide evidence of documentation that the communication plan includes a method for sharing information from the emergency plan, and that the facility has determined it is appropriate with residents or clients and their families or representatives by reviewing the plan. The findings include: On 09/13/18 at 3:15 p.m. a review of the facility's emergency preparedness plan and interview was	E 035	E 035 LTC and ICF/IID Sharing Plan with Patients CFR(s) 1. Brookside Rehab's Emergency Preparedness plan will be posted and available for all visitors, residents/clients and their families or representatives on or before 10/28/18. Additionally, the Emergency Preparedness plan will be discussed upon admission with all new residents and their advocates. Emergency Preparedness will be discussed, ongoing with residents during the Resident Council and education provided as needed. 2. Facility determined that all residents are potentially affected by deficient practice. 3. Staff educated on or before 10/28/18 by Administrator or designee regarding communication of the facility's updated Emergency Preparedness plan to clients, visitors, advocates, residents and representatives.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 035	Continued From page 18 conducted with ASM (administration staff member) # 1, administrator. Review of the facility's emergency preparedness plan failed to evidence documentation that the communication plan includes a method for sharing information from the emergency plan, and that the facility has determined it is appropriate with residents or clients and their families or representatives by reviewing the plan. ASM # 1 stated, "We don't have the documentation." On 09/13/18 at approximately 5:55 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings. No further information was provided prior to exit.	E 035	E 035 LTC and ICF/IID Sharing Plan with Patients CFR(s) continued from page 22 4. Upon completion of initial staff education, the Administrator or designee will monitor the effectiveness of the Emergency Preparedness Manual plan through staff interview and provide outcomes to the QA committee monthly. Additional education to residents, staff, or other relevant individuals will be provided monthly and as necessary and plan to be updated as indicated. Emergency Preparedness plan will be reviewed and updated at least annually. Auditing for compliance will occur weekly x 3 months, October, November and December; and compliance reported monthly at the QA meetings. Random audits will be conducted for 3 additional months to March 2019. 5. The facility dutifully alleges compliance of these tasks on or before 10/28/18.	
E 036 SS=C	EP Training and Testing CFR(s): 483.73(d) (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this	E 036		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 036	Continued From page 19 section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(h). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be reviewed and updated at least annually. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to provide evidence of documentation that the facility has a written training and testing program that meets the requirements of the regulation and documentation that the training and testing program has been reviewed and updated on, at least an annual basis. The findings include: On 09/13/18 at 3:15 p.m. a review of the facility's emergency preparedness plan and interview was conducted with ASM (administration staff	E 036	E 036 EP Training and Testing 1. Brookside Rehab's Emergency Preparedness plan reviewed and updated on or before 10/28/18 by facility QA committee and community emergency personnel and includes, but not limited to written/documented, updated and site-specific current and comprehensive policies and procedures, plus regulatory standards regarding training and testing of employees for the Emergency Preparedness plan upon orientation and annually and will include documentation and staff competency and completion. See also E 037. 2. Facility determined that all residents are potentially affected by deficient practice. 3. Staff educated on or before 10/28/18 by Administrator or designee to validate understanding of facility's updated Emergency Preparedness plan. Additional education to be provided as indicated. Staff Development Coordinator/ADON and Human Resources educated on or before 10/28/18 by Administrator to validate training and testing program is available and offered	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 036	Continued From page 20 member) # 1, administrator. Review of the facility's emergency preparedness plan failed to evidence that the facility has a written training and testing program that meets the requirements of the regulation and documentation that the training and testing program has been reviewed and updated on, at least an annual basis. ASM # 1 stated, "We don't have the documentation." On 09/13/18 at approximately 5:55 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings. No further information was provided prior to exit.	E 036	E 036 Training and Testing continued from page 24 upon orientation and annually to employees. Training calendar to include updates. 4. Upon completion of initial staff education, the Administrator or designee will monitor the effectiveness of the Emergency Preparedness Manual plan through staff interview and provide outcomes to the QA committee monthly. Additional education will be provided monthly and as necessary and plan to be updated as indicated. Emergency Preparedness plan will be reviewed and updated at least annually. Auditing for compliance will occur weekly x 3 months, October, November and December; and compliance reported monthly at the QA meetings. Random audits will be conducted for 3 additional months to March 2019. 5. The facility dutifully alleges compliance of these tasks on or before 10/28/18.	
E 037 SS=C	EP Training Program CFR(s): 483.73(d)(1) (1) Training program. The [facility, except CAHs, ASCs, PACE organizations, PRTFs, Hospices, and dialysis facilities] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospitals at §482.15(d) and RHCs/FQHCs at §491.12:] (1) Training program. The [Hospital or RHC/FQHC] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under	E 037		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 037	Continued From page 21 arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least annually. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency	E 037	E 037 EP Training Program 1. Brookside Rehab's Emergency Preparedness plan reviewed and updated on or before 10/28/18 by facility QA committee and community emergency personnel and includes, but not limited to documented, updated and site-specific current and comprehensive policies regarding training and testing of employees, individuals providing services under arrangement and volunteers consistent with their expected role for the facility's Emergency Preparedness plan. Furthermore, employee orientation to the Emergency Preparedness plan will occur upon orientation and annually; and will include documentation and staff competency completion. 2. Facility determined that all residents are potentially affected by deficient practice.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 037	Continued From page 22 preparedness training. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following:	E 037	E 037 EP Training Program continued from page 26 3. Staff, individuals providing services under arrangement, volunteers educated on or before 10/28/18 by Administrator or designee to ensure understanding of the facility's updated Emergency Preparedness plan policies and procedures. Additional education to be provided as indicated. Staff Development Coordinator/ADON and Human Resources educated on or before 10/28/18 by Administrator to ensure training and testing program is available and offered upon orientation and annually to employees. In-Service calendar to include updates. 4. Upon completion of initial staff education, the Administrator or designee will monitor the effectiveness of the Emergency Preparedness Manual plan through staff interview and provide outcomes to the QA committee monthly. Additional education will be provided monthly and as necessary and plan to be updated as indicated. Emergency Preparedness plan will be reviewed and updated at least annually.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 037	Continued From page 23 (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least annually. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to provide evidence of documentation of the facility's initial emergency preparedness training and annual emergency preparedness training offerings and	E 037	E 037 EP Training Program continued from page 27 Auditing for compliance will occur weekly x 3 months, October, November and December; and compliance reported monthly at the QA meetings. Random audits will be conducted for 3 additional months to March 2019. 5. The facility dutifully alleges compliance of these tasks on or before 10/28/18.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 037	Continued From page 24 documentation that facility staff have received initial & annual emergency preparedness training. The findings include: On 09/13/18 at 3:15 p.m. a review and interview of the facility's emergency preparedness plan was conducted with ASM (administration staff member) # 1, administrator. Review of the facility's emergency preparedness plan failed to evidence documentation of the facility's initial emergency preparedness training and annual emergency preparedness training offerings and documentation that facility staff have received initial & annual emergency preparedness training. ASM # 1 stated, "We don't have the documentation." On 09/13/18 at approximately 5:55 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings. No further information was provided prior to	E 037		
E 039 SS=C	EP Testing Requirements CFR(s): 483.73(d)(2) (2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following: *[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the	E 039	E 039 EP Testing Requirements 1. Brookside Rehab's Emergency Preparedness plan reviewed and updated on or before 10/28/18 by facility QA committee and community emergency personnel to include participation in a full-scale exercise, including but not limited to unannounced staff drills using the emergency procedures and an additional full-scale or table-top exercise for two (2) exercises annually. Additionally, the facility will analyze the facility's response to and maintain documentation of all drills, table-top exercises, emergency events, and revise the facility's Emergency Preparedness	

			E 039 EP Testing Requirements continued from page 29 plan as necessary. If full-scale community-based exercise not accessible, an individual facility-based emergency exercise will be conducted and documented. 2. Facility determined that all residents are potentially affected by deficient practice. 3. Facility to participate with assistance from Fauquier County/Local Health Emergency Coordinator in community exercise on or before 10/31/18, Followed by table-top exercise on, or before 12/31/18. 4. Administrator will monitor the effectiveness of the Emergency Preparedness plan through evaluation of full-scale drill and table-top exercises. Outcomes will be provided to QA Committee. Additional education will be provided as necessary. Results of the audit(s) will be reviewed in QA to validate systems followed. Emergency Preparedness plan to be updated as indicated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 039	Continued From page 25 following:] (i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based. (B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an	E 039	E 039 EP Testing Requirements continued from page 30 Auditing for compliance will occur weekly x 3 months, October, November and December; and compliance reported monthly at the QA meetings. 5. The facility dutifully alleges compliance of these tasks on or before 10/28/18.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 039	Continued From page 26 emergency plan. (ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to provide evidence of documentation of the facility's tabletop and full-scale exercise, efforts to identify a full-scale community based exercise, exercise analysis, response and how the facility updated its emergency program based on the exercise analysis. The findings include: On 09/13/18 at 3:15 p.m. a review of the facility's emergency preparedness plan and interview was conducted with ASM (administration staff member) # 1, administrator. Review of the facility's emergency preparedness plan failed to evidence documentation of the facility's tabletop and full-scale exercise, efforts to identify a full-scale community based exercise, exercise analysis, response and how the facility updated its emergency program based on the exercise analysis. ASM # 1 stated, "We don't have the documentation." On 09/13/18 at approximately 5:55 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 039	Continued From page 27 were made aware of the findings. No further information was provided prior to exit. exit.	E 039		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 09/11/18 through 09/13/18. Four complaints were investigated during the survey. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 130 certified bed facility was 122 at the time of the survey. The survey sample consisted of 34 current resident reviews (Residents #38, #100, #66, #27, #81, #5, #36, # 113, #39, #96, #76, #60, #71, #75, #2, #61, #50, #23, #101, #54, #49, # 77, #117, #112, #108, #4, # 64, #115, #53, #74, #8, #102, #273, #97) and three closed record reviews (Residents #40, #57 and #123).	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's	F 550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 28 individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and review of facility documentation it was determined the staff failed to promote dignity during dining in one of two facility dining rooms, (the north unit dining room). The facility staff failed promote resident dignity during dining in the north dining room. Residents were observed being given plastic silverware and disposable plastic cups during observation of	F 550	F 550 Resident Rights/Exercise of Rights 1. Styrofoam and plastic cups were removed from the dining room and no further Styrofoam plates or plastic cups and silverware were given to residents since September 13th, 2018. 2. The utensils for all residents at the facility will be monitored for the serving of meals with the appropriate utensils. 3. Dietary Staffing levels will be monitored, and increased recruiting efforts will be initiated. A facility policy and procedure governing the use of Styrofoam and plastic utensils has been developed and education will be provided to dietary staff by October 28th, 2018. 4. Auditing of meal times for compliance using an auditing tool that addresses the use of Styrofoam and plastic utensils. Auditing for compliance will occur daily x3months, October, November and December and compliance reported monthly at the QA meetings. Random audits will be conducted for 3 additional months to March 2019 by the Dietary Manager.	

			F 550 Resident Rights/Exercise of Rights continued from page 34. 5. The facility dutifully alleges compliance of these tasks on or before 10/28/18.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 29 three meals on 9/12 and 9/13/18, in the north dining room. The findings include: A dining observation was conducted on 9/11/18 at 12:40 p.m. of the north dining room. Residents were observed being given plastic silverware and disposable plastic cups. An interview was conducted on 9/11/18 at 12:46 p.m. with LPN (licensed practical nurse) #2, the unit manager. When asked why residents were given plastic silverware and disposable plastic cups, LPN #2 stated, "They (dietary) don't have any (silverware or regular cups). It's out of my control." When asked if this was acceptable, LPN #2 stated it was not. LPN #2 stated, "They (the residents) need something hard to hold on to. I've been asking for months for the hard plastic cups. Because they need something hard to hold on to, we get more spills. I don't have a choice but to use them. I need to keep them hydrated." An interview was conducted on 9/11/18 at 12:51 p.m. with OSM (other staff member) #3, the dietary manager. When asked why plastic silverware and disposable plastic cups were being used in the north dining room, OSM #3 stated, "I've ordered some and we've run out that's why we're using plastic. Some (of the residents) keep it in their rooms or hoard it." A resident group meeting was conducted on 9/11/18 at 3:30 p.m. with ten residents. Seven of the residents were cognitively intact. When asked about the food the residents stated that the food	F 550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 30	F 550		

could be cold especially when served in the Styrofoam containers. When asked why they were given Styrofoam containers, the residents stated, "Because they're short staffed in the kitchen."

A dining observation was conducted on 9/12/18 at 8:00 a.m., 9/12/18 at 12:15 p.m. and 9/13/18 at 8:15 a.m. of the north dining room. On each day, residents were given a mix of hard and soft plastic cups.

An interview was conducted on 9/13/18 at 10:10 a.m. with OSM #3, the dietary manager. When asked if residents were served their meals in Styrofoam containers, OSM #3 stated, "We use it when we're staff challenged." When asked what that meant, OSM #3 stated, "Not enough people to run the kitchen." OSM #3 stated that they used the Styrofoam containers so they didn't have to wash the dishes because they didn't have enough staff. When asked what the facility was to the residents, OSM #3 stated, "It's their home." When asked if it was homelike to serve meals in Styrofoam containers, OSM #3 stated, "No ma'am. It's a dignity issue. I'm trying to do it better."

An interview was conducted on 9/13/18 at 9:14 a.m. with CNA (certified nursing assistant) #1, an assistant that worked on the north unit. When asked how often residents received the disposable plastic cups and plastic silverware, CNA #1 stated, "I'm not going to lie. When there's not enough cups they get the plastic cup. Same with the silverware."

An interview was conducted on 9/13/18 at 10:30 a.m. with ASM (administrative staff member) #2,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 31 the director of nursing. When asked what the facility was to the residents, ASM #2 stated, "This place is home. Where their needs are being met." When asked if she ate out of Styrofoam containers, ASM #2 stated, "When I order food in and it comes in Styrofoam I transfer it to my own dishes." When asked why, ASM #2 stated, "I don't like the taste." When asked if it was acceptable for the residents to be given meals in Styrofoam containers, ASM #2 stated it was not. On 9/13/18 at 10:35 a.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings. ASM #1 stated, "I've talked to her about that." An interview was conducted on 9/13/18 at 1: 11 p.m. with OSM #4, the assistant dietary manager. When asked about residents being served their meals in Styrofoam containers, OSM #4 stated they had used Styrofoam containers because of short staffing so they didn't have to wash dishes. OSM #4 stated, "We've been short for quite a while. We usually only have two aides when we should have three." When asked if he liked to eat his meals out of Styrofoam, OSM #4 stated, "No." When asked what the facility was to the residents, OSM #4 stated, "This is their home. For a lot of people in here this is going to be their final home. I feel the residents shouldn't have to eat out of Styrofoam at all." When asked about the disposable plastic cups, OSM #4 stated, "I don't know why they use those cups. We need to get a better type of cup." The facility policy titled "Quality of Life- Dignity" documents, "Each resident shall be cared for in a manner that promotes and enhances quality of	F 550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 32 life, dignity, respect and individuality."	F 550		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to ensure one of 37 residents in the survey sample, Resident # 8, needs were accommodated. The facility staff failed to ensure Resident #10's call bell (a device with a button that can be pushed to alert staff when assistance is needed), personal cell phone and water bottles were within the resident's reach. The findings include: Resident # 8 was admitted to the facility on 06/01/18 with diagnoses that included but were not limited to cerebral palsy (1), diabetes mellitus, (2), and hypertension (3). Resident # 8's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 06/08/18, coded Resident # 8 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0	F 558	F 558 Reasonable Accommodations Needs/Preferences 1. **Resident #8** had cellphone, water, and call bell placed within reach. This was addressed on 9/13/2018. 2. Daily audits of resident rooms will be conducted to identify any other residents with personal items that might be out of reach. 3. Audits and immediate resolutions for identified issues with compliance. Reeducation of all facility staff. 4. Daily Management Rounds and Staff rounds. Daily management rounds in each room to identify and address the positioning of personal items are within the resident's reach. Daily x 3months and reported to QA committee monthly. 5. The facility dutifully alleges compliance of these tasks on or before 10/28/18.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 558	Continued From page 33 - 15, 13 - being cognitively intact for making daily decisions. Resident # 8 was coded as requiring limited to extensive assistance of one staff member for activities of daily living. On 09/11/18 04:10 p.m., an interview was conducted with Resident # 8 in her room. Resident # 8 was lying in her bed in a diagonal position, with her feet at the bottom left corner of the bed and her head, in upper right corner lying flat on the mattress. Two pillows were directly on the mattress to the left of Resident #8's head. Observation of the call bell revealed it was hanging over the left side of the head board of Resident # 8's bed with the activation switch toward the inside of the bed. Further observation of the room revealed the over-the-bed table, was positioned parallel to the left side of the bed. The over-the-bed table contained three water bottles with water in each of them. When asked to activate the call bell Resident # 8 partially extended her right arm and stated, "I can't reach it. It's always difficult to reach the call bell." When asked if she could reach and obtain the water bottle on the over-the-bed table, Resident # 8 partially extended her right arm and stated, "I can't reach it." During the course of the interview, a telephone rang in Resident # 8's room. When asked if that was her phone ringing Resident # 8 stated, "It my cell phone." Resident # 8's cell phone was located on a bedside table at the foot of the bed in front of the window in the room. When asked if she wanted to answer her cell phone, Resident # 8 stated, "That's another problem. I can't get to my cell phone to answer it too." When asked how she gets assistance when she cannot reach the call bell, Resident # 8 stated, "I yell or I have to ask my roommate a lot of the time to put her call bell on." When how it	F 558		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 558	Continued From page 34 made her feel to have to yell to get assistance and not having access to her personal cell phone, Resident # 8 stated, "It's just the way it is." When asked about her position in the bed Resident # 8 stated she was uncomfortable. When asked about being put to bed Resident # 8 stated she was assisted by one staff member and "They seemed to be in a hurry." When asked about how she felt, Resident # 8 stated, "It makes me uncomfortable." On 09/12/18 at 8:00 a.m., an observation conducted of Resident # 8 and her room, revealed Resident # 8 was lying in bed. An observation of the call bell revealed it was hanging over the left side of the head board of Resident # 8's bed with the activation switch toward the inside of the bed. Further observation of the room revealed the over-the- bed- table position parallel to the left side of the bed. The over-the-bed table contained three water bottles with water in each of them. When asked to reach for and activate the call bell, Resident # 8 stated, "I can't reach it." Observation of Resident # 8's cell phone revealed it was located on a bedside table at the foot of the bed in front the window in the room, out of Resident # 8's reach. Resident # 8 stated she was unable to reach her water bottles. 09/13/18, 8:30 a.m., observation of Resident # 8 and her room revealed Resident # 8 was lying in bed. An observation of the call bell revealed it was hanging over the left side of the head board of Resident # 8 bed with the activation switch toward the inside of the bed. Further observation of the room revealed the over-the-bed-table position parallel to the left side of the bed. The over-the-bed table contained three water bottles	F 558		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 558	Continued From page 35	F 558		

with water in each of them. When asked to reach for and activate the call bell, Resident # 8 stated, "I can't reach it." Observation of Resident # 8's cell phone revealed it was located on a bedside table at the foot of the bed in front the window in the room out of Resident # 8's reach. Resident # 8 stated she was unable to reach her water bottles.

The comprehensive care plan for Resident # 8 dated 06/11/2018 documented, "Focus: The resident has alteration in musculoskeletal status." Under "Interventions" it documented, "Anticipate and meet needs. Be sure call light is within reach and respond promptly to all requests for assistance."

On 09/13/18 at approximately 11:00 a.m., an interview and observation of Resident # 8's room was conducted with LPN (licensed practical nurse) # 3. While observing the placement of the call bell, water bottles, and cell phone in Resident # 8's room with this surveyor, Resident # 8 stated she was unable to reach the call bell, the water bottles on the over-the-bed table and her personal cell phone. LPN # 3 stated the call bell, cell phone and water should have been within Resident # 8's reach. LPN # 3 then rearranged the over-the-bed table closer to Resident # 8 and put her cell phone where Resident # 8 could access it after asking Resident # 8 where she would prefer to have it and moved the call bell within Resident # 8's reach.

On 09/13/18 at approximately 11:30 a.m., an interview was conducted with CNA (certified nursing assistant) # 2. When asked to describe how to accommodate a resident's needs after assisting them to bed, CNA # 2 stated, "The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 558	Continued From page 36 resident should be check every two hours. Make sure the call bell is within reach, they have access to their water or fluids and personal items, make sure they are safe and meet the resident's needs or request before leaving the room. The facility's policy "Virginia Resident Rights and Responsibility" documented, "9. Is treated with consideration, respect, and full recognition of his dignity and individually ...." On 09/13/18 at approximately 5:55 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings. No further information was provided prior to exit. References: (1) A group of disorders that affect a person's ability to move and to maintain balance and posture. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/cerebralpalsy.html. (2) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm. (3) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.	F 558		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15)	F 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 37 §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform theresident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (thatis, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).	F 580	F 580 Notify of Changes (Injury/Decline/Room etc.) 1. The **#66 resident** RP was notified of a change in medication order on 8/14/2018 at 20:48. The order was received at 8/14/2018 at 3:45. The facility notified the RP within 24 hrs. upon receipt of the order. 2. A full house audit on new orders received and RP notification will be conducted by the Unit Managers to determine if any other residents are affected by this deficient practice. 3. Routine auditing of eMAR by the night shift for compliance that meets the professional standards of nursing. 4. Random audits of the night shift nursing staff and review of their audits of all new medication and treatment orders. The facility was compliant within the standards of practice time frame. We will continue to ensure that the residents responsible party is notified within 24 hrs of any changes in medications prescribed. 5. The facility dutifully alleges compliance of these tasks on or before 10/28/18.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 38 §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determined the facility staff failed to notify the responsible representative of an new medication order in a timely manner for one of 37 residents in the survey sample, Resident #66. The facility staff failed to immediately (with in twenty-four hours) notify the responsible representative of a new medication order for Resident #66, prescribed 8/14/18. Documentation in the clinical record evidenced the residents representative was not aware of the new medication on 8/18/18, four days after the medication was prescribed. The findings include: Resident #66 was admitted on 7/20/18 with diagnoses that included but were not limited to: Alzheimer's disease (A brain disorder that seriously affects a person's ability to carry out daily activities) (1), lack of coordination, and difficulty walking. The most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 7/27/18 coded the	F 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 39	F 580		

resident as scoring a "7" on the BIMS (brief interview for mental status) score, indicating the resident was severely impaired to make daily cognitive decisions. The resident was coded as having behaviors of inattention and disorganized thinking. Resident #66 was coded as requiring limited assistance of one staff member for all of his activities of daily living expect personal hygiene in which he needed extensive assistance.

A physician order dated, 8/14/18 at 4:30 p.m. documented, "Haldol 0.5 mg (milligrams) po (by mouth) Q (every) 12 hrs (hours) (BPSD* r/t [related to] dementia)."
(*Behavioral and psychological symptoms of dementia [BPSD] are an integral part of dementia syndrome. Decline in emotional control or motivation, or a change in social behavior manifesting as emotional lability, irritability, apathy and coarsening of social behavior have been a part of diagnostic criteria for dementia.) (2)

The block on the telephone physician order documented, "Name of person contacted," was blank. "Date notified" was blank.

A piece of paper located in the clinical record revealed documented, "8/18/18 - (name of nurse practitioner) RP (responsible person) would like to D/C (discontinue) Haldol. States she was not informed he would he would still be on Haldol PRN (as needed). RP stated she will be in Monday to speak with you." An LPN [licensed practical nurse] who no longer works at the facility wrote and signed this note.

Review of the nurse's notes failed to evidence any documentation of notification to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 40	F 580		

responsible representative of the new order for Haldol.

In an interview conducted with LPN (licensed practical nurse) #4 on 9/13/18 at 9:43 a.m., LPN #4 regarding the process staff follow for new medication orders. LPN #4 stated, "Now we have the nurse practitioner writing the orders on the computer. It will come up in the cue to confirm the order. I will then check the MAR (medication administration record) to ensure it got onto the MAR as sometimes there can be a delay. I then notify the family." When asked where the notification of the family is documented, LPN #4 stated, "Different places, if it's a written order on a TO (telephone order) form, it should be on that TO. If it's through the computer, you then write a note in the nurse's notes."

The administrator, ASM [administrative staff member] #1 and ASM #2, the director of nursing were informed of the above concern on 9/13/18 at 4:56 p.m.

On 9/13/18 at 6:06 p.m. ASM #2, the assistant director of nursing, informed this surveyor the facility did not have a policy on the notification of the responsible representative.

In Basic Nursing, Essential for Practice, 6th edition (Potter and Perry, 2007, pages 56-59), was a reference source for physician's orders and notification. Failure to monitor the patient's condition appropriately and communicate that information to the physician or health care provider are causes of negligent acts. The best way to avoid being liable for negligence is to follow standards of care, to give competent health care, and to communicate with other health care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 41 providers. The physician or health care provider is responsible for directing the medical treatment of a patient. No further information was provided prior to exit. (1) This information was obtained from the following website: https://www.nlm.nih.gov/medlineplus/alzheimersdisease.html. (2) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3038531/	F 580		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safetyrisk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance	F 584	F 584 Safe/Clean/Comfortable/Homelike Environment 1. **Resident #102** – The recliner was cleaned, and cobwebs removed. **Resident Rm 108A**- The wall behind the bed was gouged and chipped. This repair will be completed by the October10th 2018. **Rm 111B**_Damaged baseboard- The maintenance department has initiated a plan to remove and replace the baseboard with attention to drying out the damp areas.	

			F 584 Safe/Clean/Comfortable/Homelike Environment continued from page 48 **Rusted base of the HVAC** Unit-Plans have been initiated to resolve this issue. 2. Room Rounds will be conducted daily to identify the condition of walls, ceilings, floors, baseboards etc. 3. Housekeeping staff will communicate daily, weekly and monthly duties and audit compliance. The maintenance department will conduct daily, weekly and monthly audits of the room conditions. 4. Compliance will be maintained by continuing to audit and correct deficient practice per maintenance schedule. Maintenance and Housekeeping Managers will be auditing for compliance daily x3months, October, November and December and compliance reported monthly at the QA meetings. Report to the QA committee will include corrective actions to address any issue that will negatively affect the safe clean comfortable and homelike environment of our residents.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 42 services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility policy review and clinical record review and in the course of a complaint investigation, it was determined, that the facility staff failed to ensure a clean, home like environment for one of 35 residents in the survey sample, Resident #102; and failed to provide a homelike environment for two of 35 rooms on the secured unit. 1. The facility staff failed to ensure the area behind Resident #102's recliner was maintained in a clean homelike manner. During separate observations, the area behind Resident #102's recliner revealed multiple cobwebs, with non-living spiders in them and food crumbs. 2. The facility staff failed to maintain two of 35	F 584	F 584 Safe/Clean/Comfortable/Homelike Environment continued from page 49 5. The facility dutifully alleges compliance with these tasks on or before 10/28/18.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 43	F 584		

resident rooms in good repair on the South Wing unit.

The findings include:

1. Resident #102 was admitted to the facility on 04/04/18 and readmitted on 08/07/18 with diagnoses that included but were not limited to: congestive heart failure (CHF), high blood pressure, diabetes, and acute respiratory failure (A condition in which not enough oxygen passes from your lungs into your blood.) (1)

The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 8/21/18, coded Resident #102 as having a 14 out of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact to make daily decisions.

An observation was made on 09/12/18 at approximately 12:46 p.m. of Resident #102's room. Resident #102 was observed to have a recliner instead of a bed. Observation of the area behind Resident #102's recliner revealed multiple cobwebs, with non-living spiders in them and food crumbs. The rest of the room including the bathroom, appeared to have been cleaned.

An interview was conducted on 09/12/18 at approximately 12:50 p.m. with Resident #102 regarding how often her room is cleaned. Resident #102 stated, I don't know, a new crew cleaned yesterday but I don't remember the last time I saw them clean. When asked if staff clean behind the recliner, Resident #102 replied, "I don't remember seeing them clean back there."

A second observation was made on 09/13/18 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 44 approximately 8:41 a.m., of Resident #102's room. The resident was not in the room. Observation of the area behind Resident #102's recliner revealed multiple cobwebs, with non-living spiders and crumbs. A third observation was made on 09/13/18 at approximately 12:04 p.m., of Resident #102's room with OSM (other staff member) #7, housekeeper. OSM #7 was asked to observe the area behind Resident #2's recliner. OSM #7 observed the area and stated, "A couple of cobwebs, spider and a couple of crumbs of food." When asked if this area should be cleaned during daily cleaning, OSM #7 responded "Yes." An interview was conducted on 09/13/18 at approximately 2:13 p.m. with ASM (administrative staff member) #1. When asked if facility staff cleaning under a resident's bed or behind recliners daily, ASM #1 responded "Yes." An interview was conducted on 09/13/18 at approximately 2:52 p.m. OSM #19, housekeeping supervisor, regarding the cleaning of resident rooms. OSM #19 stated, "We clean sinks, stools, windows, floors, corners, sweep and then mop. OSM #19 was asked if the staff clean the area behind a recliner if a resident has a recliner instead of a bead, OSM #19 responded "Yes." The facility policy, "Quality of Life-Homelike Environment" documents, "Residents are provided with a safe, clean, comfortable and homelike environment ... 2. The facility staff and management shall maximize ... a. Clean, sanitary and orderly environment."	F 584		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 45 On 09/13/18 at approximately 5:00 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. No further information was provided prior to exit. 1. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/respiratoryfailure.html. 2. The facility staff failed to maintain two of 35 resident rooms in good repair on the South Wing unit. On 09/11/18 at approximately 2:55 p.m., 09/12/18 at approximately 8:55 a.m., and on 09/13/18 at approximately 3:00 p.m., an observation of resident room 108A was conducted. The wall behind the head of the bed and to the left of the bed was gouged, and chipped. On 09/11/18 at approximately 2:58 p.m., 09/12/18 at approximately 9:00 a.m., and 09/13/18 at approximately 8:55 a.m., an observation of resident room 111B was conducted. The baseboard on the wall to the left of the bed was rotting, noted with black substance on it and was wet to the touch. Further observation revealed the bottom of the HVAC (heating, ventilation, and air conditioning) unit was covered in rust. On 09/13/18 at 10:45 a.m., an observation of resident rooms 108A and 111B and interview was conducted with OSM (other staff member) # 11, director of maintenance. After observing the wall in resident room 108A, OSM # 11 acknowledged	F 584		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 46 the wall was gouged and chipped. OSM # 11 further stated it was in need of repair. Upon observation of resident room 111B, OSM # 11 pulled the resident's bed away from the wall. Upon further observation of the baseboard, it was revealed that a larger section of the baseboard was damaged. When OSM was asked to describe the condition of the baseboard, he stated it appeared to be rotted and had a black substance on it. When asked to touch the baseboard, OSM # 11 agreed it was wet to the touch. When asked for the dimensions of the baseboard that was damaged, OSM # 11 stated it was approximately 11 inches high by six feet long. When OSM # 11's attention was directed to the base of the HVAC unit, he acknowledged it was rusted. When asked to describe the process for identifying and making repairs in the resident's rooms, OSM # 11 stated, "If staff find anything in need of repair in the resident's room, they fill out a work order form and place it in the box at the nurse's station. We have them in the lobby area and at each nurse's station. The box is checked throughout the day.' When asked if regular maintenance rounds are conducted in each resident room, OSM # 11 stated, "One of the maintenance guys comes in early at 6:00 a.m., and looks in the resident's rooms but doesn't go into the rooms to inspect. We rely on staff to tell us and identify problem with the rooms." When asked if he was aware of the problems identified in resident rooms 108A and 111B, OSM # 11 stated no. When asked if resident rooms 108 A and 111B were in a homelike condition, OSM # 11 stated no. Review of the facility's document "Team Member	F 584		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 47 Responsibility" it documented, "During your daily routines, look for cracked or missing floor or ceiling tiles, leaks, wet spots on ceiling tiles, equipment needing repairs, etc." On 09/13/18 at approximately 5:55 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings. No further information was provided prior to exit.	F 584		
F 585 SS=E	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights	F 585	F 585 Grievances 1. Facility has pasteurized eggs on-hand since May 2018. **Resident #53** and those residents requesting fried eggs that do not conflict with his or her ordered dietary restrictions may have fried eggs upon request. Facility staff documented any issues/concerns expressed and followed-up as needed. Brookside Rehab's Facility policy and procedure on Grievances/Comments/Issues reviewed and updated on or before 10/28/18 by facility QA committee. 2. Facility determined that all residents are potentially affected by deficient practice. All grievances received were reviewed to ensure any issues/concerns were resolved timely and follow up was completed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 585	Continued From page 48 contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect,	F 585	F 585 Grievances continued from page 53 Resident interviews initiated with goal of all residents interviewed on or before 10/28/18 regarding their care and services and any issues and concerns were documented on Feedback Forms in Grievance Log with appropriate follow up. New Admissions given Grievance procedure guidance in writing with appropriate follow up. 3. Staff educated on or before 10/28/18 by Administrator or designee regarding facility's updated Facility Guideline/policies/procedures for Grievances and follow up. 4. Upon completion of initial staff education, the Administrator or designee will complete random weekly audits using audit tools x 3 months to ensure staff compliance with facility guideline for grievances. Random audits will be conducted for 3 additional months to March 2019. Auditing for compliance will occur weekly x 3 months, October, November and December; and random audits up until March 2019 with compliance reported monthly at the QA meetings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 585	Continued From page 49 abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review, facility document review, and during the course of a complaint investigation, it was determined that the facility staff failed to address resident grievances in a timely manner. On 9/11/18 at 3:30 p.m., a group interview was conducted with eleven current facility residents. The group expressed that it took 3 months to get	F 585	F 585 Grievances continued from page 54 5. The facility dutifully alleges compliance of these tasks on or before 10/28/18.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 585	Continued From page 50	F 585		

fried eggs returned to the menu.

The findings include:

Resident #53 was admitted to the facility on 11/3/17 with the diagnoses of but not limited to congestive heart failure, hypothyroidism, insomnia, chronic kidney disease, atrial fibrillation, peripheral vascular disease, and asthma. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 7/23/18. The resident was coded as being cognitively intact in ability to make daily life decisions.

As part of a complaint investigation regarding Resident #53, who alleged that eggs had been removed from the menu, a group interview was conducted on 9/11/18 at 3:30 p.m., with eleven current facility residents. Resident #53 was one of the residents in attendance. The group expressed that they wanted fried eggs and it took 3 months to get fried eggs returned to the menu.

The resident council minutes from November 2017 through August 2018 were reviewed, on the minutes themselves, no specific dietary concerns were identified. This was consistently documented as, "Dietary concerns addressed with the dietary manager."

On 9/13/18 at approximately 4:30 p.m., in an interview with OSM #17 (Other Staff Member), the activities director, she provided hand written documentation of what the specific dietary concerns were. This document identified the following: December 2017: "Residents would like fried eggs vs. scrambled eggs." January

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 585	Continued From page 51	F 585		

2018: "No fried eggs.....per residents." February 2018: "No more fresh eggs....Residents were told they'd be getting fried eggs back." March 2018 - no mention of eggs. April 2018: "Residents would like fried eggs. Per D Mgr (dietary manager), she will check on. Do not like the boiled eggs." May 2018: "Residents want fried eggs. D Mgr. will do a few (orders) at a time for residents who wish to have fried eggs for breakfast."

In reviewing the dietary concerns notes related to the resident council minutes, the residents had requested fried eggs from December 2017 through May 2018. There was no explanations provided as to why pasteurized eggs were not ordered for fried eggs, why the residents could not have fried eggs, and there was no documentation of what the residents were told about the eggs, and when they were told. There was no evidence that the concern was addressed timely as the residents requested the same item month after month and the facility had no documentation of how they were addressing this concern and when they were addressing it.

The dietary food order slips from November 2017 to August 2018 were reviewed and revealed, pasteurized eggs to be used for fried eggs were not ordered until May 11, 2018.

On 9/13/18 at approximately 4:38 p.m., in an interview with OSM #17, she stated she did not know why it took so long, and did not have any documentation regarding how or when the facility was addressing this concern expressed by the residents.

On 9/13/18 at 5:05 p.m., at the end of day

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 585	Continued From page 52 meeting, ASM #1 (Administrative Staff Member) the Administrator, and ASM #2 the Director of Nursing, were made aware of the findings. ASM #1 stated that he has only been at the facility for a couple of months, but that the residents should be told what is going on when they express a concern and should be made aware of any follow up on their concerns within about 3 days or so, not 6 months. ASM #1 stated he did not know why the pasteurized eggs required to make fried eggs, were not or could not be obtained and provided to the residents per their request. A review of the facility policy, "Grievance Policy-Resident Concern, Complaint and/or Suggestion" documented, "15. Resolution of the concern is desired within three (3) to five (5) working days from the date the concern was filed. If it is not possible to resolve the complaint in the time frame identified, the Administrator and/or Grievance official will present a plan to the resident outlining the action being taken."	F 585		
F 622 SS=E	COMPLAINT DEFICIENCY Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the	F 622		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 622	Continued From page 53 services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care	F 622	*Complaint Deficiency* F 622-Transfer and Discharge Requirements 1. **Resident #75** on 8/1/2018- The facility failed to provide documented evidence of all required documentation for a facility-initiated transfer. **Resident # 40**- The facility staff failed to evidence that a comprehensive care plan goal was provided to the receiving provider for a facility-initiated transfer on 8/9/18. **Resident # 113**- The facility staff failed to evidence that a comprehensive care plan goal was provided to the receiving provider for a facility-initiated transfer on 8/6/18. **Resident #61**- The facility staff failed to provide evidence that all required information (including Physician contact information, resident representative contact information, special instructions for ongoing care, advance directives and comprehensive care plan goals were provided to the hospital on 8/30/18.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 622	Continued From page 54 institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plangoals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, it was determined that the facility staff failed to evidence that all required documentation was provided to the	F 622	*Complaint Deficiency* F 622-Transfer and Discharge Requirements continued from page 59 2. All discharges/transfers from the facility will be audited utilizing a check list that identifies all the documents that must be included in the transfer package. 3. The development of a comprehensive discharge tool that must be completed by the nurse and will be reviewed by the Unit Manager/designee for completeness. 4. Education of all nurses on discharge planning process that meets the required standards of care and to ensure continuity of care to our residents. Daily audits of all transfers/discharges starting October 2018 and for 3 months November, December 2018 and January 2019. The results of these audits including analysis of the data gathered and corrective measures to address deficient practice will be presented to the QA committee monthly by the Unit Manager. 5. The facility dutifully alleges compliance of these tasks on or before 10/28/18.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 622	Continued From page 55 receiving facility for four of 37 residents in the survey sample; Residents #75, #40, #113 and #61. 1. The facility staff failed to provide documented evidence all required documentation was provided to the receiving facility for a facility initiated transfer of Resident #75 on 8/1/18. 2. The facility staff failed to evidence that Resident #40's comprehensive care plan goals were provided to the receiving provider for a facility-initiated transfer on 8/9/18. 3. The facility staff failed to evidence that Resident #113's comprehensive care plan goals were provided to the receiving provider for a facility initiated transfer to the hospital on 8/6/18. 4. The facility staff failed to provide evidence that all required information (including physician contact information, resident representative contact information, special instructions for ongoing care, advance directives and comprehensive care plan goals) were provided to the hospital staff when Resident # 61 was transferred to the hospital on 08/30/18. The findings include: 1. The facility staff failed to provide documented evidence all required documentation was provided to the receiving facility for a facility initiated transfer of Resident #75 on 8/1/18. Resident #75 was admitted to the facility on 7/20/18, with a most recent readmission of	F 622		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 622	Continued From page 56 8/3/18, with diagnoses that included but were not limited to: confusion, Wernicke's encephalopathy (1) (A degenerative brain disorder caused by the lack of thiamine (vitamin B1), history of alcohol dependence, generalized weakness, difficulty in walking, depression, anxiety, restlessness, and agitation. The most recent MDS (minimum data set) assessment, a five day Medicare assessment, with an assessment reference date of 8/7/18, coded the resident as scoring a "12" on the BIMS (brief interview for mental status) score, indicating he moderate cognitive impairment for daily decision making. The nurse practitioner's note dated 8/1/18 at 2:22 p.m., documented in part, "CC (chief complaint): staff asked to see patient s/p (status post) fall this afternoon ...Assessment and plan: #Head lac (laceration) after fall; Needs ED (emergency department) eval (evaluation) for possible CT (Computed tomography*) scan, closure of lac (laceration)." * Computed tomography (CT) is a type of imaging. It uses special x-ray equipment to make cross-sectional pictures of the body. (2) The nurse's note dated 8/1/18 at 3:52 p.m. documented in part, "Resident was witnessed falling stiffly backwards to the floor at the nursing station. He was unresponsive for a [sic] 10 seconds then was able to answer staff's questions appropriately. Vitals obtained FNP (family nurse practitioner) [FNP's name] to assess resident new orders received to send resident to ED (emergency department) to eval (evaluate) and treat ...RP (responsible party)	F 622		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 622	Continued From page 57 called by [RN (registered nurse) #2] ...Report called to [hospital's name] ED (emergency department." Review of the clinical record failed to evidence what resident information, including clinical information, was included in the resident's transfer documentation. An interview was conducted on 9/13/18 at 12:40 p.m. with LPN (licensed practical nurse) #3, regarding the information provided to hospital staff when a resident is transferred to the hospital. LPN #3 stated she provides a face sheet, physician order sheet, advanced directive, and a completed transfer sheet. When asked if she provides the resident's comprehensive care plan goals, LPN #3 stated, "No." When asked how she evidences the information she provides to hospital staff, LPN #3 stated she documents it in the nursing progress note and on the transfer sheet that is sent with the resident to the facility. A written request for a copy of Resident #75's hospital transfer sheet for date of service 8/1/18 was requested from the administrative staff on 9/13/18 at approximately 2 p.m. ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were made aware of the above findings on 9/13/18 at 4:55 p.m. A review of the facility's policy, "Transfer or Discharge, Emergency", documents in part, "4. Should it become necessary to make an emergency transfer or discharge to a hospital or other related institution, our facility will implement the following procedures:	F 622		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 622	Continued From page 58 a. Notify the resident's Attending Physician; b. Notify the receiving facility that the transfer is being made; c. Prepare the resident for transfer; d. Prepare a transfer form to send with the resident; e. Notify the representative (sponsor) or other family member ..." No further information was provided prior to exit. 1) This information was obtained from the National Institutes of Health at https://www.ninds.nih.gov/Disorders/All-Disorders/Wernicke-Korsakoff-Syndrome-Information-Page 1) This information was obtained from the National Institutes of Health at https://medlineplus.gov/ctscans.html 2. The facility staff failed to evidence that Resident #40's comprehensive care plan goals were provided to the receiving provider for a facility-initiated transfer on 8/9/18. Resident #40 was admitted to the facility on 5/18/18 and readmitted on 8/28/18 with diagnoses that included but not limited to: anemia, enlarged heart, irregular heartbeat, high blood pressure and peripheral vascular disease (1). The most recent MDS (minimum data set), a five day assessment, with an ARD (assessment reference date) of 9/4/18 coded the resident as having scored a 13 out of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact to make daily decisions.	F 622		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 622	Continued From page 59 Review of the 8/9/18 nurse's note documented, "Recheck vss (vital signs) 102.3 (temperature in degrees) - 117 (pulse) and irregular 18 (respirations)- 192/100 (blood pressure) and sat (oxygen saturation) 95 (percent) room air. Patient remains alert and oriented x3 but c/o (complained of) not feeling well. (Name of doctor) office notified and NP (nurse practitioner) stated to send patient to ER [emergency room]. Patient aware." An interview was conducted on 9/13/18 at 12:40 p.m. with LPN (licensed practical nurse) #3. When asked what information was sent with the resident to the hospital, LPN #3 stated, "The face sheet, their POS (physician order sheet) with their diagnosis and the transfer slip." When asked what was included on the transfer slip, LPN #3 stated, "Their social activities, their ambulatory status and diet." When asked if the comprehensive care plan goals were sent with the resident, LPN #3 stated, "No, I have not sent that." Review of the facility's transfer slip did not evidence documentation regarding providing the comprehensive care plan goals to the receiving facility. On 9/13/18 at 5:00 p.m. ASM (administrative staff member) #1, the administrator and ASM #, the director of nursing were made aware of the findings. No further information was provided prior to exit. 1. Peripheral vascular disease -- Peripheral artery disease (P.A.D.) is a disease in which plaque builds up in the arteries that carry blood to your head, organs, and limbs. Plaque is made up of	F 622		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 622	Continued From page 60 fat, cholesterol, calcium, fibrous tissue, and other substances in the blood. This information was obtained from: https://www.nhlbi.nih.gov/health-topics/peripheral-artery-disease 3. The facility staff failed to evidence that Resident #113's comprehensive care plan goals were provided to the receiving provider for a facility initiated transfer to the hospital on 8/6/18. Resident #113 was admitted to the facility on 5/21/18 and readmitted on 8/9/18 with diagnoses that included but not limited to: aphasia (A disorder caused by damage to the parts of the brain that control language. It can make it hard for you to read, write, and say what you mean to say.) (1), cerebral infarction (stroke), heart failure (A condition in which the heart can't pump enough blood to meet the body's needs.) (2) The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 8/18/18 coded the resident as having a score of 99 on the BIMS (brief interview for mental status) indicating the resident was unable to complete the interview. Resident # 113 was coded as moderately impaired for cognitive skills for daily decision making. Review of Resident #113's clinical record revealed that he had been sent to the hospital on 8/6/18. A nursing note dated 8/6/18 document the following: "Resident observed by this nurse on bed having grand mal seizure for approximately 2 minutes. Observed throughout. Remained unresponsive for several minutes following seizure. Vital signs unremarkable. Call placed to (Name of Doctor); orders received to send	F 622		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 622	Continued From page 61 resident to ER (emergency room). Resident becoming responsive when EMS (Emergency Medical Service) arrived; exited facility at 0940 a.m. Resident sent to (Name of hospital). Responsible party notified with each event." There was no documentation in the clinical record evidencing that Resident #113's comprehensive care plan goals were sent to the receiving provider for the facility- initiated transfer on 8/6/18. An interview was conducted on 9/13/18 at 12:40 p.m. with LPN (licensed practical nurse) #3. When asked what information was sent with the resident to the hospital, LPN #3 stated, "The face sheet, their POS (physician order sheet) with their diagnosis and the transfer slip." When asked what was included on the transfer slip, LPN #3 stated, "Their social activities, their ambulatory status and diet." When asked if the comprehensive care plan goals were sent with the resident, LPN #3 stated, "No, I have not sent that." On 09/13/18 4:50 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings. No further information was provided prior to exit. 1. This information was obtained from the website: https://medlineplus.gov/epilepsy.html. 2. This information was obtained fromthe website: https://medlineplus.gov/heartdiseases.html. 3. Generalized tonic-clonic seizure is 1 type of seizure that involves the entire body. It is also	F 622		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 622	Continued From page 62	F 622		

called grand mal seizure. The terms seizure, convulsion, or epilepsy are most often associated with generalized tonic-clonic seizures. This information was obtained from website: https://medlineplus.gov/ency/article/000695.htm

4. The facility staff failed to provide evidence that all required information (including physician contact information, resident representative contact information, special instructions for ongoing care, advance directives and comprehensive care plan goals) was provided to the hospital staff when Resident # 61 was transferred to the hospital on 08/30/18.

Resident # 61 was admitted to the facility on 05/30/2017, with a readmission on 07/23/2018 with diagnoses that included but were not limited to: atrial fibrillation (1), dementia (2), Parkinson's disease (3) and hypertension (4).

Resident # 61's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 06/26/18, coded Resident # 61 as scoring a 14 on the brief interview for mental status (BIMS) of a score of 0 - 15, 14 - being cognitively intact for making daily decisions. Resident # 61 was coded as being independent for activities of daily living.

The "Nurse's Note" for Resident # 61 dated, "8/31/2018 at 10:49" (a.m.) documented, " IDT (Interdisciplinary Team) NOTE: On 08/30/18 at 19:30 (7:30 p.m.) resident was observed on the floor in her room with bleeding noted from [sic] NP (nurse practitioner) made aware and ordered to ER (emergency room) for eval. (evaluation). Resident went to (Name of Hospital) ER. Returned early AM. CT (computed tomography)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 622	Continued From page 63 scan neg (negative). Will monitor for latent bruising and assess for pain or discomfort. Will have therapy screen. Will keep MD (medical doctor) and RP (responsible party) updated." Review of Resident # 61's clinical record and EHR (electronic health record) failed to evidence documentation that the facility provided physician contact information, resident representative contact information, special instructions for ongoing care, advance directives and comprehensive care plan goals were provided to the hospital staff when Resident # 61 was transferred to the hospital on 08/30/18. On 09/13/18 at 12:40 p.m., an interview was conducted with LPN (licensed practical nurse) # 3 regarding the paperwork that is sent with the resident upon a facility-initiated transfer. LPN # 3 stated, "We send a copy of the resident's code status, face sheet, physician order sheet, diet ambulation status and a copy of the transfer form. When asked if a copy of the resident's care plan goals are sent as part of the transfer paperwork LPN # 3 stated, "No." On 09/13/18 at approximately 1:30 p.m., a request for Resident # 61's "Transfer Form" for the facility initiated transfer on 08/30/18. At approximately 6:30 p.m., LPN # 1, unit manager stated they were unable to locate the "Resident Transfer Form" for Resident # 61 and did not have any documentation of what paperwork was sent to the hospital on 08/30/18. On 09/13/18 at approximately 5:55 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings.	F 622		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 622	Continued From page 64 No further information was provided prior to exit. References: (1) A problem with the speed or rhythm of the heartbeat. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/atrialfibrillation.html. (2) A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm. (3) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html. (4) A type of movement disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/parkinsonsdisease.html.	F 622		
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.	F 623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 65 (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficientlyto allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) Aresident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights,	F 623	F 623 Notice Requirements Before Transfer/Discharge 1. The facility failed to provide written notification to the resident, resident representative and ombudsman for a facility-initiated transfer to the hospital for the following residents, **Resident #76** on 7/7/18 **Resident #75** on 8/1/18 **Resident #40** on8/9/18 **Resident #113on** 8/6/18 **Resident #61**on 8/30/18 Notification was mailed out by the Director of Social Work to the Ombudsman for the Months of July, August and September. 2. All transfers out of the facility will have the proper notification to the identified personnel and comply with CMS guidelines articulated in the 2567 document. 3. The admission department will provide the director of social with the names of all patient transfers to the hospital. The Social Worker will ensure that written notification is sent out. Nurses will be educated on the appropriate documentation of notification of all personnel identified IN the clinical record-resident and responsible parties.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 66 including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the	F 623	F 623 Notice Requirements Before Transfer/Discharge continued from page 71 4. Daily audits of the charts of residents who have been transferred to the hospital to ensure compliance. This will be conducted by the Unit Managers. Education of nursing by October 28th, 2018. Daily audits by the director of social services x 1 month (October) Deficiencies would be identified and corrected. Weekly audits x 3 months by the unit managers. Reports will be analyzed, deficient practice corrected, and the findings presented at the QA monthly meetings. 5. The facility dutifully alleges compliance of these tasks on or before 10/28/18.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 67 State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to provide written notification to the resident, resident representative, and ombudsman upon transfer to the hospital for five of 37 residents in the survey sample; Residents #76, #75, #40, #113, and #61. 1. The facility staff failed to provide written documentation to the resident and/or resident representative and notify the ombudsman for a facility initiated transfer to the hospital on 7/7/18 for Resident #76. 2. The facility staff failed to provide written documentation to the resident and/or resident representative and notify the ombudsman for a facility initiated to the hospital on 8/1/18 for Resident #75. 3. The facility staff failed to provide written documentation to the resident and/or resident representative and notify the ombudsman for a facility initiated to the hospital on 8/9/18 for Resident #40. 4. The facility staff failed to provide the resident and or resident representative and ombudsman with written documentation of a facility initiated transfer on 8/6/18 for Resident #113. 5. The facility staff failed to provide written	F 623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 68	F 623		

notification to the resident and responsible party (RP) and the ombudsman of a facility initiated transfer to the hospital on 08/30/18 for Resident # 61.

The findings include:

1. Resident #76 was admitted to the facility on 10/17/16, with a most recent readmission of 7/11/18, with diagnoses that included but were not limited to: heart attack, respiratory failure high blood pressure, muscle weakness, emphysema (1) (A type of lung disease involving damage to the air sacs (alveoli) in the lungs. As a result, the body does not get the oxygen it needs, making it hard to catch one's breath), and asthma.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 9/5/18, coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating he has no cognitive impairment for daily decision making.

The nurse's note dated 7/7/18 at 12:17 p.m. documented in part, "Nurse received call from transport agency stating patient fainted x 3 and was noted with diaphoresis and pallor, 911 was called and patient was transported to [hospital's name]...3:39 p.m.: Patient was admitted to [hospital's name] with urosepsis (2) (a severe urinary tract infection) and elevated troponin (3) family is at hospital and aware of patients [sic] situation, message left for MD (medical doctor) regarding patients [sic] situation, MAR (medication administration record), labs [laboratory tests] and DNR (do not resuscitate) faxed to the hospital."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 69	F 623		

On 9/13/18 at 12:40 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated she calls residents' representatives when residents are transferred to the hospital but she does not provide written notification of the transfers to residents' representatives.

On 09/13/18 at 1:10 p.m., an interview was conducted with ASM (administrative staff member) #1, the administrator, OSM #1 (other staff member), the social worker and OSM #2, the admissions director. When asked who was responsible for notifying the ombudsman of a facility-initiated transfer, OSM #1, stated, "I was not aware we were supposed to do that." OSM #2 stated, "We don't do it", and ASM #1 stated he was not aware that it was required.

ASM #1, the administrator, and ASM #2, the director of nursing, were made aware of the above findings on 9/13/18 at 4:55 p.m.
No further information was provided prior to exit.

1) This information was obtained fromthe National Institutes of Health at https://medlineplus.gov/emphysema.html

2) This information was obtained from the National Institutes of Health at https://medlineplus.gov/ency/article/000666.htm

3) Tropin is a protein that is released when the heart muscle has been damaged, such as occurs with a heart attack. The more damage there is to the heart, the greater the amount of troponin protein will be in the blood. This information was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 70 obtained from the National Institutes of Health at https://medlineplus.gov/pressuresores.html 2. The facility staff failed to provide written documentation to the resident and/or resident representative and notify the ombudsman for a facility initiated to the hospital on 8/1/18 for Resident #75. Resident #75 was admitted to the facility on 7/20/18, with a most recent readmission of 8/3/18, with diagnoses that included but were not limited to: confusion, Wernicke's encephalopathy (1) (A degenerative brain disorder caused by the lack of thiamine (vitamin B1), history of alcohol dependence, generalized weakness, difficulty in walking, depression, anxiety, restlessness, and agitation. The most recent MDS (minimum data set) assessment, a five day Medicare assessment, with an assessment reference date of 8/7/18, coded the resident as scoring a "12" on the BIMS (brief interview for mental status) score, indicating he moderate cognitive impairment for daily decision making. The nurse practitioner's note dated 8/1/18 at 2:22 p.m., documents in part, "CC (chief complaint): staff asked to see patient s/p (status post) fall this afternoon ...Assessment and plan: #Head lac (laceration) after fall; Needs ED (emergency department) eval (evaluation) for possible CT (Computed tomography*) scan, closure of lac (laceration)." *Computed tomography (CT) is a type of imaging. It uses special x-ray equipment to make cross-sectional pictures of the body. (2)	F 623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 71 The nurse's note dated 8/1/18 at 3:52 p.m. documented in part, "Resident was witnessed falling stiffly backwards to the floor at the nursing station. He was unresponsive for a [sic] 10 seconds then was able to answer staff's questions appropriately. Vitals obtained FNP (family nurse practitioner) [FNP's name] to assess resident new orders received to send resident to ED (emergency department) to eval (evaluate) and treat ...RP (responsible party) called by [RN (registered nurse) #2] ...Report called to [hospital's name] ED (emergency department." On 9/13/18 at 12:40 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated she calls residents' representatives when residents are transferred to the hospital but she does not provide written notification of the transfers to residents' representatives. On 09/13/18 at 1:10 p.m., an interview was conducted with ASM (administrative staff member) #1, the administrator, OSM #1 (other staff member), the social worker and OSM #2, the admissions director. When asked who was responsible for notifying the ombudsman of a facility-initiated transfer, OSM #1, stated, "I was not aware we were supposed to do that." OSM #2 stated, "We don't do it", and ASM #1 stated he was not aware that it was required. ASM #1, the administrator, and ASM #2, the director of nursing, were made aware of the above findings on 9/13/18 at 4:55 p.m. No further information was provided prior to exit.	F 623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 72 1) This information was obtained from the National Institutes of Health at https://www.ninds.nih.gov/Disorders/All-Disorders/Wernicke-Korsakoff-Syndrome-Information-Page 1) This information was obtained from the National Institutes of Health at https://medlineplus.gov/ctscans.html 3. The facility staff failed to provide written documentation to the resident and/or resident representative and notify the ombudsman for a facility initiated to the hospital on 8/1/18 for Resident #75. Resident #40 was admitted to the facility on 5/18/18 and readmitted on 8/28/18 with diagnoses that included but not limited to: anemia, enlarged heart, irregular heartbeat, high blood pressure and peripheral vascular disease (1). The most recent MDS (minimum data set), a five day assessment, with an ARD (assessment reference date) of 9/4/18 coded the resident as having a 13 out of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact to make daily decisions. Review of the 8/9/18 nurse's note documented, "Recheck vss (vital signs) 102.3 (temperature in degrees) - 117 (pulse) and irregular 18 (respirations) - 192/100 (blood pressure) and sat (oxygen saturation) 95 (percent) room air. Patient remains alert and oriented x3 but c/o (complained of) not feeling well. (Name of doctor) office notified and NP (nurse practitioner) stated to send patient to ER [emergency room]. Patient aware." Further review of the record did not evidence	F 623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 73	F 623		

documentation regarding the responsible party or the ombudsman receiving notification regarding the transfer in writing.

An interview was conducted on 9/13/18 at 12:40 p.m. with LPN #3, regarding the process staff follows to notify the resident's representative when a resident was sent to the hospital. LPN #3 stated, "We call them." When asked if they were given any written notification, LPN #3 stated, "Not unless they come in and request something but usually they're not here."

An interview was conducted on 09/13/18 at 1:10 p.m. with ASM (administrative staff member) # 1, administrator, OSM # 1 (other staff member), social worker and OSM # 2, admissions director. When asked who was responsible for notifying the ombudsman for a facility initiated transfer OSM # 1, stated, "I was not aware we were supposed to do that." OSM # 2 stated, "We don't do it" and ASM # 1 stated he was not aware that it was required.

On 9/13/18 at 5:00 p.m. ASM #1, the administrator and ASM #2, the director of nursing were made aware of the findings.

No further information was obtained prior to exit.

1. Peripheral vascular disease -- Peripheral artery disease (P.A.D.) is a disease in which plaque builds up in the arteries that carry blood to your head, organs, and limbs. Plaque is made up of fat, cholesterol, calcium, fibrous tissue, and other substances in the blood. This information was obtained from: https://www.nhlbi.nih.gov/health-topics/peripheral-artery-disease

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 74 4. The facility staff failed to provide the resident and or resident representative and ombudsman with written documentation of a facility initiated transfer on 8/6/18 for Resident #113. Resident #113 was admitted to the facility on 5/21/18 and readmitted on 8/9/18. Diagnoses included but were not limited to: aphasia (A disorder caused by damage to the parts of the brain that control language. It can make it hard for you to read, write, and say what you mean to say.)(1), cerebral infarction (stroke), heart failure (A condition in which the heart can't pump enough blood to meet the body's needs.) (2) The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 8/18/18 coded the resident as having a score of 99 on the BIMS (brief interview for mental status) indicating the resident was unable to complete the interview. Resident # 113 was coded as moderately impaired for cognitive skills for daily decision making. Review of Resident #113's clinical record revealed a nursing note dated 8/6/18 that documented the following: "Resident observed by this nurse on bed having grand mal seizure for approximately 2 minutes. Observed throughout. Remained unresponsive for several minutes following seizure. Vital signs unremarkable. Call placed to (Name of Doctor); orders received to send resident to ER (emergency room). Resident becoming responsive when EMS (Emergency Medical Service) arrived; exited facility at 0940 a.m. Resident sent to (Name of hospital). Responsible party notified with each event." Review of the clinical record failed to evidence	F 623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 75 that the resident/resident representative and the ombudsman were provided written notification of the facility- initiated transfer on 8/6/18 for Resident #113. An interview was conducted on 9/13/18 at 12:40 p.m. with LPN #3, regarding the process staff follows to notify the resident's representative when a resident was sent to the hospital. LPN #3 stated, "We call them." When asked if they were given any written notification, LPN #3 stated, "Not unless they come in and request something but usually they're not here." On 09/13/18 at approximately 1:10 p.m. an interview was conducted with ASM (administrative staff member) # 1, the administrator, OSM (other staff member) # 1, social worker and OSM # 2, admissions director. When asked who was responsible for notifying the ombudsman for a facility-initiated transfer OSM # 1, stated, "I was not aware we were supposed to do that." OSM # 2 stated, "We don't do it" and OSM # 1 stated he was not aware that it was required. On 09/13/18 4:50 p.m. ASM #1, the administrator and ASM #2, the director of nursing were made aware of the findings. No further information was provided prior to exit. 1. This information was obtained from the website: https://medlineplus.gov/epilepsy.html. 2. This information was obtained from the website: https://medlineplus.gov/heartdiseases.html. 5. The facility staff failed to provide written notification to the resident and responsible party (RP) and the ombudsman of a facility initiated	F 623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 76 transfer to the hospital on 08/30/18 for Resident # 61. Resident # 61 was admitted to the facility on 05/30/2017 and a readmission of 07/23/2018 with diagnoses that included but were not limited to: atrial fibrillation (1), dementia (2), Parkinson's disease (3) and hypertension (4). Resident # 61's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 06/26/18, coded Resident # 61 as scoring a 14 on the brief interview for mental status (BIMS) of a score of 0 - 15, 14 - being cognitively intact for making daily decisions. Resident # 61 was coded as being independent for activities of daily living. The "Nurse's Note" for Resident # 61 dated, "8/31/2018 at 10:49" (a.m.) documented, " IDT (Interdisciplinary Team) NOTE: On 08/30/18 at 19:30 (7:30 p.m.) resident was observed on the floor in her room with bleeding noted from [sic] NP (nurse practitioner) made aware and ordered to ER (emergency room) for eval. (evaluation). Resident went to (Name of Hospital) ER. Returned early AM. CT (computed tomography) scan neg (negative). Will monitor for latent bruising and assess for pain or discomfort. Will have therapy screen. Will keep MD (medical doctor) and RP (responsible party) updated." Review of Resident # 61's clinical record and EHR (electronic health record) failed to evidence documentation that the ombudsman, Resident # 61 and Resident # 61's responsible party were notified in writing of Resident # 61's facility-initiated transfer to the hospital on 08/30/18.	F 623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	**614 HASTINGS LANE WARRENTON, VA 20186**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 77 On 09/13/18 at 12:40 p.m., an interview was conducted with LPN (licensed practical nurse) # 3 regarding written notification to Resident # 61 and Resident # 61's responsible party. LPN # 3 stated, "We call the responsible party. We only provide something written if they request it." On 09/13/18 at 1:10 p.m., an interview was conducted with ASM (administrative staff member) # 1, administrator, OSM # 1 (other staff member), social worker and OSM # 2, admissions director. When asked who was responsible for notifying the ombudsman for a facility initiated transfer OSM # 1, stated, "I was not aware we were supposed to do that." OSM # 2 stated, "We don't do it" and ASM # 1 stated he was not aware that it was required. On 09/13/18 at approximately 5:55 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings. No further information was provided prior to exit. References: (1) A problem with the speed or rhythm of the heartbeat. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/atrialfibrillation.html. (2) A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm.	F 623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 78 (3) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html. (4) A type of movement disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/parkinsonsdisease.html.	F 623		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.	F 656	F 656 Develop/Implement Comprehensive Care Plan 1. **Resident #5's** care plan was adjusted to include his refusal to take the dialysis book from the facility to the dialysis center **Resident #8** care plan was adjusted to include the use of the call bell to meet her needs **Resident #102** care plan was adjusted to address the use of oxygen as prescribed by the physician	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 79 (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to develop and/or implement the comprehensive care plan for three of 37 residents in the survey sample, Residents # 5, # 8 and # 102. 1. The facility staff failed to develop a comprehensive care plan to address Resident # 5's refusal of taking the dialysis communication book back and forth from the facility to the dialysis center. 2. The facility staff failed to implement Resident# 8's comprehensive care plan for the use of the call bell to meet their needs. 3. The facility staff failed to develop a comprehensive care plan to address the use of oxygen as prescribed by the physician for Resident #102.	F 656	F 656 Develop/Implement Comprehensive Care Plan continued from page 84 2. The MDS coordinator will review all care plans to ensure that they are care planned with appropriate interventions that are specific to the residents who reside at Brookside. 3. The MDS coordinator/designee will review all care plans to ensure compliance. 4. A weekly audit will be conducted by the MDS department and nursing to identify and address that all dialysis patients and those who require oxygen are care planned. This audit will include all residents who require call bells to meet their needs. Weekly audits to be completed by the MDS department starting October 1st, 2018 x1 month , monthly x 3 months November, December 2018 and January 2019 and the analysis of results and corrective measures employed reported monthly to the QA committee. 5. The facility dutifully alleges compliance of these tasks on or before 10/28/18.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 80 The finding include: 1. The facility staff failed to develop a comprehensive care plan to address Resident # 5's refusal of taking the dialysis communication book back and forth from the facility to the dialysis center. Resident # 5 was admitted to the facility on 06/03/2016 with diagnoses that included but were not limited to: end stage renal disease (1), anemia (2), diabetes mellitus (3) and hypertension (4). Resident # 5's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 09/03/18, coded Resident # 5 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions. Resident # 5 was coded as being independent and requiring only set up to the assistance of one staff member for activities of daily living. Section O "Special Treatments, Procedures and Programs" coded Resident # 5 as receiving dialysis while a resident. The POS (physician's order sheet) dated September 2018 for Resident # 5 documented, "Dialysis Monday, Wednesday, Friday. Order Date: 12/06/2017. Order Status: Active." Review of Resident # 5's dialysis communication book failed to evidence communication sheets between the facility and the dialysis center after 09/05/18. On 09/12/18 at 4:30 p.m., an interview was conducted with LPN (licensed practical nurse) #	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 81 1, unit manager. When asked about the missing dialysis communication sheets for Resident # 5, LPN # 1 stated, "He (Resident # 5) refuses to take his dialysis book to the center. When asked if it is documented that Resident # 5 refuses to take the dialysis communication book to the dialysis center LPN # 1 stated, "I doubt it but I'll check." Review of the comprehensive care plan with a revision date of 06/18/2018 for Resident # 5 failed to evidence documentation of Resident # 5's refusal to take his dialysis communication book back and forth from the facility to the dialysis center. On 09/13/18 at approximately 12:50 p.m., an interview was conducted with Resident # 5. When asked if takes the communication book with him to dialysis Resident # 5 stated, "No. They never write anything in it why should I bother to take it." On 09/13/18 at approximately 2:35 p.m., an interview was conducted with LPN # 8, MDS coordinator. When asked if Resident # 5's behavior of refusing to take the dialysis communication book back and forth between the facility and the dialysis center should be documented on the care plan, LPN # 8 stated, "It should be." After reviewing Resident # 5's care plan with a revision date of 06/18/2018 LPN # 8 stated, "I was not aware he was not taking to communication book to dialysis. There is no care plan for it." References: (1) The last stage of chronic kidney disease. This is when your kidneys can no longer support your	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 82	F 656		

body's needs. This information was obtained from the website: https://medlineplus.gov/ency/article/000500.htm.

(2) Low iron. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anemia.html .

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

(4) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.

2. The facility staff failed to implement Resident # 8's comprehensive care plan for the use of the call bell to meet their needs.

Resident # 8 was admitted to the facility on 06/01/18 with diagnoses that included but were not limited to cerebral palsy (1), diabetes mellitus, (2), and hypertension (3).

Resident # 8's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 06/08/18, coded Resident # 8 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 13 - being cognitively intact for making daily decisions. Resident # 8 was coded as requiring limited to extensive assistance of one staff member for activities of daily living.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 83 On 09/11/18 04:10 p.m., an interview was conducted with Resident # 8 in her room. Resident # 8 was lying in her bed in a diagonal position, with her feet at the bottom left corner of the bed and her head, in upper right corner lying flat on the mattress. Two pillows were directly on the mattress to the left of Resident #8's head. Observation of the call bell revealed it was hanging over the left side of the head board of Resident # 8's bed with the activation switch toward the inside of the bed. Further observation of the room revealed the over-the-bed table, was positioned parallel to the left side of the bed. The over-the-bed table contained three water bottles with water in each of them. When asked to activate the call bell Resident # 8 partially extended her right arm and stated, "I can't reach it. It's always difficult to reach the call bell." When asked if she could reach and obtain the water bottle on the over-the-bed table, Resident # 8 partially extended her right arm and stated, "I can't reach it." During the course of the interview, a telephone rang in Resident # 8's room. When asked if that was her phone ringing Resident # 8 stated, "It my cell phone." Resident # 8's cell phone was located on a bedside table at the foot of the bed in front of the window in the room. When asked if she wanted to answer her cell phone, Resident # 8 stated, "That's another problem. I can't get to my cell phone to answer it too." When asked how she gets assistance when she cannot reach the call bell, Resident # 8 stated, "I yell or I have to ask my roommate a lot of the time to put her call bell on." When how it made her feel to have to yell to get assistance and not having access to her personal cell phone, Resident # 8 stated, "It's just the way it is." When asked about her position in the bed Resident # 8 stated she was uncomfortable. When asked	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 84 about being put to bed Resident # 8 stated she was assisted by one staff member and "They seemed to be in a hurry." When asked about how she felt, Resident # 8 stated, "It makes me uncomfortable." On 09/12/18 at 8:00 a.m., an observation conducted of Resident # 8 and her room, revealed Resident # 8 was lying in bed. An observation of the call bell revealed it was hanging over the left side of the head board of Resident # 8's bed with the activation switch toward the inside of the bed. Further observation of the room revealed the over-the- bed- table position parallel to the left side of the bed. The over-the-bed table contained three water bottles with water in each of them. When asked to reach for and activate the call bell, Resident # 8 stated, "I can't reach it." Observation of Resident # 8's cell phone revealed it was located on a bedside table at the foot of the bed in front the window in the room, out of Resident # 8's reach. Resident # 8 stated she was unable to reach her water bottles. 09/13/18, 8:30 a.m., observation of Resident # 8 and her room revealed Resident # 8 was lying in bed. An observation of the call bell revealed it was hanging over the left side of the head board of Resident # 8 bed with the activation switch toward the inside of the bed. Further observation of the room revealed the over-the-bed-table position parallel to the left side of the bed. The over-the-bed table contained three water bottles with water in each of them. When asked to reach for and activate the call bell, Resident # 8 stated, "I can't reach it." Observation of Resident # 8's cell phone revealed it was located on a bedside	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

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

table at the foot of the bed in front the window in the room out of Resident # 8's reach. Resident # 8 stated she was unable to reach her water bottles.

The comprehensive care plan for Resident # 8 dated 06/11/2018 documented, "Focus: The resident has alteration in musculoskeletal status." Under "Interventions" it documented, "Anticipate and meet needs. Be sure call light is within reach and respond promptly to all requests for assistance."

On 09/13/18 at approximately 11:00 a.m., an interview and observation of Resident # 8's room was conducted with LPN (licensed practical nurse) # 3. While observing the placement of the call bell, water bottles, and cell phone in Resident # 8's room with this surveyor, Resident # 8 stated she was unable to reach the call bell, the water bottles on the over-the-bed table and her personal cell phone. LPN # 3 stated the call bell, cell phone and water should have been within Resident # 8's reach. LPN # 3 then rearranged the over-the-bed table closer to Resident # 8 and put her cell phone where Resident # 8 could access it after asking Resident # 8 where she would prefer to have it and moved the call bell within Resident # 8's reach.

On 09/13/18 at approximately 12:40 p.m., an interview was conducted with LPN (licensed practical nurse) # 3 regarding care plans. When asked to describe the purpose of the care plan LPN # 3 stated, "The goals of the resident to be achieved." When asked about implementing the care plan LPN # 3 stated, "If it's on the care plan we should be following it." After being informed of the reviewing the care plan for Resident #8

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 86 LPN # 3 was asked if the care plan was being followed for Resident # 8's call and meeting her needs. LPN # 3 stated, "No." On 09/13/18 at approximately 5:55 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings. No further information was provided prior to exit. References: (1) A group of disorders that affect a person's ability to move and to maintain balance and posture. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/cerebralpalsy.html. (2) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm. (3) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html. 3. The facility staff failed to develop a comprehensive care plan to address the use of oxygen as prescribed by the physician for Resident #102. Resident #102 was admitted to the facility on 04/04/18 and readmitted on 08/07/18 with diagnoses that included but were not limited to: congestive heart failure (CHF), high blood	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 87 pressure, diabetes, and acute respiratory failure (A condition in which not enough oxygen passes from your lungs into your blood.) (1) The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 8/21/18 coded the resident as having a 14 out of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact to make daily decisions. Resident #102's most recent POS (physician order summary) dated 04/04/18 documented "Oxygen 2 liter a min (minute) via nasal cannula to keep O2 (oxygen) Sat's. (oxygen saturation) greater than 90% PRN (as needed) every shift for COPD (Chronic Obstructive pulmonary Disease*)" Review of Resident #102's comprehensive care plan with a quarterly revision dated 09/04/18 failed to evidence any reference to oxygen use by Resident #102. On 09/11/18 at approximately 11:29 a.m., Resident #102 was observed wearing a nasal cannula with oxygen being delivered at 2 liters/minute as read on oxygen flow meter of the oxygen concentrator. On 09/13/18 at approximately 9:36 a.m., an interview was conducted with LPN (Licensed Practical Nurse) #1, regarding when a care plan needs to be updated. LPN #1 stated when anything major changes with the resident like a new diagnosis or behavior. LPN #1 was asked if a resident ' s use of oxygen would be care planned, LPN #1 stated, "Yes."	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 88 On 09/13/18 at approximately 12:18 p.m., an interview was conducted with LPN #7. LPN #7 was asked if a resident uses oxygen should that be included on their care plan, LPN #7 responded "Yes." When asked why oxygen should be included on the comprehensive care plan, LPN#7 stated, "If they try to wean themselves off we would put that on the care plan and we would want to know the amount (Of oxygen). LPN #7 was then asked to find oxygen on Resident #102's care plan. LPN #2 stated, "I don't see it." On 09/13/18 at approximately 4:50 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concern. No further information was obtained prior to exit.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 89 and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, it was determined that facility staff failed to review and revise the comprehensive care plan for one of 35 residents in the survey sample, Resident #113. The facility staff failed to revise Resident #113's comprehensive care plan after the resident had a seizure on 8/6/18. The findings include: Resident #113 was admitted to the facility on 5/21/18 and readmitted on 8/9/18 with diagnoses that included but not limited to: aphasia (A disorder caused by damage to the parts of the brain that control language. It can make it hard for you to read, write, and say what you mean to say.) (1), cerebral infarction (stroke), heart failure (A condition in which the heart can't pump enough blood to meet the body's needs.) (2) The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 8/18/18 coded the resident as having a score of 99 on the BIMS (brief interview	F 657	F 657 Care Plan Timing and Revision 1. **Resident #113** care plan was updated to include aphasia and Cerebral infarct. 2. The Assistant Director of Nursing /MDS coordinator will adjust all care plans to reflect any changes in the care of the residents as clinically indicated. 3. The daily morning clinical meetings will include immediate updating of any care plans that are reflected on the 24hr report or Risk Management meetings. 4. A daily audit of care plans to ensure all changes of conditions that occur are reflected and updated in the resident's care plans. Daily audits by Nurse Unit Managers starting October 1st x 3 months November and December. This practice will be formally integrated into the morning clinical meetings. Compliance and analysis of the data reported to the QA committee monthly x 6months October, November, December 2018 January, February and March 2019 5. The facility dutifully alleges compliance of these tasks on or before 10/28/18.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 90	F 657		

for mental status) indicating the resident was unable to complete the interview. Resident # 113 was coded as moderately impaired for cognitive skills for daily decision making.

Review of Resident #113's clinical record revealed a nursing note dated 8/6/18 that documented the following: "Resident observed by this nurse on bed having grand mal seizure for approximately 2 minutes. Observed throughout. Remained unresponsive for several minutes following seizure. Vital signs unremarkable. Call placed to (Name of Doctor); orders received to send resident to ER (emergency room). Resident becoming responsive when EMS (Emergency Medical Service) arrived; exited facility at 0940 a.m. Resident sent to (Name of hospital). Responsible party notified with each event."

Review of Resident #113 clinical record included a hospital discharge summary dated 8/9/18, that documented Resident #113 presented from the facility following a new onset "tonic-clonic seizure"(3) that lasted "2-3 minutes than a postictal. Of 10-15 minutes". The reviewed plan section documented Resident #113 was started on Keppra (Levetiracetam, an anti-seizure medication) during this admission.

Resident #113's most recent POS (physician order summary) dated 8/9/18 documented "Levetiracetam tablet 500 mg (milligrams) give 1 tablet through G- tube (Gastrostomy tube) two times a day for seizures."

The medication administration record (MAR) dated August and September 2018 documented "Levetiracetam tablet 500 mg give 1 tablet through G-tube two times a day for seizures."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 91 Review of Resident #113's care plan with a quarterly revision dated 9/11/18 failed to evidence any reference to Resident #113's new diagnosis of seizure or the new medication the physician prescribed for Resident #113 for seizure prevention. On 09/13/18 at approximately 9:36 a.m., an interview was conducted with LPN (Licensed Practical Nurse) #1. LPN #1 was asked when care plans are updated. LPN #1 stated when anything major changes with the resident like a new diagnosis or behavior. LPN #1 was asked if a resident transfer to the hospital for a seizure would be on a care plan, LPN #1 stated, "Yes." On 09/13/18 at approximately 12:18 p.m., an interview was conducted with LPN #7. LPN #7 was asked if a resident's comprehensive care plan should be updated after a new diagnosis of seizure, LPN #7 stated, "Yes." When asked to locate seizures on Resident #113's comprehensive care plan, LPN #7 stated, "I don't see it." The facility policy titled, "Care Planning and Discharge Planning" documented, "The comprehensive person- centered care plan will be reviewed and revised as appropriate after each OBRA (Omnibus Budget Reconciliation Act) assessment." On 09/13/18 at approximately 4:50 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns.	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 92 No further information was presented prior to exit. 1. This information was obtained from the website: https://medlineplus.gov/epilepsy.html. 2. This information was obtained from the website: https://medlineplus.gov/heartdiseases.html. 3. Generalized tonic-clonic seizure is type of seizure that involves the entire body. It is also called grand mal seizure. The terms seizure, convulsion, or epilepsy are most often associated with generalized tonic-clonic seizures. This information was obtained from the website:https://medlineplus.gov/ency/article/000695.htm	F 657		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, it was determined the facility staff failed to follow professional standards of practice for four of 37 residents in the survey sample, Residents #39, #117, #115 and #77. 1. The facility staff failed to transcribe Resident #39's physicians order for laboratory (lab) work. 2. The facility staff failed to clarify physician's orders for Resident #117's two as needed pain	F 658	F 658 Services Provided Meet Professional Standards 1. **Resident #117**- The physician's order for pain medication was clarified **Resident 115**- The physician's order for pain medication was rectified **Resident #39** The order for lab work was rectified **Resident #77** The physician's order for the two pain medications were clarified 2. All facility residents' e-mars will be reviewed for accuracy of pain medications by Nurses receiving the order	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 93 medications to determine when and which as needed pain medication should be administered. 1. The facility staff failed to clarify the physician's orders for pain medication for Resident#115. 2. The facility staff failed to clarify the physician orders for two pain medications for Resident # 77. The findings include: 1. The facility staff failed to transcribe Resident #39's physicians order for laboratory (lab) work. Resident #39 was admitted to the facility on 1/21/18 with diagnoses that included but were not limited to: subarachnoid hemorrhage [subarachnoid hemorrhage (SAH) is bleeding into the brain from a ruptured cerebral aneurysm or head trauma. SAH is a form of a stroke. (1)], pneumonia, dementia, and history of falling. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 7/14/18, coded the resident as having both short and long-term memory difficulties. The resident was coded as requiring extensive assistance of one staff member for all of his activities of daily living except eating in which he required supervision after set up help was provided. A telephone physician order dated, 7/9/18, documented, "Na+ (sodium) tabs (tablets) 1 gram BID (twice a day) dx [diagnosis] - hyponatremia (lower than normal concentration of sodium in the blood) (2). BMP [basic metabolic panel (2)] in 1	F 658	F 658 Services Provided Meet Professional Standards continued from page 98 3. All new orders will be reviewed by the 11-7 shift and the audit reviewed at the morning clinical meeting. All new medications will be documented on the 24hr report 4. All facility nursing staff will be educated on the accurate transcription of physician's orders Physicians and Nurse practitioners will be informed of the expectations when writing orders that include different dosages for pain medication. All new orders will be reviewed by the ADONs at morning clinical meetings. The resident's chart will be brought to morning clinical to ensure accuracy of information A facility wide review of all orders for accuracy will be conducted and completed by October 28th, 2018 The result of this audit will be reviewed at the QA monthly meeting. 5. The facility dutifully alleges compliance with these tasks on or before 10/28/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 94	F 658		

week." There was nothing documented on the line, "Signature of Nursing Receiving Order."

Review of the clinical record failed to evidence the laboratory test results for the BMP as ordered by the physician.

Review of the comprehensive care plan, dated 3/17/18, revised on 7/20/18, failed to evidence documentation of the hyponatremia.

On 9/13/18 at approximately 9:45 a.m., OSM (other staff member) #5, the ward clerk stated she had access to the laboratory results on the computer. She proceeded to access the laboratory website and could only locate the laboratory results for 7/6/18 and 8/16/18. There were no results for one week after 7/9/18, which would have been around 7/16/18.

On 9/13/18 at approximately 9:50 a.m., LPN (licensed practical nurse) # 4 stated she could not locate the laboratory test results and that they weren't done.

On 9/13/18 at 10:03 a.m. LPN #2, the unit manager, reviewed the telephone order with this surveyor and stated, "The order doesn't look like it was taken off." At 10:17 a.m., after researching this concern, LPN #2 stated it doesn't look like I have anything (laboratory results) related to that order.

The facility policy, "Medication and Treatment Orders" failed to evidence the steps to take to transcribe a physician order. The facility policy, "Lab and Diagnostic Test Results - Clinical Protocol" documented in part, "2. The staff will process test requisitions and arrange for tests.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 95 The ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the above concern on 9/13/18 at 4:56 p.m. On 9/13/18 at 6:21 p.m., ASM #2, the director of nursing stated the facility follows their policy and procedures as their standard of practice. No further information was provided prior to exit. (1) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pubmedhealth/?term=Subarachnoid+hemorrhage (2) The basic metabolic panel (BMP) is a group of blood tests that provides information about your body's metabolism. Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 285. (3) This information was obtained from the following website: http://www.nlm.nih.gov/medlineplus/ency/article/003462.htm 2. The facility staff failed to clarify physician's orders for Resident #117's two as needed pain to determine which, and when each as needed pain medication should be administered. Resident #117 was admitted to the facility to 12/6/17 with a readmission on 1/25/18 with diagnoses that included but were not limited to: pain in right shoulder, depression, high blood pressure, atrial fibrillation [a condition	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 96 characterized by rapid and random contraction of the atria of the heart causing irregular beats of the ventricles and resulting in decreased heart output and frequently clot formation in the atria (1)], and malnutrition. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 8/29/18, coded the resident as scoring an "11" on the BIMS (brief interview for mental status) score indicating she was moderately impaired to make daily cognitive decisions. The resident was coded as having periods of inattention and disorganized thinking. Resident #117 was coded as requiring supervision of one staff member for all of her activities of daily living. The physician order summary documented, "Acetaminophen (Tylenol) [Tylenol temporarily relieves minor aches and pains (2)] 325 MG (milligrams); Give 3 tablets by mouth every 6 hours as needed for pain." This order was dated 12/12/17. The physician orders documented, "Tramadol Tablet [Used to relieve moderate to moderately severe pain. (3)] 50 MG; Give 50 mg by mouth every 6 hours as needed for headache/pain." This order was dated 6/11/18. The August 2018 MAR (medication administration record) documented the above medications. The Tylenol was documented as given on 8/13/18 for a pain level of "6." The Tramadol was documented as given on the following dates: 8/3/18 at 9:51 a.m. for a pain level of "9." 8/9/18 at 9:28 p.m. for a pain level of "6." 8/18/18 at 7:59 p.m. for a pain level of "5." 8/26/18 at 8:03 a.m. for a pain level of "7." 8/27/18 at 4:15 p.m. for a pain level of "7."	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 97 The September 2018 MAR documented the resident did not receive any Tylenol or Tramadol . The comprehensive care plan dated as revised on 9/11/18, documented i part, "Focus: (Resident #117) is at risk for pain." The "Interventions" documented in part, "Anticipate the resident's need for pain relief and respond immediately to any complaint of pain. Identify and record previous pain history and management of that pain and impact on function. Identify previous response to analgesia including pain relief, side effect and impact on function. Monitor/document for probable cause of each pain episode. Remove/limit causes where possible." An interview was conducted with LPN (licensed practical nurse) #2, the unit manager; on 9/12/18 at 3:08 p.m., LPN #2 was asked to review the above orders for Tylenol and Tramadol. When asked how staff know which as needed pain medication should be administered, LPN #2 stated she would start with the Tylenol and if that's not working I'd call the doctor so I don't go over the grams per day." LPN #2 stated the order should state moderate or mild pain. I would need to talk to the doctor or clarify the order." The facility policy, "Medication and Treatment Orders," documented in part, "9. Orders for medications must include: a. Name and strength of the drug. b. Number of doses, start and stop date, and/or specific duration of therapy. c. Dosage and frequency of administration. d. Route of administration. e. Clinical condition or symptoms for which the medication is prescribed."	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 98 According to Fundamentals of Nursing, 6th edition Potter and Perry, 2005, page 846, " A medication order is required for any medication to be administered by a nurse...If the medication order is incomplete, the nurse should inform the prescriber and ensure completeness before carrying out any medication order." The administrator and director of nursing were made aware of the above concern on 9/13/18 at 4:56 p.m. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 55. (2) This information was obtained from the following website: https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?setid=1622f694-4d63-4c56-8737-fae31f0ecfb7 (3) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a695011.html. 3. The facility staff failed to clarify the physician's orders for two as needed pain medication for Resident #115 to determine when and which as needed pain medication should be administered. Resident #115 was admitted to the facility on 8/18/18 with diagnoses that included but were not limited to: pancreatitis, diabetes, hypertension, heart failure and encephalopathy [a disease of the brain which affects the brain's ability to	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 99 function (1)]. The most recent MDS (minimum data set) assessment, a Medicare 14 day assessment, with an assessment reference date of 9/1/18, coded the resident as scoring a "14" on the BIMS (brief interview for mental status) score, indicating he has no cognitive impairment for daily decision making. The resident was coded as requiring extensive assistance of at least one staff members for bed mobility, transfers, dressing, toileting, and personal hygiene. In Section N - Medications, the resident was coded as using opioids during the look back period. The physician order dated, 8/19/18, documented, "Acetaminophen [A class of medications called analgesics (pain relievers) and antipyretics (fever reducers). It is used to relieve mild to moderate pain. (1)] Tablet 650 mg (milligram): Give 650 mg by mouth every 4 hours as needed for general discomfort." The physician order dated 8/31/18, documented: "Oxycodone-Acetaminophen Tablet 5-325 [a hydrocodone and acetaminophen combination product used to relieve moderate-to-severe pain. It is in a class of medications called opiate (narcotic) analgesics (2)] mg: Give 1 tablet by mouth every 6 hours as needed for pain." Neither order documented which pain medication should be used based on the resident's pain level. The September 2018 MAR (medication administration record) documented the above physician orders. The Oxycodone-Acetaminophen 5-325 was documented as having been administered on 9/1/18 at 8:55 a.m. for a pain level of 8 and at 4:01 p.m. for a pain level of 9; on 9/2/18 at 4:30	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 100	F 658		

a.m. for a pain level of 9 and at 4:59 p.m. for a pain level of 8; on 9/3/18 at 1:24 a.m. for a pain level of 8 and at 11:00 a.m. for a pain level of 7; on 9/6/18 at 1:13 a.m. for a pain level of 6 and at 8:20 p.m. for a pain level of 5; on 9/7/18 at 4:05 p.m. for a pain level of 7 and at 11:30 p.m. for a pain level of 9; on 9/10/18 at 8:49 p.m. for a pain level of 4; on 9/11/18 at 5:01 p.m. for a pain level of 7; and on 9/12/18 at 11:30 a.m. for a pain level of 7.

The September 2018 MAR documented the above physician order. The Acetaminophen was documented as having been administered on 9/1/18 at 6:50 a.m. for a pain level of 6.

The comprehensive care plan dated 8/21/18, with a most recent revision date of 9/11/18, documented in part, "Focus: The resident is at risk for pain." The "Interventions" documented in part, "Anticipate the resident's need for pain relief and respond immediately to any complaint of pain".

An interview was conducted with LPN (licensed practical nurse) #3 on 9/13/18 at 12:40 p.m. When asked how staff determine which pain medication to give a resident when the resident has multiple orders for as needed pain medications, LPN #3 stated, "We ask them the pain level or to number the pain they are having." When asked to review the above order for Oxycodone-Acetaminophen 5-325 and Acetaminophen, LPN #3 stated, "We need to ask the doctor to clarify which level of pain requires which pain medication."

ASM (administrative staff member) #1, the administrator, and ASM #2, the director of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 101 nursing, were made aware of the above findings on 9/13/18 at 4:55 p.m. According to "Lippincott Manual of Nursing Practice", Eighth Edition: by Lippincott Williams & Wilkins, pg. 87 read: "Nursing Alert: Unusual dosages or unfamiliar drugs should always be confirmed with the health care provider and pharmacist before administration." On pg. 15, the following is documented in part, "Inappropriate Orders: 2. Although you cannot automatically follow an order you think is unsafe, you cannot just ignore a medical order, either. b. .. Call the attending physician, discuss your concerns with him, obtain appropriate ...orders. c. Notify all involved medical and nursing personnel.... d. Document clearly." No further information was provided prior to exit. 1) This information was obtained from the National Institutes of Health at https://medlineplus.gov/druginfo/meds/a681004.html 2) This information was obtained from the National Institutes of Health at https://medlineplus.gov/druginfo/meds/a601006.html 4. The facility staff failed to clarify the physician's orders for Resident # 77's two as needed pain medications to determine when and which medication to administer. Resident # 77 was admitted to the facility on 10/25/2016 with diagnoses that included but were not limited to: kidney failure (1), dysphagia (2),	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 102 anemia (3) and anxiety (4). Resident # 77's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 08/04/18, coded Resident # 77 as scoring a 14 on the brief interview for mental status (BIMS) of a score of 0 - 15, 14 - being cognitively intact for making daily decisions. Resident # 77 was coded as being independent and requiring limited assistance of one staff member for activities of daily living . Section J0400 "Pain Frequency" coded Resident # 77 as "Almost constantly." The POS (physician's order sheet) dated 07/01/2018 - 09/30/2018 for Resident # 77 documented, "Hydro/Apap (Hydrocodone and acetaminophen [5]) 5-325MG (milligram). Give one tablet orally every 4 (four) hours as needed for pain. Order Status: Active. Order Date: 02/01/2018." "Ibuprofen (6) TAB (tablet) 400MG. Give 1 (one) tablet orally every 6 (six) hours as needed for pain. Order Status: Active. Order Date: 11/16/2017." The eMAR (electronic medication administration record) dated July 2018 documented, the above physician's orders. Further review of the July eMAR revealed Ibuprofen 400MG was not administered from 07/01/18 through 07/31/18 and Hydro/Apap 5-325MG was administered on the following dates: "07/04/18 at 9:49 p.m. with a pain level of 3. 07/05/18 at 6:50 p.m. with a pain level of 5. 07/06/18 at 1:36 p.m. with a pain level of 7. 07/08/18 at 8:31 p.m. with a pain level of 7. 07/09/18 at 1:22 p.m. with a pain level of 5.	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 103 07/11/18 at 7:00 p.m. with a pain level of 3. 07/14/18 at 2:00 p.m. with a pain level of 5. 07/15/18 at 6:34 p.m. with a pain level of 5. 07/17/18 at 12:59 a.m. with a pain level of 8 and at 2:54 p.m. with a pain level of 6. 07/18/18 at 5:15 p.m. with a pain level of 2. 07/19/18 at 11:53 p.m. with a pain level of 8. 07/20/18 at 1:15 p.m. with a pain level of 7 and at 8:22 p.m. with a pain level of 5. 07/21/18 at 9:22 a.m. with a pain level of 4 and at 6:56 p.m. with a pain level of 2. 07/22/18 at 4:10 p.m. with a pain level of 5. 07/23/18 at 10:19 a.m. with a pain level of 6. 07/24/18 at 10:33 a.m. with a pain level of 6 and at 4:24 p.m. with a pain level of 3. 07/25/18 at 3:45 p.m. with a pain level of 6. 07/26/18 at 10:25 a.m. with a pain level of 6. 07/29/18 at 12:09 a.m. with a pain level of 5 and at 1:30 p.m. with a pain level of 5. 07/30/18 at 11:53 a.m. with a pain level of 5 and at 5:12 p.m. with a pain level of 5. 07/31/18 at 11:55 p.m. with a pain level of 5." The eMAR (electronic medication administration record) dated August 2018 documented the above physician's orders. Further review of the August eMAR revealed Ibuprofen 400MG was administered on 08/31/18 at 5:20 p.m. and Hydro/Apap 5-325MG was administered on the following dates: "08/01/18 at 1:14 p.m. with a pain level of 5. 08/02/18 at 2:38 p.m. with a pain level of 5 and at 8:38 p.m. with a pain level of 6. 08/03/18 at 5:19 p.m. with a pain level of 6. 08/05/18 at 1:25 p.m. with a pain level of 5. 08/06/18 at 11:53 a.m. with a pain level of 8 and at 4:08 p.m. with a pain level of 8. 08/07/18 at 8:05 p.m. with a pain level of 5. 08/19/18 at 10:22 a.m. with a pain level of 5.	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 104 08/20/18 at 10:17 a.m. with a pain level of 8. 08/21/18 at 7:59 p.m. with a pain level of 5. 08/24/18 at 8:43 p.m. with a pain level of 10. 08/25/18 at 5:02 p.m. with a pain level of 6." The eMAR (electronic medication administration record) dated September 2018 documented the above physician's orders. Further review of the August eMAR revealed Ibuprofen 400MG was not administered from 09/01/18 through 09/12/18 and Hydro/Apap 5-325MG was administered on the following dates: "09/02/18 at 5:27 a.m. with a pain level of 3. 09/03/18 at 9:59 p.m. with a pain level of 8. 09/10/18 at 5:20 a.m. with a pain level of 5. 09/11/18 at 3:24 p.m. with a pain level of 5." On 09/13/18 at 12:40 a.m., an interview was conducted with LPN (licensed practical nurse) # 3. When asked to describe the procedure for administering prn (as needed) pain medication, LPN # 3 stated, "Get the location of the pain, the pain level zero to ten, sign out the medication, administer it, recheck the resident's pain in 30 minutes to an hour." When asked about the procedure staff follows regarding two prn pain medications without parameters, LPN # 3 stated, "I would get clarification from the physician." After reviewing the POS and EMARs for Resident # 77 dated July, August and September 2018, LPN # 3 was asked if there were parameters for the medication. LPN # 3 stated, "No." When asked which prn pain medication should be administered LPN # 3stated, "The order should have been clarified." On 09/13/18 at approximately 5:55 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 105 were made aware of the findings. No further information was provided prior to exit. References: (1) If your kidneys fail, you need treatment to replace the work they normally do. The treatment options are dialysis or a kidney transplant. Each treatment has benefits and drawbacks. No matter which treatment you choose, you'll need to make some changes in your life, including how you eat and plan your activities. But with the help of health care providers, family, and friends, most people with kidney failure can lead full and active lives. This information was obtained from the website: https: https://medlineplus.gov/kidneyfailure.html. (2) A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html. (3) Low iron. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anemia.html . (4) Fear. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html #summary. (5) Hydrocodone is available in combination with other ingredients, and different combination products are prescribed for different uses. Some hydrocodone combination products are used to relieve moderate-to-severe pain. Other hydrocodone combination products are used to	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 106 relieve cough. Hydrocodone is in a class of medications called opiate (narcotic) analgesics and in a class of medications called antitussives. Hydrocodone relieves pain by changing the way the brain and nervous system respond to pain. Hydrocodone relieves cough by decreasing activity in the part of the brain that causes coughing. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a601006.html. (6) Prescription ibuprofen is used to relieve pain, tenderness, swelling, and stiffness caused by osteoarthritis (arthritis caused by a breakdown of the lining of the joints) and rheumatoid arthritis (arthritis caused by swelling of the lining of the joints). It is also used to relieve mild to moderate pain, including menstrual pain (pain that happens before or during a menstrual period). This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682159.html.	F 658		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review	F 684	F 684 Quality of Care 1. **Resident #39–** The facility failed to follow physician's orders to obtain the laboratory tests' **Resident # 60-** The facility failed to obtain the laboratory tests 2. A facility wide audit of lab orders received, and identification of any deficient practice will be conducted by October 28th 2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 107 and clinical record review, it was determined the facility staff failed to obtain laboratory tests as ordered by the physician for two of 37 residents in the survey sample, Resident #39 and #60. 1. The facility staff failed to follow physician orders to obtain the laboratory tests for Resident #39. 2. The facility staff failed to follow physician orders to obtain the laboratory tests for Resident #60. The findings include: 1. The facility staff failed to follow physician orders to obtain the laboratory tests for Resident #39. Resident #39 was admitted to the facility on 1/21/18 with diagnoses that included but were not limited to: subarachnoid hemorrhage [subarachnoid hemorrhage (SAH) is bleeding into the brain from a ruptured cerebral aneurysm or head trauma. SAH is a form of a stroke. (1)], pneumonia, dementia, and history of falling. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 7/14/18, coded the resident as having both short and long-term memory difficulties. The resident was coded as requiring extensive assistance of one staff member for all of his activities of daily living except eating in which he required supervision after set up help was provided. A telephone physician order dated, 7/9/18, documented, "Na+ (sodium) tabs (tablets) 1 gram	F 684	F 684 Quality of Care continued from page 112 3. The revision of the policy and procedure for the management of lab orders in collaboration with the Lab will be completed by the ADON 4. Development of a lab book that addresses and rectifies all the deficient practices will be initiated by the Director of Nursing. An audit of lab orders daily x 1 month starting October 1st, 2018 and x3 months. Results and correction of deficient practice reported to the QA Committee monthly. 5. The facility dutifully alleges compliance of these tasks on or before 10/28/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 108	F 684		

BID (twice a day) dx [diagnosis] - hyponatremia (lower than normal concentration of sodium in the blood) (2). BMP [basic metabolic panel (2)] in 1 week." There was nothing documented on the line, "Signature of Nursing Receiving Order."

Review of the clinical record failed to evidence the laboratory test results for the BMP as ordered by the physician.

Review of the comprehensive care plan, dated 3/17/18, revised on 7/20/18, failed to evidence documentation of the hyponatremia.

On 9/13/18 at approximately 9:45 a.m., OSM (other staff member) #5, the ward clerk stated she had access to the laboratory results on the computer. She proceeded to access the laboratory website and could only locate the laboratory results for 7/6/18 and 8/16/18. There were no results for one week after 7/9/18, which would have been around 7/16/18.

On 9/13/18 at approximately 9:50 a.m., LPN (licensed practical nurse) # 4 stated she could not locate the laboratory test results and that they weren't done.

On 9/13/18 at 10:03 a.m. LPN #2, the unit manager, reviewed the telephone order with this surveyor and stated, "The order doesn't look like it was taken off." At 10:17 a.m., after researching this concern, LPN #2 stated it doesn't look like I have anything (laboratory results) related to that order.

The facility policy, "Medication and Treatment Orders" failed to evidence the steps to take to transcribe a physician order. The facility policy,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 109 "Lab and Diagnostic Test Results - Clinical Protocol" documented in part, "2. The staff will process test requisitions and arrange for tests. The ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the above concern on 9/13/18 at 4:56 p.m. The administrator and director of nursing were made aware of the above concern on 9/13/18 at 4:56 p.m. On 9/13/18 at 6:21 p.m., the director of nursing stated the facility follows their policy and procedures as their standard of practice. In "Fundamentals of Nursing" 6th edition, 2005; Patricia A. Potter and Anne Griffin Perry; Mosby, Inc.; Page 419. "The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm clients." No further information was provided prior to exit. (1) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pubmedhealth/?term=Subarachnoid+hemorrhage (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 285. (3) This information was obtained from the following website: http://www.nlm.nih.gov/medlineplus/ency/article/003462.htm	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 110	F 684		

2. The facility staff failed to follow physician orders to obtain the laboratory tests for Resident #60.

Resident #60 was admitted to the facility on 4/26/18 with diagnoses that included but were not limited to Schizophrenia [Any of a group of mental disorders characterized by gross distortions of reality, withdrawal of thought, language, perception and emotional response. (1)], dementia, high blood pressure, and Bipolar Disorder [a mental disorder characterized by episodes of mania and depression. (2)].

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 7/30/18, coded the resident as scoring a "9" on the BIMS (brief interview for mental status) score, indicating he was moderately impaired to make cognitive daily decisions. The resident was coded as having periods of inattention and having episodes of verbal behavior directed toward others that occurred every one to three days. Resident #60 was coded as requiring extensive assistance of one or more staff members for all his activities of daily living except eating in which he only required supervision after set up assistance was provided.

The physician order dated, 6/1/18, documented, "CBC [A complete blood count test measures the following: The number of red blood cells (RBC count) the number of white blood cells (WBC count) (3)] + (plus) VPA (valproic acid) level in 1 week d/t (due to) Depakote (valproic acid) [used to treat seizures, Bipolar Disorder and prevent migraine headaches (4)].

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 111 The physician order dated, 8/1/18, documented in part, "1. Two view CXR (chest x-ray) - fever/AMS (altered mental status). 3. Labs (laboratory tests) ASAP (as soon as possible): CBC, BMP (basic metabolic panel). [The basic metabolic panel (BMP) is a group of blood tests that provides information about your body's metabolism (5)]. Review of the clinical record failed to evidence documentation of the physician ordered laboratory tests ordered on 6/1/18. There was a laboratory report with the above ordered tests, CBC and VPA level dated, 6/22/18, 21 days after the order was written. On 9/13/18, at 10:45 a.m., LPN (licensed practical nurse) #2, the unit manager, presented a "Laboratory Services Log" dated 6/8/18 that documented the resident refused the blood draw. A "Missed Draw Sheet" documented the "Reason for Missed Draw," refused and combative were checked." The form documented "Will Return for re-draw: 6/11/18." No further documentation was provided for the dates of 6/11/18 until the results of 6/22/18. Review of the clinical record revealed a laboratory test results dated, 8/6/18 with the test results ordered by the physician on 8/1/18. A nurse's note dated, 8/3/18 at 3:55 p.m. documented in part, "CBC, BMP every shift for 1 day unable to draw blood rescheduled on Monday." There were no other notes documented related to the physician ordered laboratory tests between the order of 8/1/18 and the results of 8/6/18. An interview was conducted with LPN #2 on 9/13/18 at 11:02 a.m. When asked how often	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 112	F 684		

laboratory tests are drawn, LPN #2 stated they are drawn on a Monday, Wednesday and Fridays." When asked if the above laboratory tests were drawn according to the physician order, LPN #2 stated, "No, they weren't and I can't find anything that states why they were late." When asked what it meant when the physician orders labs ASAP, LPN #2 stated, "Right away. I checked with the hospital to see if they were drawn there but I have no further information to provide to you."

The facility policy, "Lab and Diagnostic Test Results - Clinical Protocol" documented in part, "2. The staff will process test requisitions and arrange for tests."

The administrator and director of nursing were made aware of the above concern on 9/13/18 at 4:56 p.m.

No further information was provided prior to exit.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 522. .
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 72. .
(3) This information was obtained from the following website: http://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&query=CBC&x=24&y=17.
(4) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0012594/?report=details.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 113	F 697		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview, and clinical record review, it was determined the facility staff failed to ensure a comprehensive pain management program for two of 37 resident in the survey sample, Resident #117 and Resident # 77. 1. The facility staff failed to attempt non-pharmacological interventions prior to the administration of pain medication for Resident #117. 2. The facility staff failed to attempt non-pharmacological interventions prior to the administration of as needed pain medication for Resident # 77. The findings include: 1. The facility staff failed to attempt non-pharmacological interventions prior to the administration of pain medication for Resident #117. Resident #117 was admitted to the facility to 12/6/17 with a readmission on 1/25/18 with diagnoses that included but were not limited to: pain in right shoulder, depression, high blood pressure, atrial fibrillation [a condition	F 697	F 697 Pain Management 1. **Resident #117**- The facility staff failed to attempt non-pharmacological interventions prior to the administration of pain medication. **Resident #77**- The facility staff failed to attempt non-pharmacological interventions prior to the administration of as needed pain medication 2. Review of 100% of the E-Mars to determine the % of residents who have pain medications ordered and who will be potentially affected by the same deficient practice. A list will be developed for auditing. 3. Facility staff will receive reeducation by the Assistant Director of Nursing on what constitutes a non-pharmacological intervention and the documentation of these interventions and outcomes prior to the administration of pain medications.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 114 characterized by rapid and random contraction of the atria of the heart causing irregular beats of the ventricles and resulting in decreased heart output and frequently clot formation in the atria (1)], and malnutrition. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 8/29/18, coded the resident as scoring an "11" on the BIMS (brief interview for mental status) score indicating she was moderately impaired to make daily cognitive decisions. The resident was coded as having periods of inattention and disorganized thinking. Resident #117 was coded as requiring supervision of one staff member for all of her activities of daily living. The physician order summary documented, "Acetaminophen (Tylenol) (temporarily relieves minor aches and pains) (2) 325 MG (milligrams); Give 3 tablets by mouth every 6 hours as needed for pain." This order was dated 12/12/17. The physician orders documented, "Tramadol Tablet (Used to relieve moderate to moderately severe pain.(3) 50 MG; Give 50 mg by mouth every 6 hours as needed for headache/pain." This order was dated 6/11/18. The August 2018 MAR (medication administration record) documented the above medications. The Tylenol was documented as having been given on 8/13/18 for a pain level of "6." The Tramadol was documented as having been given for the following dates: 8/3/18 at 9:51 a.m. for a pain level of "9." 8/9/18 at 9:28 p.m. for a pain level of "6." 8/18/18 at 7:59 p.m. for a pain level of "5." 8/26/18 at 8:03 a.m. for a pain level of "7."	F 697	F 697 Pain Management continued from page 119 4. Audits of the e-mar on the patients identified as routinely receiving pain medications will be conducted by the Unit Managers or designee. Completion of the in-service education by the ADON will be presented at the October QA Meeting and at monthly QA meetings x 3 months November, December and January 2018 Facility-wide audit of e-mars will be completed to ensure that nurses are documenting non-pharmacological interventions prior to the administration of pain meds. To be Completed by October 28th, 2018. 5. The facility dutifully alleges compliance with these tasks on or before 10/28/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 115 8/27/18 at 4:15 p.m. for a pain level of "7." The September 2018 MAR documented the resident did not receive any Tylenol or Tramadol . The comprehensive care plan dated as revised on 9/11/18, documented i part, "Focus: (Resident #117) is at risk for pain." The "Interventions" documented in part, "Anticipate the resident's need for pain relief and respond immediately to any complaint of pain. Identify and record previous pain history and management of that pain and impact on function. Identify previous response to analgesia including pain relief, side effect and impact on function. Monitor/document for probable cause of each pain episode. Remove/limit causes where possible." The nurse's notes were reviewed for August and September 2018 and failed to evidence documentation of the non-pharmacological interventions that were attempted prior to the administration of the pain medications. An interview was conducted with LPN #6 on 9/12/18 at 5:20 p.m. LPN #6 was about the process staff follows when a resident complains of pain, LPN #6 stated, "I first would assess the pain, do a touch assessment, then check to see what medications they have ordered. If they don't have anything ordered I'd call the doctor and get an order. I'd call the family if there was a new order." LPN #6 stated, "If they can't tell me I would try to redirect them or reposition them to see if that helps." When asked where the things attempted before administering the medication are documented, LPN #6 stated, "In the nurse's notes." The nurse's notes for Resident # 117 were reviewed with LPN #6, there was no	F 697		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 116 documented evidence of non-pharmacological interventions being attempted prior to the administration of pain medication. An interview was conducted with LPN #2, the unit manager, on 9/12/18 at 5:27 p.m., regarding the process staff follows when a resident complains of pain. LPN #2 stated, "I assess the pain, location, intensity and look for verbalizations or change in their face, grimacing, and take their vital signs. If there are no orders for pain management, I go to the standing orders, then give it or call the doctor if I feel it is more severe than what medication could handle." When asked if she tries anything prior to giving a medication, LPN #2 stated she tries relaxation, repositioning and even reads to them. When asked where the things attempted prior to administering the medication are documented, LPN #2 stated, "In the nurse's note. That's nursing 101. If it's not documented, it's not done." The administrator and director of nursing were made aware of the above concern on 9/13/18 at 4:56 p.m. No further information was provided prior to exit. 2. The facility staff failed to attempt non-pharmacological interventions prior to the administration of as needed pain medication for Resident # 77. Resident # 77 was admitted to the facility on 10/25/2016 with diagnoses that included but were not limited to: kidney failure (1), dysphagia (2), anemia (3) and anxiety (4). Resident # 77's most recent MDS (minimum data set), a quarterly assessment with an ARD	F 697		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 117 (assessment reference date) of 08/04/18, coded Resident # 77 as scoring a 14 on the brief interview for mental status (BIMS) of a score of 0 - 15, 14 - being cognitively intact for making daily decisions. Resident # 77 was coded as being independent and requiring limited assistance of one staff member for activities of daily living . Section J0400 "Pain Frequency" coded Resident # 77 as "Almost constantly." The POS (physician's order sheet) dated 07/01/2018 - 09/30/2018 for Resident # 77 documented, "Hydro/Apap (Hydrocodone and acetaminophen [5]) 5-325MG (milligram). Give one tablet orally every 4 (four) hours as needed for pain. Order Status: Active. Order Date: 02/01/2018." "Ibuprofen (6) TAB (tablet) 400MG. Give 1 (one) tablet orally every 6 (six) hours as needed for pain. Order Status: Active. Order Date: 11/16/2017." The eMAR (electronic medication administration record) dated July 2018 documented, The above physician's orders. Further review of the July eMAR revealed Ibuprofen 400MG was not administered from 07/01/18 through 07/31/18 and Hydro/Apap 5-325MG was administered on the following dates: "07/04/18 at 9:49 p.m. with a pain level of 3. 07/05/18 at 6:50 p.m. with a pain level of 5. 07/06/18 at 1:36 p.m. with a pain level of 7. 07/08/18 at 8:31 p.m. with a pain level of 7. 07/09/18 at 1:22 p.m. with a pain level of 5. 07/11/18 at 7:00 p.m. with a pain level of 3. 07/14/18 at 2:00 p.m. with a pain level of 5. 07/15/18 at 6:34 p.m. with a pain level of 5. 07/17/18 at 12:59 a.m. with a pain level of 8 and at 2:54 p.m. with a pain level of 6.	F 697		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 118 07/18/18 at 5:15 p.m. with a pain level of 2. 07/19/18 at 11:53 p.m. with a pain level of 8. 07/20/18 at 1:15 p.m. with a pain level of 7 and at 8:22 p.m. with a pain level of 5. 07/21/18 at 9:22 a.m. with a pain level of 4 and at 6:56 p.m. with a pain level of 2. 07/22/18 at 4:10 p.m. with a pain level of 5. 07/23/18 at 10:19 a.m. with a pain level of 6. 07/24/18 at 10:33 a.m. with a pain level of 6 and at 4:24 p.m. with a pain level of 3. 07/25/18 at 3:45 p.m. with a pain level of 6. 07/26/18 at 10:25 a.m. with a pain level of 6. 07/29/18 at 12:09 a.m. with a pain level of 5 and at 1:30 p.m. with a pain level of 5. 07/30/18 at 11:53 a.m. with a pain level of 5 and at 5:12 p.m. with a pain level of 5. 07/31/18 at 11:55 p.m. with a pain level of 5." The eMAR (electronic medication administration record) dated August 2018 documented, the above physician's orders. Further review of the August eMAR revealed Ibuprofen 400MG was administered on 08/31/18 at 5:20 p.m. and Hydro/Apap 5-325MG was administered on the following dates: "08/01/18 at 1:14 p.m. with a pain level of 5. 08/02/18 at 2:38 p.m. with a pain level of 5 and at 8:38 p.m. with a pain level of 6. 08/03/18 at 5:19 p.m. with a pain level of 6. 08/05/18 at 1:25 p.m. with a pain level of 5. 08/06/18 at 11:53 a.m. with a pain level of 8 and at 4:08 p.m. with a pain level of 8. 08/07/18 at 8:05 p.m. with a pain level of 5. 08/19/18 at 10:22 a.m. with a pain level of 5. 08/20/18 at 10:17 a.m. with a pain level of 8. 08/21/18 at 7:59 p.m. with a pain level of 5. 08/24/18 at 8:43 p.m. with a pain level of 10. 08/25/18 at 5:02 p.m. with a pain level of 6."	F 697		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 119 The eMAR (electronic medication administration record) dated September 2018 documented, "Hydro/Apap 5-325MG. Give one tablet orally every 4 (four) hours as needed for pain. Order Status: Active. Order Date: 02/01/2018." "Ibuprofen (6) TAB (tablet) 400MG. Give 1 tablet orally every 6 hours as needed for pain. Order Status: Active. Order Date: 11/16/2017." Further review of the August eMAR revealed Ibuprofen 400MG was not administered from 09/01/18 through 09/12/18 and Hydro/Apap 5-325MG was administered on: "09/02/18 at 5:27 a.m. with a pain level of 3. 09/03/18 at 9:59 p.m. with a pain level of 8. 09/10/18 at 5:20 a.m. with a pain level of 5. 09/11/18 at 3:24 p.m. with a pain level of 5." Review of the nurse's notes dated 07/10/18 through 09/12/18 failed to evidence any documentation non-pharmacological interventions were attempted prior to the administration of as needed pain medication for Resident # 77. An interview was conducted with LPN #6 on 9/12/18 at 5:20 p.m., regarding the process the staff follows when a resident complains of pain. LPN #6 stated, "I first would assess the pain, do a touch assessment, then check to see if what medications they have ordered. If they don't have anything ordered I'd call the doctor and get an order. I'd call the family if there was a new order." LPN #6 stated, "If they can't tell me I would try to redirect them or reposition them to see if that helps." When asked where the things attempted, before the administration of as needed pain medication are documented, LPN #6 stated, "In the nurse's notes." An interview was conducted with LPN #2, the unit	F 697		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 120 manager, on 9/12/18 at 5:27 p.m., regarding the process the staff follows when a resident complains of pain. LPN #2 stated, "I assess the pain, location, intensity and look for verbalization or change in their face, grimacing, and take their vital signs. If there are no orders for pain management, I go to the standing orders, then give it or call the doctor if I feel it is more severe than what medication could handle." When asked if she tries anything prior to giving a medication, LPN #2 stated she tries relaxation, repositioning and even reads to them. When asked where the things attempted prior to the administration of as needed pain medication are documented, LPN #2 stated, "In the nurse's note. That's nursing 101. If it's not documented, it's not done." On 09/13/18 at approximately 5:55 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings. No further information was provided prior to exit.	F 697		
F 773 SS=D	Lab Srvcs Physician Order/Notify of Results CFR(s): 483.50(a)(2)(i)(ii) §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per theordering	F 773		

F 773 Lab Services Physician Order/Notify Results

1. **Resident #39** had a physician's order for a BMP in 1 week for hyponatremia. There was nothing documented as the nurse receiving the order. No results were located. The staff indicated the lab ordered by the physician was not done. The revised care plan failed to document the new diagnosis.

   Resident #60- on 6/1/18, the physician ordered CBC and Valporic acid Level in 1 week due to Depakote. On 8/1/18, The physician ordered Labs ASAP- BMP and the clinical record showed that the CBC and VPA results were received 21 days after it was first ordered. The resident initially refused blood draw and there was a plan to re-draw on 6/11/18. No further documentation was received.

2. Facility staff will be in serviced on lab services and all the policies and procedures that govern lab services. All refusals of lab draws will be documented and reported to the ordering physician or nurse practitioner.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 773	Continued From page 121 physician's orders. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to ensure physician ordered laboratory tests were obtained as ordered for of two of 37 residents in the survey sample, Resident #39 and #60. 1. The facility staff failed to obtain the laboratory tests as ordered by the physician forResident #39. 2. The facility staff failed to obtain the laboratory tests as ordered by the physician forResident #60. The findings include: 1. The facility staff failed to obtain the laboratory tests as ordered by the physician for Resident #39. Resident #39 was admitted to the facility on 1/21/18 with diagnoses that included but were not limited to: subarachnoid hemorrhage [subarachnoid hemorrhage (SAH) is bleeding into the brain from a ruptured cerebral aneurysm or head trauma. SAH is a form of a stroke. (1)], pneumonia, dementia, and history of falling. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 7/14/18, coded the resident as having both short and long-term memory difficulties. The resident was coded as requiring extensive assistance of one staff member for all of his activities of daily living	F 773	F 773 Lab Services Physician Order/Notify Results continued from page 127 3. The entire administration of lab services will be reviewed by Nurse Administration by October 28th, 2018. Deficient practices will be corrected. 4. Facility nursing staff will be educated on diagnostics tests and laboratory services. Lab process and documentation will be audited daily for accuracy by ADON /nursing supervisor and compliance and analysis of the data reported to the QA committee monthly x 6months October, November, December 2018 January, February and March 2019. 5. The facility alleges compliance of these tasks on or before 10/28/18.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 773	Continued From page 122 except eating in which he required supervision after set up help was provided. A telephone physician order dated, 7/9/18, documented, "Na+ (sodium) tabs (tablets) 1 gram BID (twice a day) dx [diagnosis] - hyponatremia (lower than normal concentration of sodium in the blood) (2). BMP [basic metabolic panel (2)] in 1 week." There was nothing documented on the line, "Signature of Nursing Receiving Order." Review of the clinical record failed to evidence the laboratory test results for the BMP as ordered by the physician. Review of the comprehensive care plan, dated 3/17/18, revised on 7/20/18, failed to evidence documentation of the hyponatremia. On 9/13/18 at approximately 9:45 a.m., OSM (other staff member) #5, the ward clerk stated she had access to the laboratory results on the computer. She proceeded to access the laboratory website and could only locate the laboratory results for 7/6/18 and 8/16/18. There were no results for one week after 7/9/18, which would have been around 7/16/18. On 9/13/18 at approximately 9:50 a.m., LPN (licensed practical nurse) # 4 stated she could not locate the laboratory test results and that they weren't done. On 9/13/18 at 10:03 a.m. LPN #2, the unit manager, reviewed the telephone order with this surveyor and stated, "The order doesn't look like it was taken off." At 10:17 a.m., after researching this concern, LPN #2 stated it doesn't look like I have anything (laboratory results) related to that	F 773		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 773	Continued From page 123 order. The facility policy, "Medication and Treatment Orders" failed to evidence the steps to take to transcribe a physician order. The facility policy, "Lab and Diagnostic Test Results - Clinical Protocol" documented in part, "2. The staff will process test requisitions and arrange for tests. The ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the above concern on 9/13/18 at 4:56 p.m. The facility policy, "Medication and Treatment Orders" failed to evidence the steps to take to transcribe a physician order. The facility policy, "Lab and Diagnostic Test Results - Clinical Protocol" documented in part, "2. The staff will process test requisitions and arrange for tests. The administrator and director of nursing were made aware of the above concern on 9/13/18 at 4:56 p.m. On 9/13/18 at 6:21 p.m., the director of nursing stated the facility follows their policy and procedures as their standard of practice. According to "Fundamentals of Nursing-Lippincott, Williams and Wilkins 2007 page 169, "After you receive a written medication order, transcribe it onto a working document approved by your health care facility...read the order carefully, concentrate on copying it correctly, check it when you're finished. No further information was provided prior to exit.	F 773		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 773	Continued From page 124 (1) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pubmedhealth/?term=Subarachnoid+hemorrhage (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 285. (3) This information was obtained from the following website: http://www.nlm.nih.gov/medlineplus/ency/article/003462.htm 2. The facility staff failed to obtain the laboratory tests as ordered by the physician for Resident #60. Resident #60 was admitted to the facility on 4/26/18 with diagnoses that included but were not limited to Schizophrenia [Any of a group of mental disorders characterized by gross distortions of reality, withdrawal of thought, language, perception and emotional response. (1)], dementia, high blood pressure, and Bipolar Disorder [a mental disorder characterized by episodes of mania and depression. (2)]. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 7/30/18, coded the resident as scoring a "9" on the BIMS (brief interview for mental status) score, indicating he was moderately impaired to make cognitive daily decisions. The resident was coded as having periods of inattention and having episodes of verbal behavior directed toward others that occurred every one to three days. Resident #60 was coded as requiring extensive assistance of one or more staff members for all his activities of	F 773		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 773	Continued From page 125	F 773		

daily living except eating in which he only required supervision after set up assistance was provided.

The physician order dated, 6/1/18, documented, "CBC [A complete blood count test measures the following: The number of red blood cells (RBC count) the number of white blood cells (WBC count) (3)] + (plus) VPA (valproic acid) level in 1 week d/t (due to) Depakote (valproic acid) [used to treat seizures, Bipolar Disorder and prevent migraine headaches (4)].

The physician order dated, 8/1/18, documented in part, "1. Two view CXR (chest x-ray) - fever/AMS (altered mental status). 3. Labs (laboratory tests) ASAP (as soon as possible): CBC, BMP (basic metabolic panel). [The basic metabolic panel (BMP) is a group of blood tests that provides information about your body's metabolism (5)].

Review of the clinical record failed to evidence documentation of the physician ordered laboratory tests ordered on 6/1/18. There was a laboratory report with the above ordered tests, CBC and VPA level dated, 6/22/18, 21 days after the order was written.

On 9/13/18, at 10:45 a.m., LPN (licensed practical nurse) #2, the unit manager, presented a "Laboratory Services Log" dated 6/8/18 that documented the resident refused the blood draw. A "Missed Draw Sheet" documented the "Reason for Missed Draw," refused and combative were checked." The form documented "Will Return for re-draw: 6/11/18." No further documentation was provided for the dates of 6/11/18 until the results of 6/22/18.

Review of the clinical record revealed a laboratory

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 773	Continued From page 126 test results dated, 8/6/18 with the test results ordered by the physician on 8/1/18. A nurse's note dated, 8/3/18 at 3:55 p.m. documented in part, "CBC, BMP every shift for 1 day unable to draw blood rescheduled on Monday." There were no other notes documented related to the physician ordered laboratory tests between the order of 8/1/18 and the results of 8/6/18. An interview was conducted with LPN #2 on 9/13/18 at 11:02 a.m. When asked how often laboratory tests are drawn, LPN #2 stated they are drawn on a Monday, Wednesday and Fridays." When asked if the above laboratory tests were drawn according to the physician order, LPN #2 stated, "No, they weren't and I can't find anything that states why they were late." When asked what it meant when the physician orders labs ASAP, LPN #2 stated, "Right away. I checked with the hospital to see if they were drawn there but I have no further information to provide to you." The facility policy, "Lab and Diagnostic Test Results - Clinical Protocol" documented in part, "2. The staff will process test requisitions and arrange for tests." The administrator and director of nursing were made aware of the above concern on 9/13/18 at 4:56 p.m. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 522. . (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and	F 773		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 773	Continued From page 127 Chapman, page 72. . (3) This information was obtained from the following website: http://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&query=CBC&x=24&y=17. (4) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0012594/?report=details.	F 773		
F 804 SS=B	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review, and in the course of a complaint investigation, it was determined the facility staff failed to ensure food was palatable. The facility staff failed to serve food at a palatable taste and temperature. The findings include: On 9/11/18 at 3:30 p.m., a group interview was conducted with ten residents. A resident voiced complaints that her breakfast meal was "stone	F 804	F 804 Nutritive Value/Appear Palatable/Prefer Temp 1. On 9/14/18, Administrator audited a test tray for each mealtime x 24 hours for palatability. Obtained documentation and acknowledgement of documentation from **OSM #4** on the standard guidance for food and liquid textures based on the American Dietetic Association and posted guidance in the kitchen and CHHCM guide/reference "Ground and Pureed Tip" posted in kitchen as well as reference. Residents will receive food at appropriate temperatures. **OSM #9** educated on food temperature policy including proper food temperatures, serving meals and taking food Temperatures. 2. All residents dining in the facility have the potential to be affected by this practice.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 804	Continued From page 128 cold at times". On 9/12/18 at 11:25 a.m., observation was made of the tray line in the kitchen based on a complaint investigation that the "food was bad." The test tray was started at 11:40 p.m. with a surveyor and OSM (other staff member) #9, the cook. The test tray consisted of sliced turkey, mashed potatoes, broccoli-cauliflower mix, pureed turkey, pureed broccoli and cauliflower. Two surveyors tasted the food. It was agreed that the pureed turkey and the pureed broccoli-cauliflower had no taste other than that of the "instant food thickener". There was no discernable taste of turkey or the vegetables. The consistency of both were thick and gelatinous. On 9/13/18 at 8:25 a.m., a second test tray of the breakfast foods was requested and started. The following foods and their temperature upon plating are as follows: pureed ham 120 degrees, pureed eggs 110 degrees, fortified oatmeal 146 degrees; sausage patty 121 degrees, French toast 110 degrees and scrambled eggs 141 degrees. The test tray was taken to the last area served which was the south dining room. The surveyor was accompanied by OSM #9. The last tray was served in the south dining room at approximately 8:55 a.m. On 9/13/18 at 8:55 a.m., a request to check the temperature of the test tray plated food was made to OSM #9. The temperatures obtained by OSM#9 are as follows: pureed ham 105 degrees, pureed eggs 100 degrees, fortified oatmeal 115 degrees; sausage patty 96 degrees, French toast 91 degrees and scrambled eggs 105 degrees. The surveyor tasted the food. The pureed eggs	F 804	F 804 Nutritive Value/Appear Palatable/Prefer Temp continued from page 133 3. Dietary staff were in-serviced on or before 10/28/18 regarding food quality, preparation techniques and enhancing enjoyment of modified texture foods. Maintenance Director asked by Administrator to assess the following: Steam tables and plate warmers assessed and are in working order. Dietary staff will be in-serviced by Registered Dietician, Food Service Manager or designee on the food temperature policy including proper food temperatures, serving meals and taking food temperatures on or before 10/28/18 4. Administrator or designee will audit test trays of different consistencies for palatability 5x/week for 4 weeks, then weekly for 3 months. The audits will be reviewed monthly by the QA committee until it has been determined that the systems are effective. Additionally, The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed for additional interventions as necessary Additional education will be provided as indicated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 804	Continued From page 129 and ham had a slight taste of egg and ham; however, it still strongly tasted of food thickener. The food was noted to be barely warm. When OSM #9 was asked to taste the food, he declined. OSM #9 was asked to describe the process of thickening the pureed foods. OSM #9 stated that the dietitian told him that the pureed foods should be at the same consistency as the mashed potatoes. When asked if he measured the thickener or had a ratio of food to thickener to use, OSM #9 stated, "No, I look at it and compare it to the mashed potatoes". When asked if he has tasted the pureed foods before, he stated "Yes." An interview was conducted on 9/13/18 at approximately 9:32 a.m. with OSM #3, the dietary manager. When asked to describe the process for thickening pureed food, OSM #3 stated, "You should only thicken pureed food if it needs it." When informed of the results of the pureed foods on the test trays, as well, as how OSM #9 stated he determines how to thicken the pureed food, OSM #3 stated, "I have only been here three months. It looks like the staff need training on how to thicken food." An interview was conducted on 9/13/18 at 1:15 p.m. with OSM #4, the assistant dietary manager. When asked to describe how he determines the amount of thickener to add to the pureed food, OSM #4 stated, "I was never instructed on how to thicken pureed foods, but I generally add only about a tablespoon or so." OSM #4 further stated he has only been at the facility for about nine months and that when he started the facility had a "corporate" dietary manager running the kitchen.	F 804	F 804 Nutritive Value/Appear Palatable/Prefer Temp continued from page 134 The Food Service Manager will hold Resident Food Council meetings weekly x 4 weeks, bi-weekly x 4 weeks, then monthly thereafter. Additionally, the Food Service Manager/designee will audit test tray 5 times a week in alternating areas x 30 days, 3 times a week x 30 days, 2 times a week x 30 days, then weekly x 90 days. The audits will be reviewed monthly by the QA committee until it has been determined that the systems are effective. Additionally, The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed for additional interventions as necessary Further or additional education will be provided as indicated. Auditing for compliance will occur daily x 3 months, October, November and December; and compliance reported monthly at the QA committee meetings. Random audits will be conducted for 3 additional months to March 2019.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 804	Continued From page 130 An interview was conducted on 9/13/18 at 3:15 p.m. with OSM #13, the registered dietitian. OSM #13 stated she is primarily responsible for the clinical aspects of the food service and that the dietary manager is primarily responsible for the actual food being served. When asked about the process for thickening pureed food, OSM #13 stated it is prescribed by the speech therapist in response to each resident's individual needs. When informed that all of the pureed foods, regardless of a resident's specific needs, were being thickened, OSM #13 stated that it is the dietary manager's responsibility to train the staff on the appropriate thickening of food. When asked if all pureed food needs to be thickened, OSM #13 stated, "No." When asked if pureed food should be palatable, OSM #13 stated, "Yes." The facility policy, "Dietary" documented in part, "Food should be palatable, attractive, and at the proper temperature as determined by the type of food to ensure resident satisfaction." ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were made aware of the above findings on 9/13/18 at 4:55 p.m. No further information was provided prior to exit.	F 804	F 804 Nutritive Value/ Appear Palatable/ Prefer Temp continued from page 135 A QA Tool based on CMS "Kitchen Observation" will be utilized weekly x 4 weeks in October, monthly x 6 months (November, December 2018, January, February, March, April 2019), and quarterly thereafter for one year with results reported to the Quality Assurance Committee. 5. The facility dutifully alleges compliance of these tasks on or before 10/28/18 F 812 Food Procurement Store/Prepare/Serve-Sanitary 1. The following staff in-serviced on infection control practices when handling food: **CNA #1, CNA #4, OSM #18, OSM #16** No specific residents are identified. Bread is being handled appropriately and in accordance with sanitation guidelines. Open straws in residents' drinks and the rims of cups being handled appropriately and in accordance to sanitation guidelines in the dining areas. Policies and procedures based on food handling, assistance	
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.	F 812		

			F 812 Food Procurement Store/Prepare/Serve-Sanitary continued from page 136 with meals and meals service reviewed and updated by facility QA on or before 10/28/18 to address infection control practices when handling food. 2. Potentially all residents affected by deficient practice. 3. Dietary staff as well as nursing staff were in-serviced on or before 10/28/18 by Food Service Manager or designee regarding proper handling of food in a manner that is within proper sanitation guidelines. Additional education provided as indicated. 4. A Performance Improvement Tool has been initiated that randomly observes meal service in different dining areas, 3 times in a weekly period to assure that proper handling of food is occurring in accordance within the guidelines by both dietary and nursing. The Administrator, or designee, will complete this tool weekly x3, monthly x3, and then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed for additional interventions as necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 131 (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by thefacility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to serve food in a sanitary manner in two of two dining rooms, the south dining room and the north dining room. 1. The facility staff failed to serve bread without touching it with their bare hands in the north dining room during the 9/11/18 lunch observation. 2. The facility staff failed to wear gloves while preparing slices of bread for two residents in the south dining room during lunch. The findings include: 1. A dining observation was conducted on 9/11/18 at 12:31 p.m. in the north dining room. CNA (certified nursing assistant) #1 was observed taking a slice of bread out of a waxed paper bag with her bare fingers. CNA #1 then cut the bread with a spoon, held down one side of the bread with the waxed paper bag, and then pulled the	F 812	F 812 Food Procurement Store/Prepare/Serve-Sanitary continued from page 137 Auditing for compliance will occur weekly x 3 months, October, November and December; Then quarterly x 4 (until December 2019) and compliance reported monthly at the QA committee meetings. 5. The facility dutifully alleges compliance of these tasks on or before 10/28/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 132	F 812		

bread apart with her bare fingers served it to the resident. CNA #4 was observed holding the rims of the juice cups with her bare fingers and then serving them to the residents.

An interview was conducted on 9/13/18 at 9:14 a.m. with CNA #1. When asked when it was appropriate to touch a resident's food with their bare hands, CNA #1 stated, "Never." When asked why, CNA #1 stated, "Cross contamination, infection control." When asked if it was appropriate for staff to hold cups by the rim, CNA #1 stated, "No. That's where they're going to put their lips."

CNA #4 was not available for interview.

An interview was conducted on 9/13/18 at 10:35 a.m. with ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing. When informed of the above observation of the staff holding the bread with their bare fingers and holding the cups by the rim, ASM #2 stated, "Cross contamination." ASM #1 and ASM #2 were made aware of the findings at that time.

Review of the facility's policy titled, "Assistance with Meals" did not address infection control practices when handling of resident's food.

No further information was provided prior to exit.
2. The facility staff failed to wear gloves while preparing slices of bread for two residents in the south dining room during lunch.

A dining observation was conducted on 09/11/18 at approximately 12:13 p.m., in the south wing dining room.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 133	F 812		

At approximately 12:30 p.m., a resident was observed seated at a table by himself. OSM (other staff member) # 18, south wing unit secretary was observed bring a lunch tray to the resident. She placed the tray on the table and removed the resident's plates, bowls and cups, and placed them on the table in front of the resident. OSM # 18 then removed a slice a bread from a wax paper wrapping with her bare hands. OSM #18 then spread butter on the slice of bread and place it on the resident's plate. During the course of the meal, the resident was observed eating the slice of bread.

At approximately 12:46 p.m., a resident, who was in a Gerri chair, was brought to a table by OSM # 16, OTR (occupational therapist, registered). She placed the tray on the table and removed the resident's plates, bowls and cups, and placed them on the table in front of the resident. OSM # 16 then removed a slice a bread from a wax paper wrapping with her bare hands. OSM #16 then spread butter on the slice of bread and place it on the resident's plate. OSM # 16 also placed a flexible drinking straw into the resident's cup. OSM # 16 adjusted the straw by placing her bare fingers on the sipping end of the straw. During the course of the meal, the resident was observed eating the slice of bread and drinking from the straw.

On 09/11/18 at approximately 3:34p.m., an interview was conducted with OSM # 3, dietary manager. When asked to describe the procedure for handling resident's food and straws, OSM # 3 stated, "Bare hands should never touch the food, they should be wearing gloves and never touch the end of the straw where the resident is going to place their mouth. To adjust the straw, you

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 134 should wear gloves to make sure you don't touch the end of the straw." On 09/12/18 at approximately 8:27 a.m., an interview was conducted with OSM # 18. When asked to describe procedure for handling a resident's food, OSM # 18 stated, "I open everything, take it off the hot plate and cut up the food if needed." When asked to describe how she removed the bread from the packaging, OSM # 18 stated, "I used my bare hands, I should have used gloves." On 09/12/18 at approximately10:07 a.m., an interview was conducted with OSM # 16. When asked to describe procedure for handling a resident's food, OSM # 16 stated, "You shouldn't touched the food with bare hands." When informed of the observation in the south wing dining room the day before during lunch, OSM # 18 stated, "I was not aware of the position of my fingers on the straw and I should have used gloves." On 09/13/18 at approximately 5:55 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings. No further information was provided prior to exit.	F 812		
F 838 SS=F	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations	F 838	F 838 Facility Assessment 1. A thorough facility assessment was initiated and slated to be Completed on or before 10/28/18 and will address and determine resources needed to care for residents during day-to-day operations and emergencies.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 838	Continued From page 135 and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.70(e)(2) The facility's resources, including but not limited to, (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under	F 838	F 838 Facility Assessment continued from page 141 2. Current residents in facility are at risk. 100% audit initiated and will be completed on or before 10/28/18. New admissions will be evaluated by Interdisciplinary Care Team to ensure facility can meet their needs. 3. Regional Operations Manager or designee will re-educate facility Administrator on Facility Assessment on, or before 10/28/18 4. Administrator or designee will complete audit on facility assessment with focus on staff competencies that are necessary to provide the level and types of care needed for the resident population; the physical environment, equipment services and other physical plant considerations that are necessary to care for the population, ethical, cultural or religious factors that may affect the care provided by the facility. Furthermore, other factors addressed such as the facility-based and community-based risk assessment utilizing an all-hazards approach using audit tools weekly x 4 weeks then monthly x 3 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 838	Continued From page 136 contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technologyresources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, it was determined that the facility staff failed to develop a complete facility assessment. The facility assessment failed to document staff competencies that are necessary to provide the level and types of care needed for the resident population, the physical environment, equipment services and other physical plant considerations that are necessary to care for the population, ethical, cultural, or religious factors that may potentially affect the care provided by the facility , facility-based and community-based risk assessment, utilizing an all-hazards approach. The findings include: Review of the facility assessment failed to reveal evidence documentation staff competencies that are necessary to provide the level and types of care needed for the resident population, the physical environment, equipment services and	F 838	F 838 Facility Assessment continued from page 142 Results of the audits will be reported to the QA committee monthly for a period of 4 months (October, November, December and January). Random audits will be conducted for 3 additional months to April 2019. 5. The facility dutifully alleges compliance of these tasks on or before 10/28/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 838	Continued From page 137 other physical plant considerations that are necessary to care for the population, ethical, cultural, or religious factors that may potentially affect the care provided by the facility, facility-based and community-based risk assessment, utilizing an all-hazards approach. On 09/13/18 at 3:15 p.m. a review and interview of the facility's assessment was conducted with ASM (administration staff member) # 1, administrator. ASM # 1 stated, "The facility assessment was done when I came in July 2018. I haven't reviewed it." ASM # 1 agreed the facility assessment was not complete. On 09/13/18 at approximately 5:55 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings. No further information was provided prior to exit.	F 838		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 138 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents	F 880	F 880 Infection Prevention & Control 1. **Resident #113** will be monitored for signs and symptoms of infection and preventative measures e.g. Correct dressing change will be monitored, and deficient practice addressed. All Residents who could have been negatively affected by the deficient practice will have their charts audited by the ADON to see if any harm was done. The results of these audits will be reviewed by the DON and ADON. If corrective action is warranted it would be the responsibility of the DON and ADON to ensure that it is completed in a timely manner. 2. The ADON will review the findings from the monthly Infection Control Log to assess for trends in the Resident population. If trends are noted, new steps will be taken to identify ways to protect the "at risk" population. RECEIVED OCT 11 2018 VDH/OLC	

F 880 Infection Prevention and Control
continued from page 149

3. All staff, involved with direct patient care, will be in-serviced to ensure that they are aware of, and utilizing, the correct infection control technique. The person responsible for Infection Control will ensure that this training is completed. All Residents found to in the "at risk" population will have their Plan of Care reviewed to assess for new protective measures that can be implemented.

4. **Resident #113-**
The staff involved with the violation of infection prevention and control procedures during the changing of the PEG tube dressing was educated on the proper procedure to follow regarding glove changing, care of the tube and infection control procedures during a dressing change. This observation will include the care of the Peg Tube and Infection Control procedures during a dressing change. The will be completed by October 28th 2018
Random audits will be conducted by the ADON, Unit Manager, and Wound Nurse on all nurses monthly x 6 months (January, February and March 2019) to ensure compliance with Infection Control Policies and procedures.

F 880 Infection Prevention and Control
continued from page 150

All staff in the facility will be educated and observed during a dressing change by the ADON, Unit Managers and Wound Nurse
All staff, who are involved with direct patient care, will be in-serviced by October 12, 2018. The Infection Control Committee will meet to go over audits and new information by October 25, 2018
Infection audits will be analyzed and presented to the QA committee monthly x 3 months- October, November and December 2018
The ADON and DON will develop an Infection Prevention and Control Program that contains all the elements included in a viable program by October 28th, 2018
An annual review of the Infection Prevention and Control Program to all staff

5. The facility dutifully alleges compliance of these tasks on or before 10/28/18.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 139 identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review, it was determined that the facility staff failed to maintain a complete infection control program as evidenced by, incomplete Monthly Infection Logs for March 2018 through September 12, 2018; and failed to follow infection control practices for one of 37 residents in the survey sample, Resident # 113. 1. The facility staff failed to maintain a complete and accurate infection control logs that accurately recorded all infections diagnosed in the facility. 2. The facility staff failed to change gloves between tasks during percutaneous endoscopic gastrostomy (PEG) tube care for Resident #113 and failed to ensure the tubing for the residents tube feeding was maintained in a manner to prevent contamination of the tubing. The findings include: 1. Review of the facility's "Monthly Infection Logs" dated March 2018 through September 12, 2018 failed to evidence culture result dates and pathogens (a bacterium, virus, or other	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 140 microorganism that can cause disease). On 09/13/18 at approximately 10:20 a.m., an interview was conducted with ASM (administrative staff member) # 2, director of nursing. When asked to describe a complete infection control log, ASM # 2 stated, "It would include the type of infection, date of onset, diagnoses, treatment, and isolation if required." ASM # 2 was asked to review the facility's "Monthly Infection Logs"dated March 2018 through September 12, 2018. When asked if the logs were complete, ASM # 2 stated, "They should have result dates and pathogens should be identified. I will be conducting education so the logs will be complete." On 09/13/18 at approximately 5:55 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings. No further information was provided prior to exit. 2. The facility staff failed to change gloves between tasks during percutaneous endoscopic gastrostomy (PEG) tube care for Resident #113 and failed to ensure the tubing for the residents tube feeding was maintained in a manner to prevent contamination of the tubing. Resident #113 was admitted to the facility on 5/21/18 and readmitted on 8/9/18. Diagnoses for Resident #113 included but were not limited to: aphasia [A disorder caused by damage to the parts of the brain that control language. It can make it hard for you to read, write, and say what you mean to say. (1)], cerebral infarction (stroke), heart failure [A condition in which the heart can't pump enough blood to meet the body's needs.] (2)	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 141 The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 8/18/18 coded the resident as having a score of 99 on the BIMS (brief interview for mental status) indicating the resident was unable to complete the interview. The resident was coded as moderately impaired of cognition for daily decision-making. On 9/12/18 at approximately 5:55 p.m., LPN (licensed practical nurse) #5 was observed performing PEG tube care for Resident #113. LPN #5 put on non-sterile gloves and proceeded to disconnect Resident #113's tube feeding. LPN #5 placed the end of tubing disconnected from Resident #113's peg tube over pole, under the residents pillowcase uncapped. At this time LPN #5 stated she forgot saline to cleanse the peg tube site, she then proceeded to leave Resident #113's room where the procedure was being performed and walked to the treatment cart in the hall while wearing the same pair of gloves that LPN #5 begun her procedure with. On 9/12/18 at approximately 6:08 p.m., LPN #5 (wearing the same pair of gloves) attempted to pull the drawer open on the treatment cart but found the treatment cart locked. She then walked to central supply room wearing same pair of gloves. On 9/12/18 at approximately 6:10 p.m., LPN #5 returned with a bottle of saline while wearing the same pair of gloves. She then opened a new piece of sterile gauze and touched the lip of the bottle to the new gauze while still wearing the old gloves. She crumbled the new moist gauze in her right hand and proceeded to remove the old dressing. LPN #5 was observed having difficulty removing the old dressing, she	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 142 placed the clean dressing with the saline on it on the resident's abdomen and then removed the old dressing. LPN #5 then picked the clean dressing up from the resident's abdomen and cleaned the area around PEG tube with the same gloves that she initially put on. On 9/12/18 at approximately 6:12 p.m., LPN #5 opened the clean split sponge and proceeded to apply skin protectant ointment on the new dressing (still wearing the same pair of gloves). LPN #5 then applied the new dressing and reapplied Resident #113's abdominal binder. LPN #5 did not reconnect the resident's tube feeding at this time. LPN #5 stated, "it's (tube feeding) is supposed to be off for two hours". The tube feeding was observed left hanging on the pole with the uncapped tubing under a pillowcase. LPN #5 then removed her gloves, washed hands and left the resident's room. An interview was conducted with LPN #5 on 9/12/18 at approximately 6:13 p.m., regarding the process staff follow for changing gloves, LPN #5 stated, "After you are finished." An interview was conducted with RN (registered nurse) #2 on 09/13/18 at 9:07 a.m. on the process of PEG tube care. RN #2 "We use a split gauze here. First, grab all needed supplies and towel, knock on door, introduce self and say I'm here to do your wound care, dawn gloves place a towel under the residents to keep the resident clean, also put up a sterile field to put supplies down. Remove gloves then put on new gloves to take old dressing of, clean the site, and then discard old gloves. Then put on new gloves to apply the dressing. Three different glovechanges should be used, date the new dressing priorto	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 143	F 880		

putting on patient. Take off old gloves and wash your hands, then document on MAR (medication administration record) or TAR (treatment administration record)." When asked if staff should walk to central supply room with dirty gloves on, RN #2 replied, "No, because it's an infection control problem, you can ask for help or take off gloves to go get new supplies." When asked if staff should touch new supplies with gloves used to remove the old dressing, RN #2 answered "No".

An interview was conducted with ASM #2 (administrative staff member) the Director of Nursing (DON) on 09/13/18 at 10:29 a.m., regarding PEG care and changing gloves. ASM #2 stated, "Put on gloves to begin, take off old dressing, cleanse the tube and skin, asses the wafer make sure bumper is flush, then change gloves and put on new gloves before handling and applying the new dressing." When asked if staff have already started PEG care, is it okay to go get supplies from a supply room without removing the old gloves, ASM #2 responded "No, because of cross contamination, God forbid you touch something you could make someone sick, this is basic to nursing and should never be done. Don't tell me this was done."

On 09/13/18 04:50 p.m., ASM (administrative staff member) #1, the administrator and ASM #2 (the director of nursing) were made aware of the above concern.

The facility policy titled, "Personal Protective Equipment- Glove", on pages 46-48 document that all employees must wear gloves when touching blood, body fluids, secretions, excretions, mucous membranes, and/or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 144 non-intact skin or whenever in doubt. The policy also documents that "Gloves shall be used only once and discarded into the appropriate receptacle located in the room in which the procedure is being performed." According to Mosby's Textbook for Long-Term Care Assistants, 4th Edition, 2003, pg. 199 "Preventing Infection", under the category "Gloves" was documented "....change gloves between tasks and procedures on the same person.....remove gloves before touching uncontaminated items and surfaces." According to the CDC (Centers for Disease Control), "Hand hygiene is required regardless of whether gloves are used or changed. Failure to remove gloves after patient contact or between "dirty" and "clean" body-site care on the same patient must be regarded as nonadherence to hand-hygiene recommendations..." Website accessed: http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5116a1.htm According to "Lippincott Manual of Nursing Practice", Eighth Edition: by Lippincott Williams & Wilkins, pg. 723 reads: "Administration of Enteral (Tube) Feedings: Intermittent or Continuous: Performance phase: Nursing Action: 7. After feeding is completed, cover end of feeding tub with plug. Rationale: 6. Prevents bacterial contamination. ... Prevents leakage." No further information was presented prior to exit. 1. This information was obtained from the website: https://medlineplus.gov/epilepsy.html. 2. This information was obtained from the	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 09/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 145 website: https://medlineplus.gov/heartdiseases.html.	F 880		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	09/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS Surveyor: 35701 The Facility is a single story dually certified facility. The Facility is Type II (111) construction and is fully sprinklered. An unannounced Life Safety Code complaint survey was conducted on 09/20/2018 in accordance with 42 Code of Federal Regulations, Part 483.150 and 410 to 480: Requirements for Long Term Care Facilities. The Facility was surveyed for compliance using the LSC 2012 Existing Regulations. The Facility was found to be in compliance with the Requirements for Participation for Medicare and Medicaid. On 09/20/2018 at approximately from 1:40 PM to 2:45 PM a walk through of the facility was conducted. Observation revealed a total replacement of the HVAC system was currently in progress. A resident had complained of breathing issues due to mold exposure. Observation of the resident room revealed no visual signs of mold either within the room, above ceiling in the room or in the exit corridor above ceiling. At approximately 2:13 PM, observation of the North Dining area revealed black material on the vent. No confirmation was provided to conclude the presence of mold on the supply vent. An interview with the administrator at approximately 1:50 confirmed testing for mold within the facility was not conducted.	K 000	K000 The facility dutifully alleges compliance on or before 10/28/18. RECEIVED OCT 11 2018 VDH/OLC	

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

Administrator — 10/10/18

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.