PRINTED: 09/25/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED		
	1777-77		B. WING _	wing			; i3/2018
	ROVIDER OR SUPPLIER DE REHAB & NURSIN		STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186			03/13/2010	
(X4) ID PREFIX TAG	(EACH DEFICIE!	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
E 000	Initial Comments		EC	000		ALL	
= 202	survey was conduc Corrections are red CFR Part 483.73, I Care Facilities.	Emergency Preparedness cted 09/11/18 through 09/13/18. quired for compliance with 42 Requirement for Long-Term	= (Asse	Plan Based on All Hazards I essment Brookside Rehab's geographazard facility risk assessment	phic all- nent was	
E 006 SS=C	CFR(s): 483.73(a)		E (reviewed and updated by f QA committee and commu emergency personnel on o	ınity	
	and maintain an er that must be review	an. The [facility] must develop mergency preparedness plan wed and updated at least must do the following:]		- Longitude and the second and the s	10/28/18 and included, but limited to, local empirical the community-based assecurrent and comprehensive	not data for ssment,	
	facility-based and	nd include a documented, community-based risk ng an all-hazards approach.*		Additionary	and procedures and update facility-specific all-hazard assessment. Missing Resid Policy and Procedure review	ed s risk lents	
	on and include a d community-based all-hazards approa	at §483.73(a)(1):] (1) Be based locumented, facility-based and risk assessment, utilizing an ach, including missing residents.	A PROPERTY OF THE PROPERTY OF	The second secon	updated by facility QA cor on or before 10/28/18 and submitted into the Emerge Preparedness Manual.	mmittee	
	and include a doct community-based all-hazards approa	483.475(a)(1):] (1) Be based on umented, facility-based and risk assessment, utilizing an ach, including missing clients.			 Facility determined that al residents are potentially at deficient practice. 	l fected by	
		gies for addressing emergency y the risk assessment.		- 1	3. Staff educated on or befor 10/28/18 by Administrato	r or	
	strategies for addi identified by the ri management of th failures, natural di	§418.113(a)(2):] (2) Include ressing emergency events sk assessment, including the econsequences of power sasters, and other emergencies he hospice's ability to provide		MARKET THE TAXABLE AND ADDRESS OF TAXABLE A	designee regarding update hazard risk assessments at Policy and Procedure outl Missing Resident protoco	nd facility ining	
LABORATORY	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGNATUR	RE Ad	Midis	TITLE Straton	10/10	(X6) DATE

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 pretection 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 12. 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.

Facility ID: VA0178

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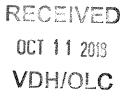
	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1''	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		495267	B. WING		C 09/13/2018	
NAME OF P	ROVIDER OR SUPPLIER		'	STREET ADDRESS, CITY, STATE, ZIP CODE	0071072010	
				614 HASTINGS LANE		
BROOKSI	DE REHAB & NURSING	CENTER		WARRENTON, VA 20186		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
E 006	This REQUIREMENT by: Based on staff interv review it was determing failed to have a compute preparedness plan. The facility staff failed facility risk assessme approach specific to the facility and that enhazards. The findings include: On 09/13/18 at 3:15 pemergency prepared conducted with ASM member) # 1, administ facility's emergency pevidence documentate assessment was base approach specific to the facility and that enhazards. ASM # 1 state documentation." On 09/13/18 at approach (administrative staff in administrator and AS were made aware of the Program Patient FCFR(s): 483.73(a)(3)	iew and facility document ned that the facility staff plete emergency It to develop a complete and based on an all-hazards the geographic location of an incompasses potential Incompasses potential Incompasses pan and interview was (administration staff strator. Review of the preparedness plan failed to be prepared to prepared the facility's risk the geographic location of the prepared prepared to prepared	EO	4. After completion of initial seducation on the all hazards approach and Missing Resisthe Administrator or design monitor the effectiveness of Emergency Preparedness March Preparedness March Preparedness of Emergency Preparedness March Preparedness of Emergency Preparedness March Preparedness of Emergency Preparedness March Preparedness to the Quantities of the Quantities of the Preparedness plan will be provided and as necessary and plan to updated as indicated. Emergency Preparedness plan will be reand updated at least annual Auditing for compliance will be reand updated at least annual Auditing for compliance will be compliance reported month QA meetings. Random and be conducted for 3 addition months to March 2019. 5. The facility dutifully alleged compliance of these tasks of before 10/28/18.	staff dents, ee will f the Ianual and A onal monthly o be gency eviewed ly. ill occur r, and ly at the its will al	
		The [facility] must develop rgency preparedness plan				

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Event ID: OTHR11

Facility ID: VA0178

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		495267	B. WING _		C 09/13/2018	
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE		
DDOOKS	DE DEUAD & MIDOMO	CENTER		614 HASTINGS LANE		
BROOKSI	DE REHAB & NURSING	CENTER		WARRENTON, VA 20186		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	E COMPLETION	
E 007	that must be reviewed	d, and updated at least	E 0	07 E 007 EP Program Patient Population	n	
	annually. The plan mid (3) Address patient/cl but not limited to, per services the [facility] an emergency; and concluding delegations plans.** *Note: ["Persons at rihospice, PACE, HHAFQHC, or ESRD facility REQUIREMENT by: Based on staff intervice it was determined to have a compreparedness plan. The facility staff failed facility's emergency propertions during an emof how the facility wood operations during	ient population, including, sons at-risk; the type of has the ability to provide in ontinuity of operations, of authority and succession sk" does not apply to: ASC, CORF, CMCH, RHC, ities.] is not met as evidenced iew and facility document ned that the facility staff elete emergency I to evidence that the claim included documentation cility would be able to ergency and documentation uld plan to continue emergency. O.m. a review of the facility's ness plan and interview was (administration staff strator. Review of the preparedness plan failed to lity's emergency plan		 Brookside Rehab's Emerger Preparedness plan reviewed updated by facility QA com and community emergency personnel on or before 10/2 and included, but not limite persons-at-risk, the types of services Brookside can providuring emergencies; and color of operations, including del of authority and succession Additional inclusions review updated by the QA committ before 10/28/18: Current and comprehensive policies and procedures and the docume updated means by which to continued operations during emergency. Facility determined that all residents are potentially affected in the procedure of the procedure of	and mittee 8/18 d to ride ntinuity egations plans. ved and ee on or d nted, provide an ected by	
	would be able to provand documentation o	ion of the services the facility ride during an emergency f how the facility would plan s during an emergency.		provide care and services in emergency.		

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Event ID: OTHR11

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
		495267	B. WING				
	ROVIDER OR SUPPLIER DE REHAB & NURSING	CENTER		614 HA	T ADDRESS, CITY, STATE, ZIP CODE ISTINGS LANE RENTON, VA 20186		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
E 007	Continued From page ASM # 1 stated, "We documentation." On 09/13/18 at appro		E	007 con	77 EP Program Patient Populati tinued from page 34. Upon completion of initial education, the Administrate	staff	
	were made aware of No further information	M # 2, director of nursing the findings. n was provided prior to exit.			designee will monitor the effectiveness of the Emerge Preparedness Manual plan staff interview and provide	ency through	
E 013 SS=C	Development of EP F CFR(s): 483.73(b) (b) Policies and procedure policies and procedure plan set forth in paragassessment at paragand the communication this section. The policies and update *Additional Requirem Facilities: *[For PACE at §460.8 procedures. The PACE at §460.8 procedures.]	Policies and Procedures edures. [Facilities] must ent emergency preparedness res, based on the emergency graph (a) of this section, risk raph (a)(1) of this section, on plan at paragraph (c) of cies and procedures must be d at least annually. eents for PACE and ESRD	E	013	outcomes to the QA comm monthly. Additional educate be provided monthly and a necessary and plan to be up indicated. Emergency Prep plan will be reviewed and up at least annually. Auditing compliance will occur were months, October, November December; and compliance reported monthly at the QA meetings. Random audits up conducted for 3 additional to March 2019.	ion will dated as aredness apdated for kly x 3 er and vill be months	
	policies and procedur plan set forth in paragassessment at paragand the communication this section. The policaddress management emergencies, includice equipment, power, or emergencies; and nathreaten the health or	res, based on the emergency graph (a) of this section, risk raph (a)(1) of this section, on plan at paragraph (c) of cies and procedures must at of medical and nonmedical ng, but not limited to: Fire; water failure; care-related atural disasters likely to r safety of the participants, ne policies and procedures			5. The facility dutifully allege compliance of these tasks obefore 10/28/18.		

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CENTERS FOR MEDICARE & MEDICAID SERVICES	OMB NO. 0938-039
	E 013 Development of EP Policies and
	Procedures
	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.

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	IPLE CON	STRUCTION	СОМ	E SURVEY PLETED C
		495267	B. WING_			ı	/13/2018
	ROVIDER OR SUPPLIER DE REHAB & NURSING	CENTER	•	614 HA	T ADDRESS, CITY, STATE, ZIP CODE ASTINGS LANE RENTON, VA 20186		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	4	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
E 013	must be reviewed and *[For ESRD Facilities procedures. The dialy implement emergency procedures, based or forth in paragraph (a) assessment at paragraph (b) assessment at paragraph (c) assessment a	at §494.62(b):] Policies and visis facility must develop and by preparedness policies and in the emergency plan set of this section, risk raph (a)(1) of this section, on plan at paragraph (c) of cies and procedures must be did at least annually. These but are not limited to, fire, failures, care-related supply interruption, and by to occur in the facility's ris not met as evidenced siew and facility document and that the facility staff plete emergency did to evidence documentation by and procedures were the facility-and-community and communication plan, is approach and failed to and procedures were did on an annual basis.	E	913 Proc	4. Upon completion of initial education, the Administrated designee will monitor the effectiveness of the Emer Preparedness Manual plastaff interview and provide outcomes to the QA commonthly. Additional education be provided monthly and necessary and plan to be indicated. Emergency Proplan will be reviewed and at least annually. Auditin compliance will occur we months, October, Novem December; and complian reported monthly at the Competings. Random audits conducted for 3 additionate to March 2019. 5. The facility dutifully alled compliance of these tasks before 10/28/18.	al staff ator or gency n through de mittee cation will as updated as eparedness I updated g for eekly x 3 ber and ce (A s will be al months	

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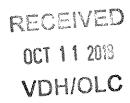
A95267 NAME OF PROVIDER OR SUPPLIER BROOKSIDE REHAB & NURSING CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186	(X5) COMPLETION
RROOKSIDE REHAB & NURSING CENTER	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	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. Subsistence Needs for Staff and Patients E 015 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, 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: (b) Food, water, medical and pharmaceutical supplies, alternate sources of energy to maintain the following: (l) Atternate sources of energy to maintain the following: (l) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions; emergency lighting, fire detection, extinguishing, and alarm systems, sewage and waste disposal.	

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Event ID: OTHR11

Facility ID: VA0178

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1''	TIPLE CON	COMP	COMPLETED		
		495267	B. WING		1000 100 100 100 100 100 100 100 100 10		C 13/2018
	ROVIDER OR SUPPLIER DE REHAB & NURSING	CENTER		614 H	T ADDRESS, CITY, STATE, ZIP CODE ASTINGS LANE RENTON, VA 20186	<u></u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
E 015	(B) Emergency lig (C) Fire detection, systems. (D) Sewage and v *[For Inpatient Hosp Policies and procedu (6) The following are hospice-operated in The policies and pro following: (iii) The provision of hospice employees evacuate or shelter i limited to the followin (A) Food, water, n supplies. (B) Alternate sour following: (1) Temperature and safety and for th of provisions. (2) Emergency (3) Fire detection systems. (C) Sewage and v This REQUIREMEN by: Based on staff inter review it was determ failed to have a compreparedness plan. The facility staff faile that the emergency	hting. extinguishing, and alarm vaste disposal. ice at §418.113(b)(6)(iii):] ures. e additional requirements for patient care facilities only. cedures must address the subsistence needs for and patients, whether they in place, include, but are not ing: nedical, and pharmaceutical ces of energy to maintainthe es to protect patient health he safe and sanitarystorage lighting. on, extinguishing, and alarm vaste disposal. T is not met as evidenced view and facility document hined that the facility staff plete emergency ed to provide documentation plan included policies and loge and waste disposal.	E		 Subsistence Needs for Staff at tents continued from page 7 Facility determined that all residents are potentially affed deficient practice. Staff educated on or before 10/28/18 by Administrator designee regarding facility's updated Emergency Prepare policies and procedures on provision of subsistence newhich also includes, but not to alternate energy sources sewage/waste disposal. Upon completion of initial education, the Administrated designee will monitor the effectiveness of the Emerge Preparedness Manual plant staff interview and provide outcomes to the QA comminmonthly. Additional education be provided monthly and as necessary and plan to be up indicated. Emergency Preparedness and plant to be up indicated. Emergency Preparedness will occur weel months, October, November December; and compliance reported monthly at the QA meetings. Random audits we conducted for 3 additional to March 2019. 	ected by or s edness the eds t limited and staff or of ency hrough ttee ion will dated as aredness pdated for dy x 3 r and	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1''	TIPLE CONSTRUCTION	COMPLET	C C	
		495267	B. WING		09/13/	/2018
	ROVIDER OR SUPPLIER DE REHAB & NURSING	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		OULD BE	(X5) COMPLETION DATE
E 015	On 09/13/18 at 3:15 emergency prepared conducted with ASM member) # 1, adminifacility's emergency plan included to evidence do emergency plan included for sewage and wast "We don't have the don't have the don't have staff in (administrative staff).	c.m. a review of the facility's ness plan and interview was (administration staff strator. Review of the preparedness plan failed staff cumentation that the ded policies and procedures a disposal. ASM # 1 stated, occumentation."	E	E 015 Subsistence Needs for S 015 Patients continued from page 8 5. The facility dutifully a compliance of these tai before 10/28/18. E 022 Policies/Procedures for S	lleges sks on or	
E 022 SS=C	No further information Policies/Procedures CFR(s): 483.73(b)(4). [(b) Policies and procedure policies and procedure policies and procedure plan set forth in para assessment at paragrand the communication this section. The policies and updates minimum, the policies address the following (4) A means to shelt and volunteers who is (2),(3),(5),(6)] A mean patients, staff, and volicitity].	n was provided prior to exit. For Sheltering in Place Redures. The [facilities] must ent emergency preparedness res, based on the emergency graph (a) of this section, risk raph (a)(1) of this section, on plan at paragraph (c) of cies and procedures must be d at least annually. At a s and procedures must	E	Place 1. Brookside Rehab's Em Preparedness plan revi updated on or before I facility QA committee community emergency and includes, but not li documented, updated comprehensive policie procedures regarding t shelter in place the fact volunteers and resident who remain in the facility determined the residents are potentially deficient practice.	ewed and 0/28/18 by and personnel mited to current and s and he means to ility staff, ts/patients lity.	

FORM CMS-2587(02-99) Previous Versions Obsolete

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PRINTED: 09/25/2018 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 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.

Facility ID: VA0178

AND DI AN OF CODDECTION IN IMPEDI		1 ' '	TIPLE CONSTRUCTION ING	COMP	COMPLETED	
		495267	B. WING			C 13/2018
	ROVIDER OR SUPPLIER DE REHAB & NURSING	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		BE	(X5) COMPLETION DATE
E 022	(6) The following are hospice-operated inp. The policies and profollowing: (i) A means to she hospice employees with the facility staff faile procedures of how the means to shelter in procedures who remains to shelter in procedures who remains to shelter in procedures who remains to shelter in procedures of how the facility's emerger management. The findings include: On 09/13/18 at 3:15 emergency prepared conducted with ASM member) # 1, adminificallity's emergency failed to evidence do procedures of how the means to shelter in procedures of how the means to shelter in procedures who remains to shelter in procedures and put the facility's emergency management. ASM is the documentation."	additional requirements for patient care facilities only. Cedures must address the alter in place for patients, who remain in the hospice. It is not met as evidenced wiew and facility document ined that the facility staff polete emergency. If the develop policies and the facility will provide a polace for patients, staff and win in the facility and how recedures are aligned with the plan and risk. In a review of the facility's almost plan and interview was a (administration staff interview of the preparedness plan failed staff polace for patients, staff and alin in the facility will provide a polace for patients, staff and alin in the facility and how recedures are aligned with the plan and risk and the facility and how recedures are aligned with the plan and risk and the facility 5:55 p.m., ASM	E	E 022 Policies/Procedures for Shel 022 Place continued from page 10 5. The facility dutifully alleg compliance of these tasks before 10/28/18.	es	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495267	B. WING		C 09/13/2018	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
BBOOKE	DE REHAB & NURSIN	COENTED		614 HASTINGS LANE		
RKOOKSI	DE KENAD & NUKSIN	GCENIER		WARRENTON, VA 20186		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	n	
				E 023 Policies/Procedures for Medic	al	
E 022	Continued From page	ge 9	E 02	22 Documentation		
	administrator and A	SM # 2, director of nursing				
·	were made aware o			1. Brookside Rehab's Emergen	ıcy	
		•		Preparedness plan reviewed		
	No further information	on was provided prior to exit.		updated on or before 10/28/		
E 023	Policies/Procedures	for Medical Documentation	E 02	facility QA committee and		
SS=C	CFR(s): 483.73(b)(5	5)	-	community emergency pers	onnel	
				and includes, but not limited	4	
		ocedures. The [facilities] must		documented, updated curren	4	
		nent emergency preparedness		comprehensive policies and		
		ures, based on the emergency	444 444 444 444 444 444 444 444 444 44	procedures regarding a syste	em of	
		agraph (a) of this section, risk		medical documentation, pro	E .	
		graph (a)(1) of this section, tion plan at paragraph (c) of		patient information confider		
		licies and procedures must be		secures and maintains the	manty,	
		ted at least annually. At a		availability of records.		
		es and procedures must		availability of records.		
	address the following			0 7 72 1 4 1 4 1 1 1 1 1		
			ļ	2. Facility determined that all	. 11	
	(5) A system of med	dical documentation that		residents are potentially affe	cted by	
	preserves patient in	formation, protects		deficient practice.		
	confidentiality of pat	tient information, and secures				
	1	ability of records. [(5) or		3. Staff educated on or before	re	
		of medical documentation		10/28/18 by Administrato	r or	
		ent information, protects		designee regarding facilit	1	
		tient information, and secures		updated Emergency	, ,	
	and maintains avail	ability of records.		Preparedness plan policie	and	
	MENT DNILLCIA ALSA	02 749/h):1 Delision and		· · · · · · · · · · · · · · · · · · ·	t e	
		03.748(b):] Policies and ystem of care documentation		procedures on preserving	- ;	
	that does the follow			information, protecting pa	itient	
	(i) Preserves patien			health information		
		ntiality of patient information.		confidentially, how the fa	cility	
		aintains the availability of		secures and maintains the		
	records.			availability of patient/pro	i	
				records.		
	*[For OPOs at §486	6.360(b):] Policies and		iccords.		
	procedures. (2) A s					
	documentation that	preserves potential and actual				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII		(X3) DATE SURVEY COMPLETED			
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DICOURGI	DE NEIMB & NONGING	Observation Control of the Control o		W	ARRENTON, VA 20186		
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E 023	Continued From page		E	023 I	Documentation continued from page	: 12	
		otects confidentiality of					
	•	lonor information, and					
	secures and maintain	s the availability of records.			4. Upon completion of initial s		
					education, the Administrator	ror	
		is not met as evidenced			designee will monitor the		
	by:	incommend for ellipse above and			effectiveness of the Emerger	ncy	
		iew and facility document ned that the facility staff			Preparedness Manual plan the	nrough	
	failed to have a comp	•			staff interview and provide		
	preparedness plan.	nete emergency		l	outcomes to the QA commit	tee	
	proparograpo piari.				monthly. Additional educati		
	The facility staff failed	I to develop policies and			be provided monthly and as		
	_	e facility plans to preserve		İ	necessary and plan to be upo	lated as	
		rotect confidentiality of			indicated. Emergency Prepa		
	patient information, h	ow it secures and maintains	plan will be reviewed and update				
	the availability of reco	ords.			at least annually. Auditing for compliance will occur week	or	
:	The findings include:				months, October, November	- ;	
		o.m. a review of the facility's		ŀ	December; and compliance		
		ness plan and interview was			reported monthly at the QA		
	conducted with ASM				meetings. Random audits wi		
	member) # 1, adminis				conducted for 3 additional n	onths	
		reparedness plan failed staff			to March 2019.		
		cumentation of policies and					
		e facility plans to preserves otect the confidentiality of			The facility dutifully alleges		
		ow it secures and maintains			compliance of these tasks or	ı or	
	•	ords. ASM # 1 stated, " We			before 10/28/18.		
	don't ave the docume		***************************************				
	On 09/13/18 at appro	ximately 5:55 p.m., ASM	***************************************				
	(administrative staff n						
	administrator and AS	M # 2, director of nursing					
	were made aware of	the findings.					
	No further information	n was provided prior to exit.					
E 024		Volunteers and Staffing	E (024			

NAME OF PROVIDER OR SUPPLIER BROOKSIDE REHAB & NURSING CENTER CA1 ID PREFIX TAG	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				IPLE CONSTRUCTION	COM	E SURVEY PLETED	
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SS=C 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	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	ULD BE	(X5) COMPLETION DATE	
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: 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.		CFR(s): 483.73(b)(6) [(b) Policies and procedure of the policies and procedure plan set forth in paragasessment at paragand the communication this section. The policies and update minimum, the policies address the following (6) [or (4), (5), or (7) volunteers in an emestaffing strategies, infor integration of Stathealth care profession during an emergency and other strategies to address emergency. This REQUIREMENT by: Based on staff interview it was determinated to have a compreparedness plan. The facility staff failed procedures for the usstaffing strategies are staffing strategies and staffing strategies are staffing strategies and staffing strategies are staffing strategies are staffing strategies and staffing strategies are staffing strategies are staffing strategies and staffing strategies are staffing strategies and staffing strategies are staffing strategies are staffing strategies and staffing strategies are staffing	redures. The [facilities] must ent emergency preparedness res, based on the emergency graph (a) of this section, risk raph (a)(1) of this section, on plan at paragraph (c) of cies and procedures must be d at least annually. At a s and procedures must it:] as noted above] The use of trigency or other emergency cluding the process and role the and Federally designated enals to address surge needs of the surgency staffing as surge needs during an an are emergency staffing as surge needs during an are mergency staffing as use of volunteers in an are emergency staffing as used to develop policies and that the facility staff colete emergency d to develop policies and se of volunteers and other e in the emergency plan.	E	1. Brookside Rehab's Emeroparedness plan revieupdated on or before 10 facility QA committee a community emergency and includes, but not lindocumented, updated ar specific current and compolicies and procedures the facility's response to capacity needs, the use volunteers, role integrated designated Federal and healthcare professionals emergency staffing strated addressing surge needs. 2. Facility determined that residents are potentially deficient practice. 3. Staff educated on or before 10/28/18 by Administrated designee regarding facility updated Emergency Preplan policies and proceder relevant to facility response updated and proceder relevant to facility response to the proceder relevant to the proceder relevant to the proceder relevant to the proceder relevant to	ergency wed and /28/18 by and personnel nited to nd site- nprehensive regarding surge of ion of State s; and other tegies all affected by fore ttor or lity's eparedness dures onse to d		

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emergency preparednes conducted with ASM (ad member) # 1, administrat facility's emergency prepevidence documentation procedures for the use of staffing strategies are in ASM # 1 stated, "We dor documentation." On 09/13/18 at approximation (administrative staff memadministrator and ASM # were made aware of the No further information was Roles Under a Waiver December of CFR(s): 483.73(b)(8) [(b) Policies and procedures, plan set forth in paragrapiand the communication put in this section. The policies are address the following:] (8) [(6), (6)(C)(iv), (7), or [facility] under a waiver of the policies and procedures.]	s plan and interview was ministration staff tor. Review of the paredness plan failed to of policies and for volunteers and other the emergency plan and the emergency plan and plan in the emergency plan and plan in the example of the emergency plan in the example of the emergency proparedness as provided prior to exit. In the example of the emergency preparedness as based on the emergency of (a) of this section, plan at paragraph (c) of the example of the example of the example of the example of the emergency proparedness and procedures must be the example of the example		026	4. Upon completion of initial seducation, the Administrator designee will monitor the effectiveness of the Emerger Preparedness Manual plan the staff interview and provide outcomes to the QA commit monthly. Additional education be provided monthly and as necessary and plan to be upout indicated. Emergency Prepared plan will be reviewed and upout at least annually. Auditing from compliance will occur week months, October, November December; and compliance reported monthly at the QA meetings. Random audits we conducted for 3 additional not of March 2019. 5. The facility dutifully alleges compliance of these tasks of before 10/28/18.	tee on will lated as redness odated or ly x 3 and	

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E 026	Continued From page	e 13	E 0	26 E	E 026 I	Roles Under a Waiver Declar	ed by	
	procedures. (8) The r	ole of the RNHCl under a		S	Secreta	ary	-	
		e Secretary, in accordance						
		Act, in the provision of care			1.	Brookside Rehab's Emerger	icv	
	at an alternative care	site identified by emergency				Preparedness plan reviewed		
	management officials	i.				updated on or before 10/28/		
	This REQUIREMENT	is not met as evidenced				facility QA committee and		
	by:					community emergency pers	onnel	
		iew and facility document				and includes, but not limited	1	
		ned that the facility staff				documented, updated and si		
	failed to have a comp	ete emergency				specific current and compre		
	preparedness plan.					policies and procedures rega		İ
	The facility staff failer	to develop policies and				the facility's role and	numg	
		ergency plan that describe				responsibilities-provision of	Care	
		oviding care and treatment				and treatment at an alternate		
	*	ınder an 1135 waiver.				site-established by the 1135	section	
**************************************	The findings include:					of the declared waiver by th Secretary.	е	
	On 09/13/18 at 3:15 p	o.m. a review of the facility's			_			
		ness plan and interview was			2.			
	conducted with ASM	•				residents are potentially affe	cted by	
	member) # 1, adminis		***************************************			deficient practice.		
		preparedness plan failed to						
	evidence documentation	•			3.	Staff educated on or before		
		ergency plan that describe oviding care and treatment		ĺ		10/28/18 by Administrator of	r	
		under an 1135 waiver. ASM				designee regarding facility's	<u>,</u>	
		have the documentation."				updated Emergency Prepare	dness	
						plan policies and procedure	S	
	On 09/13/18 at appro	eximately 5:55 p.m., ASM				concerning the facility role	and	
	(administrative staff r	nember) # 1, the				responsibilities under 1135	waiver.	
- Company Comp		M # 2, director of nursing				-		
	were made aware of	the findings.		ļ				
	No further information	n was provided prior to exit						
E 029	Development of Com		EO	120				
SS=C	CFR(s): 483.73(c)	munication Fian	_ EU	,20				

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emergency prepared that complies with F and must be reviewed annually. This REQUIREMEN by: Based on staff interreview it was determ failed to have a compreparedness plan. The facility staff failed communication plant. The findings included On 09/13/18 at 3:15 emergency prepared conducted with ASN member) # 1, admir facility's emergency evidence document plan. ASM # 1 stated documentation." On 09/13/18 at apple (administrative staff administrator and A were made aware of the work of the properties of the proper	dness communication plan ederal, State and local laws ed and updated at least IT is not met as evidenced view and facility document nined that the facility staff uplete emergency ed to develop a d. p.m. a review of the facility's dness plan and interview was full (administration staff nistrator. Review of the preparedness plan failed to ation of a communication d, "We don't have the roximately 5:55 p.m., ASM member) # 1, the SM # 2, director of nursing ff the findings. on was provided prior to exit. g Information b)-(6) st develop and maintain an	E.		education, the Administrated designee will monitor the effectiveness of the Emerge Preparedness Manual plant staff interview and provide outcomes to the QA commitmentally. Additional educate be provided monthly and as necessary and plan to be up indicated. Emergency Prepaplan will be reviewed and up at least annually. Auditing compliance will occur week months, October, November December; and compliance reported monthly at the QA meetings. Random audits we conducted for 3 additional sto March 2019.	ency chrough ttee ion will dated as aredness updated for day x 3 er and vill be months	
emergency prepare	dness communication plan		***************************************			
	Continued From page (c) The [facility] must emergency prepared that complies with F and must be reviewed annually. This REQUIREMENT by: Based on staff interreview it was determ failed to have a compreparedness plan. The facility staff failed communication plant of the findings included to the communication plant. The findings included to the communication plant of the findings included to the communication plant. The findings included to the findings included the findings included to the communication plant. The findings included the findings	CORRECTION IDENTIFICATION NUMBER: 495267 ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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. Methods for Sharing Information	A BUILDI A95267 ROVIDER OR SUPPLIER DE REHAB & NURSING CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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. Methods for Sharing Information CFR(s): 483.73(c)(4)-(6) [(c) The [facility] must develop and maintain an	CORRECTION IDENTIFICATION NUMBER: 495267 ROVIDER OR SUPPLIER DE REHAB & NURSING CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 14 E 029 Sec (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. Methods for Sharing Information CFR(s): 483.73(c)(4)-(6) [(c) The [facility] must develop and maintain an	A BUILDING 495267 8. WING STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LAINE WARRENTON, VA 20186 SUMMAPY STATEMENT OF DEPLOEMCIES GEOM DEPOCINCY WAITS PREPERED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 RECUIREMENT 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 falled 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 failed to evidence documentation of a communication plan. ASM # 1 stated, "We don't have the documentation of a communication plan. ASM # 1 stated, "We don't have the documentation of a communication plan administrator and ASM # 2, director of nursing were made aware of the findings. No further information was provided prior to exit. Methods for Sharing information CFR(s): 483.73(c)(4)-(6) [(c) The [facility] must develop and maintain an emergency preparedness plan failed to evidence documentation of a communication plan. The findings include: On 08/13/18 at 3 proximately 5:55 p.m., ASM (administration as aff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings. No further information was provided prior to exit. Methods for Sharing information CFR(s): 483.73(c)(4)-(6) [(c) The [facility] must develop and maintain an establishment of the preparedness compliance of these tasks of the provided month of the provided month of the effectiveness of the Energy Preparedness Manual plan to be up indicated. Emergency Preparedn	A BULDING A BULDING BUNDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES GENERAB & NURSING CENTER SUMMARY STATEMENT OF DEFICIENCIES GENERICHEVY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 RECUIREMENT 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 communication plan. The facility staff failed to develop a communication plan. The facility staff failed to develop a communication plan. The facility staff failed to develop a communication plan. The facility staff failed to develop a communication plan. The facility semergency preparedness plan and interview was conducted with ASM (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. Methods for Sharing Information CFR(s): 483.73(c)(4)(6) (c) The [facility] must develop and maintain an

PRINTED: 09/25/2018 FORM APPROVED OMB NO. 0938-0391

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 sitespecific current and comprehensive
 policies and procedures to
 encompass an emergency
 preparedness communications plan.
- 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.

Event ID: OTHR11

PRINTED: 09/25/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			LETED		
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E 033	that complies with Fe and must be reviewe annually.] The comm all of the following: (4) A method for shal documentation for pacare, as necessary, waintain the continuit (5) A means, in the erelease patient inform CFR 164.510(b)(1)(ii) required for HHAs un	deral, State and local laws d and updated at least unication plan must include ring information and medical tients under the [facility's] with other health providers to	EO	E 029 Development of Common Plan continued from page 18 Auditing for compliance weekly x 3 months, November and Dece compliance reported QA meetings. Rando be conducted for 3 a months to March 20 5. The facility dutifully compliance of these before 10/28/18.	ance will occur October, ember; and I monthly at the om audits will dditional 19.		
	about the general corpatients under the [faunder 45 CFR 164.5] *[For RNHCIs at §40 sharing information a patients under the RI with care providers to care, based on the winder by the patient or representative. *[For RHCs/FQHCs are of providing information and location facility's care as permited to the condition and location facility's care as permited to the condition and location facility's care as permited to the condition and location facility's care as permited to the condition and location facility's care as permited to the condition and location facility's care as permited to the condition and location facility's care as permited to the condition and location facility's care as permited to the condition and location facility's care as permited to the condition and location facility is ca	3.748(c):] (4) A method for and care documentation for NHCl's care, as necessary, o maintain the continuity of a maintain the continuity of a method or his or her legal at §491.12(c):] (4) A means and about the general and of patients under the		E 033 Methods for Sharing I 1. Brookside Rehab's I Preparedness plan re updated on or before facility QA committ community emerger and includes, but no documented, update specific current and policies and procedu methods of sharing i medical documentat health care provider	Emergency eviewed and e 10/28/18 by tee and ney personnel at limited to d and site- comprehensive ares regarding information and tion with other		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: OTHR11

Facility ID: VA0178

If continuation sheet Page 19 of 146

outcomes to the QA committee monthly. Additional education will

necessary and plan to be updated as indicated. Emergency Preparedness plan will be reviewed and updated

be provided monthly and as

at least annually.

Facility ID: VA0178

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1''	RIPLE CONSTRUCTION NG	C	X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER DE REHAB & NURSING	CENTER		STREET ADDRESS, CITY, STATE 614 HASTINGS LANE WARRENTON, VA 20186	, ZIP CODE	
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E 033	failed to have a compreparedness plan. The facility staff faile evidence that the comethod for sharing is documentation for parameters, as necessary, maintain the continual communication plan provide documentation developed policies at the means the facility information to include location of patients are communication plan. The findings include On 09/13/18 at 3:15 emergency prepared conducted with ASM member) # 1, admin facility's emergency evidence documentation plan includes a methan dedical documentation facility's care, as new providers to maintain reviewing the communication devidence documentation to evidence documentation and location and location and location of the documentation and location and location and location and location and location plan have the documentation plan have the documentation plan have the documentation.	d to provide documented mmunication plan includes a information and medical atients under the facility's with other health providers to ity of care by reviewing the . The staff also failed to ion that the facility has and procedures that address y will use to release patient the the general condition and by reviewing the	E	weekly x 3 m November an compliance re QA meetings be conducted months to Ma 5. The facility designs	compliance will onths, October, d December; and eported monthly. Random audits for 3 additional arch 2019. utifully alleges f these tasks on e	occur d at the will

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMPI	LETED
		495267	B. WING			i	C 13/2018
	ROVIDER OR SUPPLIER DE REHAB & NURSING	CENTER		614	REET ADDRESS, CITY, STATE, ZIP CODE 4 HASTINGS LANE ARRENTON, VA 20186		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
E 035 SS=C	(administrative staff radministrator and AS were made aware of No further information LTC and ICF/IID Sha CFR(s): 483.73(c)(8) [(c) The [LTC facility and maintain an emecommunication plants State and local laws updated at least annuplan must include all (8) A method for shall emergency plan, that is appropriate, with refamilies or representations appropriate, with refamilies or representations appropriate, with refamilies or staff intervence it was determined to have a compreparedness plan. The facility staff failed documentation that the includes a method for staff intervence in the staff failed documentation that the includes a method for staff intervence in the staff failed documentation that the includes a method for staff intervence in the staff failed documentation that the includes a method for staff intervence in the staff failed documentation that the includes a method for staff intervence in the staff failed documentation that the includes a method for staff intervence in the staff failed documentation that the staff intervence in the staff failed documentation that the staff intervence in the staff inter	member) # 1, the M # 2, director of nursing the findings. In was provided prior to exit. In and ICF/IID] must develop Irgency preparedness that complies with Federal, and must be reviewed and Italian information from the Interest the facility has determined esidents [or clients] and their atives. I is not met as evidenced Iriew and facility document Iried that the facility staff Collete emergency I to provide evidence of the communication plan I sharing information from		D33	2 035 LTC and ICF/IID Sharing Plate Patients CFR(s) 1. Brookside Rehab's Emergen Preparedness plan will be possible and available for all visitors, residents/clients and their far or representatives on or before 10/28/18. Additionally, the Emergency Preparedness plate discussed upon admission all new residents and their advocates. Emergency Preparedness will be discussed ongoing with residents during Resident Council and educate provided as needed. 2. Facility determined that all residents are potentially afferdeficient practice. 3. Staff educated on or before	cy ested milies ore on will of with eed, on the tion	
	determined it is approclients and their fami reviewing the plan. The findings include: On 09/13/18 at 3:15	and that the facility has operiate with residents or lies or representatives by p.m. a review of the facility's ness plan and interview was			10/28/18 by Administrator of designee regarding commun of the facility's updated Emergrane Preparedness plan to clients, visitors, advocates, residents representatives.	ication ergency	
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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED				
		495267	B. WING				, 13/2018
	ROVIDER OR SUPPLIER DE REHAB & NURSING	CENTER		6	TREET ADDRESS, CITY, STATE, ZIP CODE 14 HASTINGS LANE VARRENTON, VA 20186		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 035	conducted with ASM member) # 1, administracility's emergency pevidence documentar plan includes a methe from the emergency peridents and their familiar reviewing the plan. A have the documentation on 09/13/18 at approximation approximation and AS were made aware of the Month of	(administration staff strator. Review of the preparedness plan failed to tion that the communication od for sharing information plan, and that the facility has priate with residents or lies or representatives by SM # 1 stated, "We don't ion." Eximately 5:55 p.m., ASM member) # 1, the M # 2, director of nursing the findings. In was provided prior to exit. ting Ing. The [facility] must an emergency g and testing program that is ency plan set forth in section, risk assessment at his section, policies and eaph (b) of this section, and lan at paragraph (c) of this and testing program must atted at least annually. 3.475(d):] Training and must develop and maintain redness training and testing d on the emergency plan set		1	E 035 LTC and ICF/IID Sharing Platents CFR(s) continued from page 4. Upon completion of initial seducation, the Administrator designee will monitor the effectiveness of the Emerger Preparedness Manual plan the staff interview and provide outcomes to the QA commit monthly. Additional education residents, staff, or other relevant individuals will be provided monthly and as necessary and to be updated as indicated. Emergency Preparedness plate be reviewed and updated at a lannually. Auditing for comp will occur weekly x 3 month October, November and Decand compliance reported monthe QA meetings. Random a will be conducted for 3 addition months to March 2019. 5. The facility dutifully alleges compliance of these tasks or before 10/28/18.	taff or ney nrough tee on to vant d plan in will least liance is, rember; nthly at udits tional	
		raph (a)(1) of this section, res at paragraph (b) of this					

	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER		X2) MULTIPLE CONSTRUCTION			SURVEY LETED
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NAME OF P	ROVIDER OR SUPPLIER		1	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
DD001/01	DE DELLAD A MUDOMA	OFNTER		61	4 HASTINGS LANE		
BKOOKSI	DE REHAB & NURSING	CENTER		W	ARRENTON, VA 20186		
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E 036	section, and the comparagraph (c) of this testing program must least annually. The IC requirements for evaluation of the section of the section, and orientation program to the section, risk assessment of this section, policies (b) of this section, policies (b) of this section, and paragraph (c) of this and orientation progrupdated at least annual this REQUIREMENT by: Based on staff interview it was determined to have a compare preparedness plan. The facility staff failed documentation that the training and testing prequirements of the redocumentation that the section of the redocumentation that th	munication plan at section. The training and be reviewed and updated at CF/IID must meet the cuation drills and training at at §494.62(d):] Training, on. The dialysis facility must an emergency g, testing and patient hat is based on the forth in paragraph (a) (1) of and procedures at paragraph d the communication plan at section. The training, testing am must be reviewed and ually. I is not met as evidenced riew and facility document ined that the facility staff olete emergency I to provide evidence of the facility has a written arogram that meets the regulation and the training and testing viewed and updated on, at s.	E	036 I	 Brookside Rehab's Emergent Preparedness plan reviewed updated on or before 10/28/facility QA committee and community emergency personand includes, but not limited written/documented, update site-specific current and comprehensive policies and procedures, plus regulatory standards regarding training testing of employees for the Emergency Preparedness plus orientation and annually and include documentation and competency and completion also E 037. Facility determined that all residents are potentially affected deficient practice. Staff educated on or before 10/28/18 by Administrator of designee to validate underst of facility's updated Emergency Preparedness plan. Addition education to be provided as indicated. Staff Development Coordinator/ADON and Hu Resources educated on or be 	and 18 by onnel I to d and an upon I will staff See ected by or anding ency al int man efore	
		p.m. a review of the facility's ness plan and interview was (administration staff			10/28/18 by Administrator t validate training and testing program is available and off		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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		495267	B. WING			09/	13/2018	
NAME OF P	ROVIDER OR SUPPLIER			S.	STREET ADDRESS, CITY, STATE, ZIP CODE			
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BROOKSI	DE RENAD & HURSING	CENTER		WARRENTON, VA 20186				
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E 036 E 037 SS=C	facility's emergency pevidence that the facitesting program that the regulation and do and testing program updated on, at least a stated, "We don't have On 09/13/18 at appro (administrative staff radministrator and AS were made aware of No further information EP Training Program CFR(s): 483.73(d)(1) (1) Training program ASCs, PACE organiz and dialysis facilities] (i) Initial training in er	strator. Review of the preparedness plan failed to dility has a written training and meets the requirements of cumentation that the training has been reviewed and an annual basis. ASM # 1 we the documentation." extractly 5:55 p.m., ASM member) # 1, the SM # 2, director of nursing the findings.			E 036 Training and Testing continupage 24 upon orientation and annuemployees. Training calentinclude updates. 4. Upon completion of initial education, the Administration designee will monitor the effectiveness of the Emergange Preparedness Manual plantstaff interview and provide outcomes to the QA commonthly. Additional education be provided monthly and a necessary and plant to be usindicated. Emergency Preplanting will be reviewed and at least annually. Auditing compliance will occur were months, October, November, and compliance	staff or or ency through cittee tion will s pdated as paredness updated for skly x 3 er and e		
	staff, individuals provarrangement, and volexpected role. (ii) Provide emergence least annually. (iii) Maintain docume (iv) Demonstrate staff procedures. *[For Hospitals at §44 at §491.12:] (1) Trair or RHC/FQHC] must (i) Initial training in elepolicies and procedures.				reported monthly at the Queetings. Random audits conducted for 3 additional to March 2019. 5. The facility dutifully alleg compliance of these tasks before 10/28/18.	will be months es		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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INAME OF P	NOVIDEN ON SOFT EIEN				614 HASTINGS LANE		
BROOKS	DE REHAB & NURSING	CENTER			WARRENTON, VA 20186		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
E 037	expected roles. (ii) Provide emergence least annually. (iii) Maintain documer (iv) Demonstrate staff procedures. *[For Hospices at §44 hospice must do all of (i) Initial training in empolicies and procedure hospice employees, a services under arrange expected roles. (ii) Demonstrate staff procedures. (iii) Provide emergence least annually. (iv) Periodically reviewemergency prepared employees (including special emphasis pla	unteers, consistent with their by preparedness training at intation of the training. I knowledge of emergency 18.113(d):] (1) Training. The If the following: Inergency preparedness res to all new and existing and individuals providing I gement, consistent with their I knowledge of emergency cy preparedness training at	E	037	E 037 EP Training Program	and 18 by onnel to ce- nensive nd duals ed role nore,	
	(i) Initial training in er policies and procedure staff, individuals provarrangement, and voi expected roles. (ii) After initial training preparedness training (iii) Demonstrate staff procedures.	must do all of the following: nergency preparedness res to all new and existing iding services under unteers, consistent with their g, provide emergency			residents are potentially affe deficient practice.	cted by	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			A. BUILD		(X3) DATE SURVEY COMPLETED C		
		495267	B. WING				: 13/2018
	ROVIDER OR SUPPLIER DE REHAB & NURSING	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
E 037	preparedness training *[For PACE at §460.8 organization must do (i) Initial training in en policies and procedur staff, individuals providuals providuals providuals providuals providuals annually. (ii) Provide emergence least annually. (iii) Demonstrate staff procedures, including what to do, where to g case of an emergence (iv) Maintain docume *[For CORFs at §485 CORF must do all of (i) Provide initial train preparedness policies and existing staff, index under arrangement, a with their expected ro (ii) Provide emergence least annually. (iii) Maintain docume (iv) Demonstrate staff procedures. All new p and assigned specific the CORF's emergence their first workday. Th include instruction in alarm systems and se equipment.	all of the following: nergency preparedness res to all new and existing iding on-site services under stors, participants, and it with their expected roles. by preparedness training at if knowledge of emergency informing participants of go, and whom to contact in y. Intation of all training. In emergency is and procedures to all new lividuals providing services and volunteers, consistent of the training. Intation of the training at intation of the training. Intation of the training at intation of the training at intation of the training. Interview preparedness training at intation of the training at intation of the training. Interview preparedness training at intation of the training at intation of the training. Interview preparedness training at intation of the training at intation of the training. Interview preparedness training at intation of the training at intation of the training. Interview preparedness training at intation of the training. Interview preparedness training at intation of the training. Interview preparedness training at intation of the training. Interview preparedness training at intation of the training. Interview preparedness training at intation of the training. Interview preparedness training at intation of the training. Interview preparedness training at intation of the training. Interview preparedness training at intation of the training. Interview preparedness training at intation of the training. Interview preparedness training at intation of the training. Interview preparedness training at intation of the training. Interview preparedness training at intation of the training at intation of the training. Interview preparedness training at intation of all training at intation of all training at intation of all training at intation of all training at intation of all training at intation of all training at intation of all training at intation of all training at intation of all training at intation of all training at intation of all training at intation of all training at intation of all	E		E 037 EP Training Program continue page 26 3. Staff, individuals providing services under arrangement, volunteers educated on or be 10/28/18 by Administrator of designee to ensure understart the facility's updated Emerg Preparedness plan policies a procedures. Additional educe be provided as indicated. State Development Coordinator/A and Human Resources educe or before 10/28/18 by Administrator to ensure train and testing program is availated offered upon orientation and annually to employees. In-Scalendar to include updates. 4. Upon completion of initial seducation, the Administrator designee will monitor the effectiveness of the Emergency Preparedness Manual plan the staff interview and provide outcomes to the QA commit monthly. Additional education be provided monthly and as necessary and plan to be updindicated. Emergency Preparedness Manually.	efore or oding of ency od ation to off DON oted on oning oble and ervice taff or or or or oney on will dated as redness	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	FIPLE CONSTRUCTION NG	СОМ	(X3) DATE SURVEY COMPLETED C	
		495267	B. WING _			/13/2018
NAME OF PROVIDER OR SUPPLIER BROOKSIDE REHAB & NURSING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186		
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		1	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
E 037	(i) Initial training in er policies and procedu reporting and extinguand where necessary personnel, and guest cooperation with firef authorities, to all new individuals providing and volunteers, constroles. (ii) Provide emergence least annually. (iii) Maintain docume (iv) Demonstrate staff procedures. *[For CMHCs at §488 CMHC must provide preparedness policie and existing staff, incunder arrangement, with their expected redocumentation of the demonstrate staff kniprocedures. Thereaft emergency prepared annually. This REQUIREMENT by: Based on staff intermedialed to have a compreparedness plan. The facility staff faile documentation of the documentation of the facility staff faile documentation of the documentation of the facility staff faile documentation of the facility	mergency preparedness res, including prompt sishing of fires, protection, y, evacuation of patients, ts, fire prevention, and ighting and disaster y and existing staff, services under arrangement, istent with their expected cy preparedness training at ntation of the training. If knowledge of emergency s and procedures to all new dividuals providing services and volunteers, consistent ples, and maintain of training. The CMHC must powledge of emergency ter, the CMHC must provide mess training at least If is not met as evidenced wiew and facility document ined that the facility staff plete emergency d to provide evidence of a facility's initial emergency g and annual emergency g and annual emergency	E	Auditing for compliance weekly x 3 months, Oct November and Decemb compliance reported months to March 2019. 5. The facility dutifully all compliance of these tash before 10/28/18.	e will occur ober, er; and nthly at the nudits will ional	:

	F CORRECTION	IDENTIFICATION NUMBER:	1 ' '	G	COMPLETED
		495267	B. WING		C 09/13/2018
	ROVIDER OR SUPPLIER DE REHAB & NURSING	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186	•
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E 037	documentation that initial & annual emer The findings include On 09/13/18 at 3:15 of the facility's emergenducted with ASM member) # 1, admin facility's emergency evidence documentatemergency prepared	p.m. a review and interview gency preparedness plan was a (administration staff istrator. Review of the preparedness plan failed to ation of the facility's initial dness training and annual	EO	37	
	documentation that initial & annual emeration." On 09/13/18 at appreciation (administrative staff administrator and Adwere made aware of the No further information (EP Testing Requires CFR(s): 483.73(d)(2) (2) Testing. The [fact RNHCIs and OPOsitest the emergency [facility, except for all of the following: *[For LTC Facilities The LTC facility must the emergency plant unannounced staff of the state of the staff of	oximately 5:55 p.m., ASM member) # 1, the SM # 2, director of nursing f the findings. on was provided prior to ments	ΕO	E 039 EP Testing Requirements 1. Brookside Rehab's Emergore Preparedness plan review updated on or before 10/2 facility QA committee an community emergency poinclude participation in a exercise, including but not to unannounced staff drill the emergency procedure additional full-scale or tal exercise for two (2) exercise for two (2) exercise for two (3) exercise for two (4) exercise for two (5) exercise for two (6) exercise for two (7) exercise for two (8) exercise for two (9) exercise for two (10) e	ed and 18/18 by d ersonnel to full-scale at limited as using as and an oble-top cises are facility response tation of ses, vise the

to validate systems followed. Emergency Preparedness plan to be

updated as indicated.

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (A. BUILDING		СОМЕ	SURVEY PLETED
		495267	B. WING	-		C /13/2018
NAME OF PROVIDER OR SUPPLIER BROOKSIDE REHAB & NURSING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODI 614 HASTINGS LANE WARRENTON, VA 20186	2	,
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
E 039	following:] (i) Participate in a full community-based or exercise is not acces facility-based. If the [i actual natural or man requires activation of [facility] is exempt fro community-based or full-scale exercise for the actual event. (ii) Conduct an additional exercise for the actual event. (ii) Conduct an additional exercise for the actual event. (ii) Conduct an additional exercise for the actual event. (iii) Conduct an additional exercise for the actual event. (iii) A second full-scommunity-based or (B) A tabletop exercise for the actual exercises and emergency plan. (iiii) Analyze the [facil maintain documentate exercises, and emerge [facility's] emergency *[For RNHCIs at §40 §486.360] (d)(2) Tes must conduct exercise plan. The [RNHCI and following: (i) Conduct a paperleast annually. A table discussion led by a facilinically relevant emore problem statements.	a-scale exercise that is when a community-based sible, an individual, facility] experiences an anade emergency that the emergency plan, the im engaging in a individual, facility-based 1 year following the onset of conal exercise that may lited to the following: cale exercise that is individual, facility-based. Individual, facility-based reise that includes a group acilitator, using a narrated, ergency scenario, and a set is, directed messages, or lesigned to challenge an ity's] response to and iton of all drills, tabletop gency events, and revise the plan, as needed. 3.748 and OPOs at ting. The [RNHCI and OPO] ses to test the emergency	E	E 039 EP Testing Requirements from page 30 Auditing for compliants weekly x 3 months, on the compliance reported QA meetings. 5. The facility dutifully compliance of these the before 10/28/18.	nce will occur October, mber; and monthly at the	

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	A. BUILDING			COMPLETED	
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NAME OF PROVIDER OR SUPPLIER BROOKSIDE REHAB & NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE	
E 039	emergency plan. (ii) Analyze the [RN to and maintain doc exercises, and eme [RNHCl's and OPO' needed. This REQUIREMEN by: Based on staff interreview it was determ failed to have a compreparedness plan. The facility staff failed documentation of the full-scale exercise, community based eresponse and how the emergency program analysis. The findings include On 09/13/18 at 3:15 emergency prepare conducted with ASM member) # 1, admin facility's emergency evidence document and full-scale exercity full-scale community analysis, response its emergency programalysis. ASM # 1 stocumentation." On 09/13/18 at app (administrative staff)	IHCI's and OPO's] response umentation of all tabletop regency events, and revise the s] emergency plan, as IT is not met as evidenced review and facility document nined that the facility staff replete emergency ed to provide evidence of the facility's tabletop and efforts to identify a full-scale exercise, exercise analysis, the facility updated its in based on the exercise. E. D. m. a review of the facility's dness plan and interview was all (administration staff inistrator. Review of the preparedness plan failed to ration of the facility's tabletop ise, efforts to identify a y based exercise, exercise and how the facility updated ram based on the exercise stated, "We don't have the	E	039				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER BROOKSIDE REHAB & NURSING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186		710/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
E 039	Continued From page were made aware of No further information		EO	39			
F 000	exit. INITIAL COMMENTS		FO	000			
W	survey was conducte Four complaints were survey. Corrections a with the following 42 Term Care requireme survey/report will follo						
F 550 SS=D	122 at the time of the consisted of 34 curre (Residents #38, #100 113, #39, #96, #76, # #23, #101, #54, #49, # 64, #115, #53, #74, three closed record re and #123). Resident Rights/Exer	0, #66, #27, #81, #5, #36, # 160, #71, #75, #2, #61, #50, # 77, #117, #112, #108, #4, #8, #102, #273, #97) and eviews (Residents #40, #57 cise of Rights	F 5	550			
	§483.10(a) Resident The resident has a riq self-determination, ar access to persons an						
	with respect and digr resident in a manner promotes maintenand	ty must treat each resident lity and care for each and in an environment that ce or enhancement of his or ognizing each resident's					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		495267	5267 B. WING				C 13/2018
NAME OF PROVIDER OR SUPPLIER				s	STREET ADDRESS, CITY, STATE, ZIP CODE	1	10/2010
				61	14 HASTINGS LANE		
BROOKSI	DE REHAB & NURSING	CENTER		W	VARRENTON, VA 20186		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 550	Continued From page	⊋ 28	F :	550	F 550 Resident Rights/Exercise of l	lights	
	individuality. The faci		, ,		1. Styrofoam and plastic cups	were	
	promote the rights of				removed from the dining ro		
	promote the ngme of				no further Styrofoam plates		
	§483.10(a)(2) The fac	cility must provide equal			plastic cups and silverware		
	access to quality care	e regardless of diagnosis,			given to residents since Ser		
		or payment source. A facility			13th, 2018.	10111001	
		aintain identical policies and			1541, 2010.		
		ansfer, discharge, and the			2. The utensils for all resident	s at the	
		under the State plan for all			facility will be monitored for		
	residents regardless	or payment source.			serving of meals with the	,,	
	§483.10(b) Exercise	of Rights			appropriate utensils.		
		right to exercise his or her			uppropriate attitudes.		
		f the facility and as a citizen			3. Dietary Staffing levels will	he	-
	or resident of the Uni				monitored, and increased re		
					efforts will be initiated. A f	_	
		cility must ensure that the			policy and procedure gover	-	
	1	his or her rights without			use of Styrofoam and plasti		
	3	n, discrimination, or reprisal	-		utensils has been developed		
	from the facility.		***************************************		education will be provided		
	8483 10/h)/2) The re	sident has the right to be			dietary staff by October 28		
		coercion, discrimination, and			dictary start by october 20	, 2010.	
		ity in exercising his or her			4. Auditing of meal times for		
		orted by the facility in the			compliance using an auditi	ng tool	
	exercise of his or her	rights as required under this			that addresses the use of St	_	
	subpart.				and plastic utensils. Auditin		
	1	is not met as evidenced			compliance will occur daily	_	
	by:				x3months, October, Novem		
		on, resident interview, staff of facility documentation it			December and compliance		
		staff failed to promote dignity			monthly at the QA meeting		
	1	of two facility dining rooms,			Random audits will be con-		
	(the north unit dining				for 3 additional months to 1 2019 by the Dietary Manag	March	
	The facility staff failed	d promote resident dignity			2019 by the Dietary Manag	,U1 .	
		orth dining room. Residents					
	were observed being	given plastic silverware and					
	disposable plastic cu	ns during observation of					

DEPARTMENT OF HEALTH AND HUMAN SERVICES	FORM	APPROVED
CENTERS FOR MEDICARE & MEDICAID SERVICES	F 550 Resident Rights/Exercise of Rights	. 0938-0391
	continued from page 34.	
	Johnnada Hom page 5	
	5. The facility dutifully alleges	
	compliance of these tasks on or before 10/28/18.	
	before 10/28/18.	;
	1 1	

Event ID: OTHR11

PRINTED: 09/25/2018

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		495267	B. WING			C 9/13/2018	
	ROVIDER OR SUPPLIER	IG CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186			
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 550	Continued From pa three meals on 9/1 dining room.	age 29 2 and 9/13/18, in the north	F 5	50			
	The findings includ	e :				- L- L- Transporter Company	
	12:40 p.m. of the n	on was conducted on 9/11/18 at orth dining room. Residents ng given plastic silverware and cups.					
	p.m. with LPN (lice unit manager. Whe given plastic silven	onducted on 9/11/18 at 12:46 nsed practical nurse) #2, the en asked why residents were ware and disposable plastic ed, "They (dietary) don't have				of the second se	
	control." When ask #2 stated it was no residents) need so	regular cups). It's out of my ed if this was acceptable, LPN t. LPN #2 stated, "They (the mething hard to hold on to. I've onths for the hard plastic cups.					
	Because they need we get more spills.	d something hard to hold on to, I don't have a choice but to b keep them hydrated."					
	p.m. with OSM (oth dietary manager. V silverware and disp	onducted on 9/11/18 at 12:51 ner staff member) #3, the Vhen asked why plastic posable plastic cups were north dining room, OSM #3					
	stated, "I've ordere that's why we're us residents) keep it i	d some and we've run out sing plastic. Some (of the n their rooms or hoard it."					
	9/11/18 at 3:30 p.r the residents were	neeting was conducted on n. with ten residents. Seven of cognitively intact. When asked residents stated that the food					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	E CONSTRUCTION	COMPLETED		
		495267	B. WING		09/13/2018	
	NAME OF PROVIDER OR SUPPLIER BROOKSIDE REHAB & NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 114 HASTINGS LANE WARRENTON, VA 20186		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE COMPLETION	
F 550	could be cold espec Styrofoam containe were given Styrofoas stated, "Because the kitchen." A dining observation 8:00 a.m., 9/12/18 8:15 a.m. of the nor residents were given plastic cups. An interview was coa.m. with OSM #3, asked if residents were staff che that meant, OSM # to run the kitchen." the Styrofoam containe when we're staff. When asked residents, OSM #3 asked if it was hom Styrofoam containe ma'am. It's a dignite better." An interview was coa.m. with CNA (cer assistant that work asked how often redisposable plastic of CNA #1 stated, "I'm not enough cups the with the silverware.	cially when served in the ers. When asked why they arm containers, the residents ney're short staffed in the end of the ers. When asked why they arm containers, the residents ney're short staffed in the end of the ers. On each day, and a mix of hard and soft ers. Osh #3 stated, "We use it hallenged." When asked what a stated, "Not enough people OSM #3 stated that they used ainers so they didn't have enough what the facility was to the stated, "It's their home." When helike to serve meals in ers, OSM #3 stated, "No y issue. I'm trying to do it ers. OSM #3 stated, "No y issue. I'm trying to do it ers. Osh #3 esteed the ers. Osh #3 esteed the ers. Osh #3 esteed, "No y issue. I'm trying to do it ers. Osh #3 esteed the ers. Osh #3 esteed the ers. Osh #3 esteed the ers. Osh #3 esteed the ers. Osh #4 esteed the ers. Osh #4 esteed the ers. Osh #4 esteed the ers. Osh ers. Osh #4 esteed the ers. Osh ers. Osh ers. Osh #4 esteed the ers. Osh ers.	F 550			

PRINTED: 09/25/2018 FORM APPROVED OMB NO. 0938-0391

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) PLAN OF CORRECTION (X4) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING			OMPLETED C				
		495267	B. WING_			09/13/2018		
	NAME OF PROVIDER OR SUPPLIER BROOKSIDE REHAB & NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORF ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
F 550	the director of nursir facility was to the resplace is home. When When asked if she a containers, ASM #2 and it comes in Styrodishes." When asked don't like the taste." acceptable for the restyrofoam container. On 9/13/18 at 10:35 staff member) #1, the director of nursir findings. ASM #1 stathat." An interview was cop.m. with OSM #4, the When asked about meals in Styrofoam they had used Styroshort staffing so the OSM #4 stated, "We while. We usually or should have three." his meals out of Styrofoam the disposable plast don't know why they get a better type of the facility policy tit documents, "Each responding to the container."	ing. When asked what the sidents, ASM #2 stated, "This re their needs are being met." Interested, "When I order food in ofoam I transfer it to my own down, ASM #2 stated, "I When asked if it was esidents to be given meals in ris, ASM #2 stated it was not. a.m. ASM (administrative administrator and ASM #2, and were made aware of the ated, "I've talked to her about and acted on 9/13/18 at 1: 11 are assistant dietary manager. The action of the acti	F	550				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: OTHR11

Facility ID: VA0178

If continuation sheet Page 38 of 146



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		INCUTIFICATION NUMBER		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495267	B. WING		C 09/13/2018	
	ROVIDER OR SUPPLIER DE REHAB & NURSING	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E COMPLETION	
F 558 SS=D	life, dignity, respect a Reasonable Accomm CFR(s): 483.10(e)(3) §483.10(e)(3) The rig services in the facility accommodation of re preferences except v endanger the health other residents. This REQUIREMEN' by: Based on observation interview, facility door record review, it was staff failed to ensure	and individuality." nodations Needs/Preferences) ght to reside and receive y with reasonable esident needs and	F 55		water, each. /2018. ms will y other	
	The facility staff faile call bell (a device with pushed to alert staff personal cell phone at the resident's reach. The findings include: Resident # 8 was ad 06/01/18 with diagnoral not limited to cerebra (2), and hypertensional Resident # 8's most set), an admission a (assessment referent Resident # 8 as scott	: Imitted to the facility on oses that included but were al palsy (1), diabetes mellitus,		 Audits and immediate resolution of identified issues with compliance. Reeducation of facility staff. Daily Management Rounds Staff rounds. Daily manage rounds in each room to identified address the positioning of pritems are within the resident reach. Daily x 3months and reported to QA committee to QA committee to QA compliance of these tasks of before 10/28/18. 	fall and ment atify and ersonal t's i monthly.	

PRINTED: 09/25/2018 FORM APPROVED OMB NO. 0938-0391

AND DIAM OF CODDECTION IDENTIFICATION MINDED		1 ` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		495267	B. WING _		09/) 13/2018
NAME OF PROVIDER OR SUPPLIER BROOKSIDE REHAB & NURSING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 558	- 15, 13 - being cognidecisions. Resident # limited to extensive a member for activities On 09/11/18 04:10 p. conducted with Resident # 8 was lyin position, with her feet the bed and her head flat on the mattress. The mattress to the le Observation of the cahanging over the left Resident # 8's bed w toward the inside of to of the room revealed positioned parallel to over-the-bed table cowith water in each of activate the call bell fextended her right ar it. It's always difficult When asked if she cowater bottle on the owners.	tively intact for making daily 8 was coded as requiring ssistance of one staff of daily living. m., an interview was lent # 8 in her room. Ig in her bed in a diagonal at the bottom left corner of the interview was lent # 8 in her room. If in upper right corner lying five pillows were directly on fit of Resident #8's head. If bell revealed it was side of the head board of the head board of the head board of the bed. Further observation the over-the-bed table, was the left side of the bed. The entained three water bottles them. When asked to Resident # 8 partially m and stated, "I can't reach to reach the call beli." buld reach and obtain the ver-the-bed table, Resident #	F 5			
	can't reach it." During a telephone rang in F asked if that was her stated, "It my cell pho phone was located o of the bed in front of When asked if she w phone, Resident # 8 problem. I can't get to too." When asked ho she cannot reach the stated, "I yell or I hav	ner right arm and stated, "I y the course of the interview, Resident # 8's room. When phone ringing Resident # 8 one." Resident # 8's cell on a bedside table at the foot the window in the room. anted to answer her cell stated, "That's another o my cell phone to answer it w she gets assistance when a call bell, Resident # 8 e to ask my roommate a lot call bell on." When how it				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: OTHR11

Facility ID: VA0178

If continuation sheet Page 40 of 146

	A. BOILDING		COMPLETED				
495267	B. WING		1	3/2018			
NAME OF PROVIDER OR SUPPLIER BROOKSIDE REHAB & NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186				
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH CORRECTIVE ACTION SHO	OULD BE	(X5) COMPLETION DATE			
ave to yell to get assistance ess to her personal cell phone, d, "It's just the way it is." When sition in the bed Resident # 8 comfortable. When asked bed Resident # 8 stated she the staff member and "They thurry." When asked about lent # 8 stated, "It makes me O a.m., an observation dent # 8 and her room, # 8 was lying in bed. An call bell revealed it was the side of the head board of with the activation switch of the bed. Further observation the telft side of the bed. The contained three water bottles of them. When asked to reach the call bell, Resident # 8 stated, bservation of Resident # 8's d it was located on a bedside the bed in front the window in the sident # 8's reach. Resident # the ped Resident # 8 aled Resident # 8 was lying in the of the call bell revealed it	F 554						
d it was located on a bedside the bed in front the window in esident # 8's reach. Resident # enable to reach her water ., observation of Resident # 8							
	STATEMENT OF DEFICIENCIES ACY MUST BE PRECEDED BY FULL AR LSC IDENTIFYING INFORMATION) age 34 ave to yell to get assistance ess to her personal cell phone, di, "It's just the way it is." When esition in the bed Resident # 8 comfortable. When asked bed Resident # 8 stated she e staff member and "They hurry." When asked about eent # 8 stated, "It makes me 0 a.m., an observation lent # 8 and her room, # 8 was lying in bed. An call bell revealed it was eff side of the head board of with the activation switch of the bed. Further observation ed the over-the- bed- table the left side of the bed. The contained three water bottles of them. When asked to reach e call bell, Resident # 8 stated, beservation of Resident # 8's dit was located on a bedside the bed in front the window in esident # 8's reach. Resident # nable to reach her water 1., observation of Resident # 8 aled Resident # 8 was lying in or of the call bell revealed it the left side of the head board did with the activation switch	In CENTER STATEMENT OF DEFICIENCIES INCY MUST BE PRECEDED BY FULL INCLISC IDENTIFYING INFORMATION) Inge 34 I	STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186 STATEMENT OF DEFICIENCIES (CY MUST BE PRECEDED BY FULL RELSC IDENTIFYING INFORMATION) AND STATEMENT OF DEFICIENCY) AND STATEMENT OF DEFICIENCY AND STATEMENT OF THE APPERING (EACH CORRECTIVE ACTION SHIT CROSS-REFERENCED TO THE APPERING (EACH CORRECTIVE ACTION SHIT CROSS-REFERENCED TO THE APPERING (EACH CORRECTIVE ACTION SHIT CROSS-REFERENCED TO THE APPERING (EACH CORRECTIVE ACTION SHIT CROSS-REFERENCED TO THE APPERING (EACH CORRECTIVE ACTION SHIT CROSS-REFERENCED TO THE APPERING (EACH CORRECTIVE ACTION SHIT CROSS-REFERENCED TO THE APPERING (EACH CORRECTIVE ACTION SHIT CROSS-REFERENCED TO THE APPERING (EACH CORRECTIVE ACTION SHIT CROSS-REFERENCED TO THE APPERING (EACH CORRECTIVE ACTION SHIT CROSS-REFERENCED TO THE APPERING (EACH CORRECTIVE ACTION SHIT CROSS-REFERENCED TO THE APPERING (EACH CORRECTIVE ACTION SHIT CROSS-REFERENCED TO THE APPERING (EACH CORRECTIVE ACTION SHIT CROSS-REFERENCED TO THE APPERING (EACH CORRECTIVE ACTION SHIT CROSS-REFERENCED TO THE APPERING (EACH CORRECTIVE ACTION SHIT CROSS-REFERENCED TO THE APPERING (EACH CORRECTIVE ACTION SHIT CROSS-REFERENCED TO THE APPERING (EACH CORRECTIVE ACTION SHIT CROSS-REFERENCED TO THE APPERING (EACH CORRECTIVE ACTION SHIT CROSS-REFERENCED TO THE APPERING (EACH CORRECTIVE ACTION SHIT CROSS-REFERENCED TO THE APPERING (EACH CORRECTIVE ACTION SHIT CROSS-REFERENCED TO THE ACTION SHIT CROSS-REFERENCED TO T	STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186 STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY PULL R LSC IDENTIFYING INFORMATION) SIGN 34 IVE to yell to get assistance ess to her personal cell phone, I, "It's just the way it is." When sistion in the bed Resident # 8 comfortable. When asked bed Resident # 8 stated she e staff member and "They nurry." When asked about ent # 8 and her room, # 8 was lying in bed. An call bell revealed it was fit side of the head board of with the activation switch for them. When asked to reach a call bell, Resident # 8 stated, beservation of Resident # 8's alt fit was located on a bedside the bed in front the window in seident # 8's reach. Resident # 8 saled Resident # 8 was lying in no fit he call bell revealed it the left side of the head board of with the activation switch for them. When asked to reach a call bell revealed it window in seident # 8's reach. Resident # 8 saled Resident # 8 was lying in no fit he call bell revealed it the left side of the head board of with the activation switch for the bed. Further observation and the over-the-bed-table			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i	(X2) MULTIPLE CONSTRUCTION A. BUILDING		E SURVEY PLETED
		495267	B. WING			C /13/2018
	ROVIDER OR SUPPLIER DE REHAB & NURSING	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 558	with water in each of for and activate the of and activate the of and activate the of and activate the of and activate the offer and activate the observation of the room out of Reside stated she was unabottles. The comprehensive dated 06/11/2018 do resident has alteration Under "Interventions and meet needs. Be and respond promption assistance." On 09/13/18 at approinterview and observation was conducted with nurse) # 3. While observation was unable to resolute the over-the personal cell phone. Cell phone and water Resident # 8's reach the over-the-bed tab put her cell phone with access it after asking would prefer to have within Resident # 8's On 09/13/18 at approinterview was conducted the over-the-bed tab put her cell phone within Resident # 8's On 09/13/18 at approinterview was conducted the over-the-bed tab put her cell phone within Resident # 8's on 09/13/18 at approinterview was conducted within Resident # 8's on 09/13/18 at approinterview was conducted within Resident # 8's on 09/13/18 at approinterview was conducted within Resident # 8's on 09/13/18 at approinterview was conducted within Resident # 8's on 09/13/18 at approinterview was conducted within Resident # 8's on 09/13/18 at approinterview was conducted within Resident # 8's on 09/13/18 at approinterview was conducted within Resident # 8's on 09/13/18 at approinterview was conducted within Resident # 8's on 09/13/18 at approinterview was conducted within Resident # 8's on 09/13/18 at approinterview was conducted within Resident # 8's on 09/13/18 at approinterview was conducted within Resident # 8's on 09/13/18 at approinterview was conducted within Resident # 8's on 09/13/18 at approinterview was conducted within Resident # 8's on 09/13/18 at approinterview was conducted within Resident # 8's on 09/13/18 at approinterview was conducted within Resident # 8's on 09/13/18 at approinterview was conducted within Resident # 9's on 09/13/18 at approinterview was conducted within Resident # 9's on 09/13/18 at approinterview was conducted within Reside	them. When asked to reach call bell, Resident # 8 stated, servation of Resident # 8's to was located on a bedside to bed in front the window in dent # 8's reach. Resident # able to reach her water care plan for Resident # 8 cumented, "Focus: The in in musculoskeletal status." It documented, "Anticipate sure call light is within reach by to all requests for eximately 11:00 a.m., an action of Resident # 8's room LPN (licensed practical serving the placement of the status, and cell phone in Resident surveyor, Resident # 8 stated each the call bell, the water he-bed table and her LPN # 3 stated the call bell, should have been within and LPN # 3 then rearranged the closer to Resident # 8 and there Resident # 8 could gresident # 8 where she it and moved the call bell	F 5	58		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		495267	B. WING_			1	C 13/2018
,	ROVIDER OR SUPPLIER DE REHAB & NURSING	CENTER		61	REET ADDRESS, CITY, STATE, ZIP CODE 4 HASTINGS LANE VARRENTON, VA 20186		, , , , , , , , , , , , , , , , , , ,
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	Κ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 558	sure the call bell is w to their water or fluids sure they are safe an or request before lear The facility's policy "\ Responsibility" docur consideration, respec dignity and individual On 09/13/18 at appro (administrative staff r administrator and AS were made aware of No further information References: (1) A group of disorda ability to move and to posture. This informa website: https://www.nlm.nih.g y.htmi. (2) A chronic disease regulate the amount information was obta https://www.nlm.nih.g 001214.htm. (3) High blood presse obtained from the we https://www.nlm.nih.g essure.html.	teck every two hours. Make ithin reach, they have access and personal items, make difference the resident's needs wing the room. Virginia Resident Rights and mented, "9. Is treated with st, and full recognition of his ly" Example 1 (1) Ithe M # 2, director of nursing the findings. In was provided prior to exit. The stratt affect a person's or maintain balance and stion was obtained from the gov/medlineplus/cerebralpals In which the body cannot of sugar in the blood. This ined from the website: In which the website: In which information was obsite:	558				
F 580 SS=D		njury/Decline/Room, etc.) 4)(i)-(iv)(15)	F:	580			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	
			1,50,50			c	
		495267	B. WING	s. WING			13/2018
	ROVIDER OR SUPPLIER DE REHAB & NURSING	CENTER		6	TREET ADDRESS, CITY, STATE, ZIP CODE 14 HASTINGS LANE VARRENTON, VA 20186		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 580	Continued From page	e 37	F		F 580 Notify of Changes (Injury/Decline/Room etc.)		
	consult with the reside consistent with his or representative(s) who (A) An accident involvesults in injury and his physician intervention (B) A significant charmental, or psychosocideterioration in health status in either life-th clinical complications (C) A need to alter the aneed to discontinue treatment due to advict commence a new for (D) A decision to transident from the facility when making not (14)(i) of this section, all pertinent informati is available and proving the facility must resident and the re	nediately inform theresident; ent's physician; and notify, her authority, the resident en there is- ving the resident which as the potential for requiring n; age in the resident's physical, sial status (that is, a n, mental, or psychosocial reatening conditions or); eatment significantly (thatis, e an existing form of erse consequences, or to m of treatment); or sfer or discharge the lity as specified in ification under paragraph (g) the facility must ensure that on specified in §483.15(c)(2) ided upon request to the lent representative, if any, or roommate assignment 10(e)(6); or lent rights under Federal or ons as specified in paragraph in record and periodically mailing and email) and			 The #66 resident RP was not of a change in medication of 8/14/2018 at 20:48. The ord received at 8/14/2018 at 3:4 facility notified the RP with hrs. upon receipt of the ordereceived and RP notification conducted by the Unit Manadetermine if any other residual affected by this deficient process. Routine auditing of eMAR in might shift for compliance the meets the professional standard nursing. Random audits of the night nursing staff and review of audits of all new medication treatment orders. The facility compliant within the standard practice time frame. We will continue to ensure that the responsible party is notified 24 hrs of any changes in medications prescribed. The facility dutifully alleges compliance of these tasks of before 10/28/18. 	rder on er was 5. The in 24 er. rders a will be agers to ents are actice. by the hat lards of shift their and y was rds of 1 esidents within	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
						С	
		495267	B. WING		······································	09/	13/2018
	ROVIDER OR SUPPLIER DE REHAB & NURSING	CENTER		6	STREET ADDRESS, CITY, STATE, ZIP CODE 114 HASTINGS LANE WARRENTON, VA 20186		
	0/11/01/01/01						9(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE	
F 580	Continued From pag	e 38	F	580			
	that is a composite of §483.5) must disclosits physical configurationations that compripart, and must specimom changes betweender §483.15(c)(9). This REQUIREMEN' by: Based on staff interview, it was determnotify the responsible medication order in a residents in the surview. The facility staff faile twenty-four hours) no representative of an Resident #66, prescript the clinical record representative was medication on 8/18/2 medication was pressented. The findings included Resident #66 was accordingly affects a pedaily activities) (1), ladifficulty walking.	view and clinical record nined the facility staff failed to be representative of an new a timely manner for one of 37 ey sample, Resident #66. If to immediately (with in otify the responsible new medication order for ribed 8/14/18. Documentation evidenced the residents not aware of the new 18, four days after the acribed. It dmitted on 7/20/18 with ded but were not limited to: (A brain disorder that erson's ability to carry out ack of coordination, and					
I	-	nission assessment, with an					

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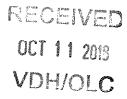
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED C		
		495267	B. WING _			09/13/2018	
	NAME OF PROVIDER OR SUPPLIER BROOKSIDE REHAB & NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP COI 614 HASTINGS LANE WARRENTON, VA 20186	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
	interview for mental a resident was severell cognitive decisions. In a cognitive decisions of the cognitive decisions of the cognitive decisions of the cognitive decisions. Resident #6 the cognitive decisions of daily hygiene in which he assistance. A physician order day decumented, "Haldo mouth) Q (every) 12 [related to] dementia (*Behavioral and psydementia [BPSD] are syndrome. Decline is motivation, or a charmanifesting as emotiand coarsening of some part of diagnostic critical procession. The block on the telestocumented, "Name blank. "Date notified A piece of paper locatevealed documented practitioner) RP (resto D/C (discontinue) informed he would he pRN (as needed). Remonday to speak with practical nurse] who wrote and signed this	a "7" on the BIMS (brief status) score, indicating the ly impaired to make daily. The resident was coded as inattention and disorganized 56 was coded as requiring one staff member for all of living expect personal needed extensive. Inted, 8/14/18 at 4:30 p.m. Inted, 8/14/18 at 4:3	F5	80			

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Facility ID; VA0178

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1''	E CONSTRUCTION	COMPLETED	
		495267	B. WING		C 09/13/2018
NAME OF PROVIDER OR SUPPLIER BROOKSIDE REHAB & NURSING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLÉTION
F 580	responsible represibilities Haldol. In an interview compractical nurse) #4 #4 regarding the properties in the nurse practition computer. It will concorder. I will then chadministration recompared in the family. We notification of the first stated, "Different properties in the nurse's The administrator, member] #1 and A were informed of the 4:56 p.m. On 9/13/18 at 6:06 director of nursing, facility did not have the responsible representation. Failure condition appropria	ducted with LPN (licensed on 9/13/18 at 9:43 a.m., LPN rocess staff follow for new LPN #4 stated, "Now we have her writing the orders on the me up in the cue to confirm the neck the MAR (medication ord) to ensure it got onto the sthere can be a delay. I then When asked where the amily is documented, LPN #4 laces, if it's a written order on a er) form, it should be on that he computer, you then write a notes." ASM [administrative staff SM #2, the director of nursing he above concern on 9/13/18 at informed this surveyor the era policy on the notification of	F 580	-	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		495267	B. WING		09/13/2018
NAME OF PROVIDER OR SUPPLIER BROOKSIDE REHAB & NURSING CENTER			6	STREET ADDRESS, CITY, STATE, ZIP CODE M4 HASTINGS LANE WARRENTON, VA 20186	•
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 580	providers. The physic is responsible for dire of a patient. No further information (1) This information with following website:	e 41 cian or health care provider ecting the medical treatment n was provided prior to exit. was obtained from the	F 580		
F 584 SS=D	following website: https://www.ncbi.nlm 38531/ Safe/Clean/Comforta		F 584		
	The resident has a ri comfortable and hon but not limited to rec supports for daily livi The facility must pro §483.10(i)(1) A safe, homelike environmenuse his or her person possible. (i) This includes ensireceive care and ser physical layout of the independence and dii) The facility shall of the protection of the or theft.	ght to a safe, clean, nelike environment, including eiving treatment and ng safely.		F 584 Safe/Clean/Comfortable/Hor Environment 1. Resident #102 — The reclince cleaned, and cobwebs removed the Resident Rm 108A. The way behind the bed was gouged chipped. This repair will be completed by the October 1 2018. Rm 111B_Damaged baseboard The maintenance department initiated a plan to remove a replace the baseboard with to drying out the damp are:	ner was oved. vall and e 0th oard- nt has und attention

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.

- Room Rounds will be conducted daily to identify the condition of walls, ceilings, floors, baseboards etc.
- 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.

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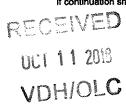
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(x2) MULTIPLE CONSTRUCTION A. BUILDING		СОМІ	PLETED
		495267	B. WING _			C /13/2018
			STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186			
PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE	(X5) COMPLETION DATE
F 584	services necessary to and comfortable interview, facility polireview and in the colinvestigation, it was staff failed to ensure environment for one sample, Resident #10 in a clean homelike observations, the an recliner revealed munon-living spiders in terview in the same secured unit.	comaintain a sanitary, orderly, rior; coded and bath linens that are closet space in each ecified in §483.90 (e)(2)(iv); ate and comfortable lighting ctable and safe temperature ally certified after October 1, a temperature range of 71 to commintenance of comfortable T is not met as evidenced con, resident interview, staff icy review and clinical record curse of a complaint determined, that the facility a clean, home like of 35 residents in the survey 02; and failed to provide a nt for two of 35 rooms on the called to ensure the area in its expectation of the interview and clinical record curse of a complaint determined, that the facility a clean home like of 35 residents in the survey 02; and failed to provide a nt for two of 35 rooms on the interview as maintained manner. During separate is a behind Resident #102's	F	F 584 Safe/Clean/Comfortable/H Environment continued from pag 5. The facility dutifully alle compliance with these tarbefore 10/28/18.	e 49 ges	

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C 09/13/2018
(X5) COMPLETION DATE

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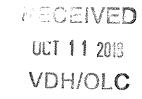
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495267	B. WING			09/	13/2018
	ROVIDER OR SUPPLIER DE REHAB & NURSING	CENTER		61	REET ADDRESS, CITY, STATE, ZIP CODE 4 HASTINGS LANE VARRENTON, VA 20186		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 584	approximately 8:41 a room. The resident w Observation of the ar recliner revealed mul non-living spiders and A third observation w approximately 12:04 room with OSM (other housekeeper. OSM # area behind Residen observed the area ar cobwebs, spider and When asked if this ard aily cleaning, OSM: An interview was con approximately 2:13 p staff member) #1. Will cleaning under a resirecliners daily, ASM: An interview was cor approximately 2:52 p housekeeping supern of resident rooms. Osinks, stools, window and then mop. OSM clean the area behind a recliner instead of a "Yes." The facility policy, "Observed with a safe, homelike environment."	as not in the room. ea behind Resident #102's tiple cobwebs, with d crumbs. as made on 09/13/18 at p.m., of Resident #102's er staff member) #7, er was asked to observe the et #2's recliner. OSM #7 ed stated, "A couple of a couple of crumbs of food." ea should be cleaned during er responded "Yes." ducted on 09/13/18 at en. with ASM (administrative enen asked if facility staff dent's bed or behind er responded "Yes." ducted on 09/13/18 at en. oSM #19, eisor, regarding the cleaning es #19 was asked if the staff d a recliner if a resident has a bead, OSM #19 responded duality of Life-Homelike ents, "Residents are clean, comfortable and ent 2. The facility staff and eaximize a. Clean, sanitary	F	584			

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Facility ID: VA0178

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '	PLE CONSTRUCTION G		E SURVEY IPLETED
		495267	B. WING _		0!	C 9/13/2018
	ROVIDER OR SUPPLIER DE REHAB & NURSING	CENTER		STREET ADDRESS, CITY, STATE, ZIP COE 614 HASTINGS LANE WARRENTON, VA 20186		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECT REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFEREN		PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 584	(administrative staff administrator and AS Nursing) were made concerns. No further information website: https://www.nlm.nih.gilure.html. 2. The facility staff for resident rooms in gounit. On 09/11/18 at approximately 8:5 approximately 3:00 president room 108A behind the head of the bed was gouged, and On 09/11/18 at approximately 9:0 approximately 8:55 are sident room 111B baseboard on the worotting, noted with bluet to the touch. Furthe bottom of the HV air conditioning) unit. On 09/13/18 at 10:4 resident rooms 108/4 conducted with OSM director of maintena	eximately 5:00 p.m., ASM member) #1, the SM #2, the DON (Director of aware of the above on was provided prior to exit. In was obtained from the gov/medlineplus/respiratoryfa aliled to maintain two of 35 od repair on the South Wing oximately 2:55 p.m., 09/12/18 5 a.m., and on 09/13/18 at o.m., an observation of was conducted. The wall he bed and to the left of the d chipped. Eximately 2:58 p.m., 09/12/18 on a.m., an observation of was conducted. The wall he bed and to the left of the dock of	F 5	84		

_	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '		CONSTRUCTION	(X3) DATE	SURVEY
rato : 04001	OOM LONG!		A. BUILDI	NG			
		495267	B. WING				C /13/2018
NAME OF PI	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE	L	
				614	HASTINGS LANE		
BROOKSI	DE REHAB & NURSING	CENTER		WA	RRENTON, VA 20186		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 584	further stated it was i observation of reside pulled the resident's Upon further observarevealed that a larger was damaged. When describe the conditions stated it appeared to substance on it. When baseboard, OSM # 1 touch. When asked for baseboard that was a was approximately 1 long. When OSM # 1 the base of the HVAC was rusted. When asked to describentifying and making rooms, OSM # 11 staneed of repair in the a work order form an nurse's station. We hand at each nurse's station. We hand at each nurse's station the day. It maintenance guys of and looks in the resident room, OSM maintenance guys of and looks in the resident rooms to inspus and identify problemasked if he was award in resident rooms 10 stated no. When ask and 111B were in a histated no.	and chipped. OSM # 11 In need of repair. Upon Int room 111B, OSM # 11 Ibed away from the wall. Ition of the baseboard, it was I section of the baseboard I OSM was asked to In of the baseboard, he Ibe rotted and had a black In asked to touch the I agreed it was wet to the I agreed it was wet to the I the dimensions of the I inches high by six feet I's attention was directed to C unit, he acknowledged it	F	584			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I IDENTIFICATION ASSESSED.		TIPLE CONSTRUCTION NG	(X3) DATE COMP	
		495267	B, WING		09/) 13/2018
	ROVIDER OR SUPPLIER DE REHAB & NURSING	CENTER		STREET ADDRESS, CITY, STATE, ZI 614 HASTINGS LANE WARRENTON, VA 20186		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 584	routines, look for cracelling tiles, leaks, we equipment needing On 09/13/18 at appr (administrative staff administrator and A were made aware or	cumented, "During your daily acked or missing floor or yet spots on ceiling tiles, repairs, etc." coximately 5:55 p.m., ASM member) # 1, the SM # 2, director of nursing	F	F 585 Grievances		
F 585 SS=E	Grievances CFR(s): 483.10(j)(1) §483.10(j) Grievance §483.10(j)(1) The re grievances to the fa that hears grievance reprisal and without reprisal. Such grieva respect to care and furnished as well as furnished, the behar residents, and other facility stay. §483.10(j)(2) The re facility must make p resolve grievances accordance with this §483.10(j)(3) The fa on how to file a grie to the resident.	es. Issident has the right to voice cility or other agency or entity as without discrimination or fear of discrimination or ances include those with treatment which has been that which has not been vior of staff and of other concerns regarding their LTC asident has the right to and the rompt efforts by the facility to the resident may have, in a paragraph. Incility must make information wance or complaint available	F	hand since May #53 and those re fried eggs that de his or her ordere restrictions may upon request. For documented any expressed and for needed. Brooks policy and proce Grievances/Con reviewed and up 10/28/18 by face 2. Facility determines residents are por deficient practice received were re to ensure any is	y have fried eggs acility staff y issues/concerns collowed-up as dide Rehab's Facility sedure on mments/Issues pdated on or before cility QA committee. ined that all stentially affected by ce. All grievances	
	to the resident. §483.10(j)(4) The fa grievance policy to	·		to ensure any is resolved timely	sues/concerns were	

*	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '		CONSTRUCTION	(X3) DATE COMP	
						(;
		495267	B. WING_			09/	13/2018
	ROVIDER OR SUPPLIER DE REHAB & NURSING	CENTER		6	TREET ADDRESS, CITY, STATE, ZIP CODE 14 HASTINGS LANE VARRENTON, VA 20186		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	1	(X5) COMPLETION DATE
F 585	contained in this para provider must give a to the resident. The ginclude: (i) Notifying resident i postings in prominent facility of the right to form (meaning spoken) or grievances anonymous of the grievance offician be filed, that is, haddress (mailing and number; a reasonable completing the review to obtain a written degrievance; and the coindependent entities be filed, that is, the program or protection (ii) Identifying a Griev responsible for oversing and tracking conclusions; leading a by the facility; maintainformation associate example, the identity grievances submitted written grievance decoordinating with statinecessary in light of so (iii) As necessary, tak prevent further potenting the while the alleger investigated; (iv) Consistent with §	graph. Upon request, the copy of the grievance policy rievance policy must a locations throughout the file grievances orally in writing; the right to file usly; the contact information all with whom a grievance is or her name, business email) and business phone expected time frame for of the grievance; the right cision regarding his or her contact information of with whom grievances may estinent State agency, Organization, State Survey ng-Term Care Ombudsman or and advocacy system; rance Official who is seeing the grievance process, and grievances through to their any necessary investigations ining the confidentiality of all and with grievances, for of the resident for those a lanonymously, issuing sisions to the resident; and the and federal agencies as specific allegations; ting immediate action to tial violations of any resident	F	585	Resident interviews initiated goal of all residents interview or before 10/28/18 regarding care and services and any iss and concerns were document Feedback Forms in Grievance with appropriate follow up. Admissions given Grievance procedure guidance in writing appropriate follow up. 3. Staff educated on or before 10/28/18 by Administrator of designee regarding facility's updated Facility Guideline/policies/procedure Grievances and follow up. 4. Upon completion of initial seducation, the Administrator designee will complete rand weekly audits using audit to months to ensure staff compliance with facility guifor grievances. Random audit be conducted for 3 additional months to March 2019. Audit for compliance will occur was months, October, November and random audit until March 2019 with compreported monthly at the QA meetings.	with wed on g their sues ted on ce Log New eng with taff or or om ols x 3 deline its will all iting eekly x per and its up	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL [*] A. BUILDI		(X3) DATE SURVEY COMPLETED			
		495267	B. WING				13/2018	
	ROVIDER OR SUPPLIER DE REHAB & NURSING	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 585	abuse, including injurand/or misappropriat anyone furnishing se provider, to the admit as required by State (v) Ensuring that all vinclude the date the grand state of the steps taken to invisuomary of the pertiregarding the resider as to whether the gric confirmed, any corretaken by the facility and the date the writt (vi) Taking appropriat accordance with State of the residents' right or if an outside entity the State Survey Age Organization, or location frights within its area (vii) Maintaining evid result of all grievance 3 years from the issudecision. This REQUIREMEN' by: Based on observation interview, clinical recreive, and during the investigation, it was a staff failed to address timely manner. On 9/11/18 at 3:30 p conducted with elever	ries of unknown source, ion of resident property, by rvices on behalf of the nistrator of the provider; and law; vritten grievance decisions grievance was received, a of the resident's grievance, restigate the grievance, a nent findings or conclusions at's concerns(s), a statement evance was confirmed or not ctive action taken or to be as a result of the grievance, are decision was issued; are corrective action in the law if the alleged violation is is confirmed by the facility having jurisdiction, such as ency, Quality Improvement I law enforcement agency or any of these residents'	F	585	5. The facility dutifully alleges compliance of these tasks or before 10/28/18.			

	OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING			PLETED C				
		495267	B. WING _		0:	9/13/2018		
BROOKSIDE REHAB & NURSING CENTER (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 585 Continued From page 50 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				STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186				
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
F 585	-	· -	F 5	85				
	med eggs returned	to the menu.						
	The findings include	e:						
	11/3/17 with the dia congestive heart fa insomnia, chronic k fibrillation, peripher asthma. The most of Set) was a quarterl (Assessment Refer resident was coded ability to make daily As part of a complet Resident #53, who removed from the reconducted on 9/11/2 current facility residents in a	agnoses of but not limited to illure, hypothyroidism, idney disease, atrial al vascular disease, and recent MDS (Minimum Data y assessment with an ARD rence Date) of 7/23/18. The las being cognitively intact in						
	The resident counc 2017 through Augu minutes themselve were identified. Thi	ietary concerns addressed						
	interview with OSM the activities direct documentation of v concerns were. Th following: December	oximately 4:30 p.m., in an #17 (Other Staff Member), or, she provided hand written what the specific dietary is document identified the er 2017: "Residents would scrambled eggs." January						

A. BUILDING C 495267 B. WING 09/13/201 NAME OF PROVIDER OR SUPPLIER BROOKSIDE REHAB & NURSING CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
A95267 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE BROOKSIDE REHAR & NURSING CENTER				A. BUILD	ING _		,	•
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE REPORKSIDE REHAR & NURSING CENTER			495267	B. WING			1	-
RPOOKSIDE REHAR & NI IRSING CENTER	NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
BROOKSIDE REHAB & NORSING CENTER WARRENTON, VA 20186	DD00//6	ine nellan a Nilhakia	OFWTED.		6	14 HASTINGS LANE		
	BROOKS	IDE KEHAB & NUKSING	CENTER		٧	WARRENTON, VA 20186		
OBERTY (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMP	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI	- 1	(X5) COMPLETION DATE
F 585 Continued From page 51 2018: "No fried eggsper residents." February 2018: "No more fresh eggsResidents were told they'd be getting fried eggs back." March 2018 - no mention of eggs. April 2018: "Residents would like fried eggs. Por 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, 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 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 clid not know why it took so long, and did not have eny 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	F 585	2018: "No fried eggs. 2018: "No more fresh they'd be getting fried no mention of eggs." would like fried eggs. manager), she will choiled eggs." May 20 eggs. D Mgr. will do residents who wish to breakfast." In reviewing the dieta the resident council requested fried eggs through May 2018. T provided as to why pordered for fried eggs not have fried eggs, documentation of whabout the eggs, and was no evidence that timely as the resident month after month all documentation of ho concern and when the The dietary food ordered until May On 9/13/18 at approximaterview with OSM aknow why it took so documentation regar was addressing this residents.	and there was no eat the residents were told when they were told when they were addressing this requested the same item and the facility had no w they were addressing it. Per slips from November 2017 reviewed and revealed, be used for fried eggs were y 11, 2018. In the stated she did not long, and did not have any rding how or when the facility concern expressed by the	F	585			

	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:		2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		495267	B. WING			09/	13/2018	
	ROVIDER OR SUPPLIER DE REHAB & NURSING	CENTER		6	STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE NARRENTON, VA 20186			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOULD		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 585 F 622 SS=E	meeting, ASM #1 (Act the Administrator, and Nursing, were made #1 stated that he has couple of months, but be told what is going concern and should but up on their concerns not 6 months. ASM # why the pasteurized eggs, were not or couprovided to the resident A review of the facility Policy-Resident Concern is desired with working days from the fit is not possible to time frame identified, Grievance official will resident outlining the COMPLAINT DEFICE Transfer and Dischart CFR(s): 483.15(c)(1) \$483.15(c)(1) Facility (i) The facility must premain in the facility, discharge the resider (A) The transfer or diresident's welfare and cannot be met in the (B) The transfer or dibecause the resident's ericlent's welfare and cannot be met in the (B) The transfer or dibecause the resident's resident's welfare and cannot be met in the resident's welfare and cannot be met in the resident's welfare and cannot be resident's w	Iministrative Staff Member) d ASM #2 the Director of aware of the findings. ASM only been at the facility for a t that the residents should on when they express a be made aware of any follow within about 3 days or so, 1 stated he did not know eggs required to make fried ald not be obtained and ents per their request. by policy, "Grievance cem, Complaint and/or nted, "15. Resolution of the thin three (3) to five (5) e date the concern was filed. resolve the complaint in the the Administrator and/or present a plan to the action being taken." ENCY reg Requirements (i)(ii)(2)(i)-(iii) and discharge- requirements- ermit each resident to and not transfer or at from the facility unless- scharge is necessary for the d the resident's needs facility; scharge is appropriate t's health has improved		622				
(X4) ID PREFIX TAG F 585	SUMMARY ST (EACH DEFICIENCY REGULATORY OR Continued From page meeting, ASM #1 (Ac the Administrator, and Nursing, were made at #1 stated that he has couple of months, but be told what is going concern and should the up on their concerns not 6 months. ASM # why the pasteurized at eggs, were not or coup provided to the resident A review of the facility Policy-Resident Conce Suggestion" docume concern is desired with working days from the If it is not possible to time frame identified, Grievance official will resident outlining the COMPLAINT DEFICE Transfer and Dischar CFR(s): 483.15(c)(1) §483.15(c) Transfer at §483.15(c)(1) Facility, (i) The facility must p remain in the facility, discharge the resider (A) The transfer or di resident's welfare an cannot be met in the (B) The transfer or di because the resident	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) 2 52 Iministrative Staff Member) d ASM #2 the Director of aware of the findings. ASM only been at the facility for a t that the residents should on when they express a pe made aware of any follow within about 3 days or so, 1 stated he did not know eggs required to make fried ald not be obtained and ents per their request. Ay policy, "Grievance pern, Complaint and/or inted, "15. Resolution of the thin three (3) to five (5) e date the concern was filed. resolve the complaint in the the Administrator and/or i present a plan to the action being taken." IENCY The Requirements (i)(ii)(2)(i)-(iii) and discharge- or requirements- ermit each resident to and not transfer or and from the facility unless- scharge is necessary for the d the resident's needs facility; scharge is appropriate	PREFIL TAG	× 585	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE COMPI	.ETED
		495267	B. WING			09/°	, 13/2018
	ROVIDER OR SUPPLIER DE REHAB & NURSING	CENTER	•	6	STREET ADDRESS, CITY, STATE, ZIP CODE 114 HASTINGS LANE WARRENTON, VA 20186		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			1	(X5) COMPLETION DATE
F 622	services provided by (C) The safety of indi- endangered due to the status of the resident (D) The health of indi- otherwise be endang (E) The resident has appropriate notice, to under Medicare or Me Nonpayment applies submit the necessary payment or after the Medicare or Medicaic resident refuses to pay resident who become admission to a facility resident only allowab or (F) The facility cease (ii) The facility may no resident while the app § 431.230 of this cha exercises his or her or discharge or transfer or safety of the reside facility. The facility m that failure to transfer §483.15(c)(2) Docum When the facility m resident under any of in paragraphs (c)(1)(i) section, the facility m or discharge is docum medical record and a	the facility; viduals in the facility is e clinical or behavioral viduals in the facility would ered; failed, after reasonable and pay for (or to have paid edicaid) a stay at the facility. if the resident does not paperwork for third party third party, including I, denies the claim and the ay for his or her stay. For a as eligible for Medicaid after the facility may charge a Ile charges under Medicaid; as to operate. It transfer or discharge the beal is pending, pursuant to pter, when a resident ight to appeal a transfer or in the facility pursuant to § chapter, unless the failure to would endanger the health ent or other individuals in the ust document the danger or discharge would pose.	F	622	Complaint Deficiency F 622-Transfer Discharge Requirements 1. Resident #75 on 8/1/2018-7 facility failed to provide documented evidence of all required documentation for a facility-initiated transfer. Resident # 40- The facility s failed to evidence that a comprehensive care plan gos provided to the receiving profor a facility-initiated transfer 8/9/18. Resident # 113- The facility failed to evidence that a comprehensive care plan gos provided to the receiving profor a facility-initiated transfer 8/6/18. Resident #61- The facility s failed to provide evidence the required information (included Physician contact information resident representative contact information, special instruction ongoing care, advance direct and comprehensive care plan were provided to the hospita 8/30/18.	taff al was ovider or on staff al was ovider or on taff at all ing on, ct ions for cives n goals	

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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		495267	B. WING			09	/13/2018	
	ROVIDER OR SUPPLIER DE REHAB & NURSING	,···		61	TREET ADDRESS, CITY, STATE, ZIP CODE 14 HASTINGS LANE VARRENTON, VA 20186			
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F 622	institution or provider (i) Documentation in must include: (A) The basis for the (i) of this section. (B) In the case of parsection, the specific reperties be met, facility atternated, and the service facility to meet the net (ii) The documentation (2)(i) of this section in (A) The resident's phecial discharge is necessar (A) or (B) of this section (B) A physician when necessary under parathis section. (iii) Information provide must include a minim (A) Contact information (C) Advance Directive (B) Resident represence contact information (C) Advance Directive (D) All special instruction ongoing care, as apperties (E) Comprehensive (F) All other necessary of the resident's consistent with §483. any other documental a safe and effective to This REQUIREMENT by: Based on staff internand facility documental the facility staff for the call the c	the resident's medical record transfer per paragraph (c)(1) agraph (c)(1)(i)(A) of this resident need(s) that cannot pts to meet the resident ce available at the receiving red(s). In required by paragraph (c) rust be made by- rysician when transfer or ry under paragraph (c) (1) rion; and rtransfer or discharge is regraph (c)(1)(i)(C) or (D) of ded to the receiving provider rum of the following: rear of the resident. Intative information including the information repriate. The information including as a discharge summary, 21(c)(2) as applicable, and tion, as applicable, to ensure	F	622	Complaint Deficiency F 622-T Discharge Requirements contipage 59 2. All discharges/transfer facility will be audited check list that identification documents that must be the transfer package. 3. The development of a comprehensive discharmust be completed by will be reviewed by the Manager/designee for completeness. 4. Education of all nursed discharge planning promeets the required state and to ensure continuour residents. Daily attransfers/discharges so October 2018 and for November, December January 2019. The reaudits including analy gathered and corrective address deficient prace presented to the QA comonthly by the Unit Manager of these to before 10/28/18.	ars from the distribution of the nurse and the nurse and the nurse and the nurse and the nurse and the nurse and the nurse and the nurse and the nurse and the nurse and the nurse and the nurse and the nurse and the nurse of care to nudits of all the nurse of the data we measures to the nurse of the data we measures to the nurse of the data we measures to the nurse of the data we measures to the nurse of t	il e	

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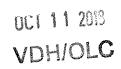
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1''	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		495267	B. WING	B. WING		09/	13/2018
	ROVIDER OR SUPPLIER DE REHAB & NURSING	CENTER		6	TREET ADDRESS, CITY, STATE, ZIP CODE 14 HASTINGS LANE VARRENTON, VA 20186		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFII TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 622	receiving facility for for survey sample; Resid #61. 1. The facility staff farevidence all required provided to the receivinitiated transfer of Rower end of the facility-initiated transfer all required to the facility-initiated transfer all required information, recontact information, recontact information, songoing care, advance comprehensive care the hospital staff whe transferred to the hospitales.	iled to provide documented documentation was ving facility for a facility esident #75 on 8/1/18. iled to evidence that rehensive care plan goals receiving provider for a fer on 8/9/18. iled to evidence that prehensive care plan goals receiving provider for a fer on 8/9/18. illed to evidence that prehensive care plan goals receiving provider for a fer to the hospital on 8/6/18. illed to provide evidence that on (including physician resident representative special instructions for the directives and plan goals) were provided to the Resident # 61 was spital on 08/30/18.	F	622			
	provided to the receivinitiated transfer of R Resident #75 was ad	ving facility for a facility esident #75 on 8/1/18. Imitted to the facility on recent readmission of	т				

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Event ID: OTHR11

Facility ID: VA0178

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED C			
		495267	B. WING			09/13/2018		
	ROVIDER OR SUPPLIER DE REHAB & NURSING	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE		
F 622	Continued From page	e 56	F 62	2				
	limited to: confusion, (1) (A degenerative b lack of thiamine (vital dependence, genera	es that included but were not Wernicke's encephalopathy brain disorder caused by the min B1), history of alcohol lized weakness, difficulty in anxiety, restlessness, and						
	assessment, a five di with an assessment a coded the resident as (brief interview for me	S (minimum data set) ay Medicare assessment, reference date of 8/7/18, s scoring a "12" on the BIMS ental status) score, indicating e impairment for daily						
	p.m., documented in staff asked to see pa afternoonAssessm (laceration) after fall; department) eval (ev	er's note dated 8/1/18 at 2:22 part, "CC (chief complaint): tient s/p (status post) fall this nent and plan: #Head lac Needs ED (emergency aluation) for possible CT ohy*) scan, closure of lac						
		phy (CT) is a type of cial x-ray equipment to make res of the body. (2)						
	documented in part, falling stiffly backwar station. He was unre seconds then was at questions appropriat (family nurse practitiassess resident new resident to ED (emer	ed 8/1/18 at 3:52 p.m. "Resident was witnessed ds to the floor at the nursing sponsive for a [sic] 10 ble to answer staff's ely. Vitals obtained FNP oner) [FNP's name] to orders received to send regency department) to evalRP (responsible party)						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		495267	B. WING			C 09/13/2018	
	ROVIDER OR SUPPLIER DE REHAB & NURSING			STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186		13/2016	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 622	Continued From page	e 57	F 6	22			
	called by [RN (registe called to [hospital's na department."	ered nurse) #2]Report ame] ED (emergency	1140 1240-				
	p.m. with LPN (licens regarding the informa staff when a resident hospital. LPN #3 state sheet, physician order and a completed transhe provides the resiplan goals, LPN #3 show she evidences the to hospital staff, LPN in the nursing progressheet that is sent with	ed she provides a face or sheet, advanced directive, sfer sheet. When asked if dent's comprehensive care tated, "No." When asked he information she provides #3 stated she documents it as note and on the transfer in the resident to the facility.					
	*	et for date of service 8/1/18 he administrative staff on tely 2 p.m.	ACADAMAN AND AND AND AND AND AND AND AND AND A				
	administrator, and AS	staff member) #1, the SM #2, the director of aware of the above findings m.					
	Discharge, Emergend Should it become ned emergency transfer of	or discharge to a hospital or on, our facility will implement					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495267	B. WING	B. WING			13/2018
	ROVIDER OR SUPPLIER DE REHAB & NURSING	CENTER		6	TREET ADDRESS, CITY, STATE, ZIP CODE 14 HASTINGS LANE VARRENTON, VA 20186		
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	- 1	(X5) COMPLETION DATE
F 622	b. Notify the receivin being made; c. Prepare the reside d. Prepare a transfer resident; e. Notify the represe family member" No further information of National Institutes of https://www.ninds.ni/Wernicke-Korsakoff 1) This information of National Institutes of https://www.ninds.ni/Wernicke-Korsakoff 1) This information of National Institutes of https://medlineplus.g 2. The facility staff faresident #40's composer provided to the facility-initiated transfer Resident #40 was a 5/18/18 and readmit diagnoses that incluanemia, enlarged he blood pressure and (1). The most recent ME day assessment, with the resident with the provided to the facility in the provided to the facility in the readmit diagnoses that incluanemia, enlarged he blood pressure and (1).	It's Attending Physician; g facility that the transfer is ent for transfer; form to send with the entative (sponsor) or other entative (sponsor) or other entative (sponsor) or other entative (sponsor) or other entative (sponsor) or other entative (sponsor) or other entative (sponsor) or other entative (sponsor) or other entative entative entative entation-Page entation-Page entation enta	F	622			
	having scored a 13 interview for mental	4/18 coded the resident as but of 15 on the BIMS (brief status) indicating the resident of to make daily decisions.	A CONTRACTOR OF THE CONTRACTOR				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: OTHR11

Facility ID: VA0178

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED		
		495267	B. WING			1	/13/2018
	ROVIDER OR SUPPLIER DE REHAB & NURSIN	G CENTER		614 H	ET ADDRESS, CITY, STATE, ZIP CODE ASTINGS LANE RENTON, VA 20186		
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F 622	Review of the 8/9/1 "Recheck vss (vital degrees) - 117 (puls (respirations)- 192/- (oxygen saturation) remains alert and or of) not feeling well. notified and NP (nur patient to ER [emer An interview was cop.m. with LPN (licer When asked what i resident to the hosp sheet, their POS (pl diagnosis and the transition of the states and diet." When the sident to the hosp sheet, their POS (pl diagnosis and the transition of the states and diet." When the states and diet. Their social status and diet. When the states are sident, LPN # that." Review of the facilities evidence document comprehensive car facility. On 9/13/18 at 5:00 member) #1, the addirector of nursing with the states of the states o	8 nurse's note documented, signs) 102.3 (temperature in se) and irregular 18 100 (blood pressure) and sat 95 (percent) room air. Patient riented x3 but c/o (complained (Name of doctor) office rese practitioner) stated to send gency room]. Patientaware." Inducted on 9/13/18 at 12:40 ased practical nurse) #3. Information was sent with the pointal, LPN #3 stated, "The face mysician order sheet) with their ransfer slip." When asked on the transfer slip, LPN #3 I activities, their ambulatory	F.	622			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:		1 ' '	3	COMPLETED			
		495267	B. WING		C 09/13/201		
	ROVIDER OR SUPPLIER	NG CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 622	fat, cholesterol, ca substances in the obtained from: https://www.nhlbi.rartery-disease 3. The facility staff Resident #113's concern were provided to the facility initiated training the facility initiated training the facility initiated training the facility initiated training the facility initiated training the facility initiated training the facility initiated training the facility initiated training the facility initiated training the facility initiated training the facility initiated training the facility initiated training the facility initiated training and the facility initiated training and the facility initiated training the facility initiated training and the facility initiated training traini	Icium, fibrous tissue, and other blood. This information was nih.gov/health-topics/peripheral-failed to evidence that comprehensive care plan goals he receiving provider for a nifer to the hospital on 8/6/18. Is admitted to the facility on nitted on 8/9/18 with diagnoses to limited to: aphasia (A y damage to the parts of the anguage. It can make it hard ite, and say what you mean to infarction (stroke), heart failure to the heart can't pump enough body's needs.) (2) IDS (minimum data set), a tent, with an ARD (assessment 8/18/18 coded the resident as 99 on the BIMS (brief interview indicating the resident # 113 derately impaired for cognitive	F 62	22			
	following: "Reside bed having grand minutes. Observe unresponsive for s seizure. Vital signs	note dated 8/6/18 document the nt observed by this nurse on mal seizure for approximately 2 d throughout. Remained several minutes following s unremarkable. Call placed to orders received to send					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED	
		495267	B. WING			C 09/13/2018
	ROVIDER OR SUPPLIER DE REHAB & NURSIN	G CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 622	resident to ER (embecoming responsis Medical Service) at a.m. Resident sent Responsible party. There was no docu evidencing that Recare plan goals we provider for the face 8/6/18. An interview was cop.m. with LPN (lice When asked what resident to the host sheet, their POS (pdiagnosis and the twhat was included stated, "Their social status and diet." Wo comprehensive can the resident, LPN # that." On 09/13/18 4:50 pmember) #1, the addirector of nursing findings. No further information website: https://medlineplus 3. Generalized to a member of the service of the servic	ergency room). Resident ve when EMS (Emergency rrived; exited facility at 0940 to (Name of hospital). notified with each event." mentation in the clinical record sident #113's comprehensive re sent to the receiving ility- initiated transfer on onducted on 9/13/18 at 12:40 nsed practical nurse) #3. information was sent with the pital, LPN #3 stated, "The face hysician order sheet) with their transfer slip." When asked on the transfer slip, LPN #3 al activities, their ambulatory	F 63			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1''	PLE CONSTRUCTION IG		COMPLETED	
		495267	B. WING _			C 09/13/2018
	ROVIDER OR SUPPLIER DE REHAB & NURSIN	G CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 622	called grand mal seconvulsion, or epile with generalized to information was ob https://medlineplus 4. The facility staff all required information contact information contact information ongoing care, advacomprehensive car the hospital staff wit transferred to the https://with a with diagnoses that to: atrial fibrillation disease (3) and hyperity as (assessment reference Resident # 61's moset), a quarterly as (assessment reference Resident # 61 as sinterview for mentally 15, 14 - being cog decisions. Resident independent for activity as (Interdisciplinary Total 19:30 (7:30 p.m.) refloor in her room with NP (nurse practitio to ER (emergency Resident went to (formation of the converse of the con	eizure. The terms seizure, epsy are most often associated nic-clonic seizures. This tained from website: .gov/ency/article/000695.htm failed to provide evidence that attion (including physician resident representative special instructions for since directives and re plan goals) was provided to hen Resident # 61 was ospital on 08/30/18. admitted to the facility on readmission on 07/23/2018 tincluded but were not limited (1), dementia (2), Parkinson's	F 6	22		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/GLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1, ,	FIPLE CONSTRUCTION NG	Į(X3	COMPLETED				
		495267	B. WING_	······		09/13/2018			
	ROVIDER OR SUPPLIER DE REHAB & NURSING	CENTER	1	STREET ADDRESS, CITY, STATE, ZIP (614 HASTINGS LANE WARRENTON, VA 20186					
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE			
F 622	scan neg (negative). bruising and assess have therapy screen doctor) and RP (response) and RP (respons	Will monitor for latent for pain or discomfort. Will will keep MD (medical ponsible party) updated." # 61's clinical record and the record) failed to evidence the facility provided physician resident representative special instructions for ceedirectives and plan goals were provided to the Resident # 61 was spital on 08/30/18. D. p.m., an interview was (licensed practical nurse) # 3 work that is sent with the ty-initiated transfer. LPN # 3 work that is sent with the ty-initi	F	622					
	On 09/13/18 at appr (administrative staff	oximately 5:55 p.m., ASM member) # 1, the SM # 2, director of nursing							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		CONSTRUCTION	(X3) DATE	SURVEY	
VIED LEVIS OF	OCINEOTION	DERTH TOATTON NOMBER.	A. BUILD	A. BUILDING			C	
		495267	B. WING				13/2018	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00,	10/2010	
				6	14 HASTINGS LANE			
BROOKSI	DE REHAB & NURSING	CENTER		N	VARRENTON, VA 20186			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E	(X5) COMPLETION DATE	
F 622	Continued From page	e 64	F	622				
	No further information	n was provided prior to exit.					***************************************	
	References:						Walania	
		e speed or rhythm of the nation was obtained from						
	the website:							
	https://www.nlm.nih.g on.html.	ov/medlineplus/atrialfibrillati						
	diseases. It affects m judgment, and behav obtained from the we	ction that occurs with certain emory, thinking, language, ior. This information was bsite: ov/ency/article/000739.htm.						
	obtained from the we	ure. This information was bsite: ov/medlineplus/highbloodpr						
		ent disorder. This ined from the website: ov/medlineplus/parkinsonsdi						
F 623 SS=E		Before Transfer/Discharge -(6)(8)	F	623				
	the reasons for the manner	fers or discharges a nust- and the resident's ne transfer or discharge and nove in writing and in a ar they understand. The opy of the notice to a Office of the State					Communication of the Communica	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
		495267	B. WING			ı	13/2018
	ROVIDER OR SUPPLIER DE REHAB & NURSING	CENTER		614 HASTI	DDRESS, CITY, STATE, ZIP CODE NGS LANE TON, VA 20186		
(X4) ID PREFIX TAG	(EACH DEFICIENC	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 623	(ii) Record the reaso discharge in the residence accordance with para and (iii) Include in the not paragraph (c)(5) of the \$483.15(c)(4) Timing (i) Except as specifie (c)(8) of this section, discharge required unade by the facility a resident is transferre (ii) Notice must be mode before transfer or dis (A) The safety of individual be endangered under this section; (B) The health of individual be endangered, under this section; (C) The resident's healtow a more immed under paragraph (c)(D) An immediate trarequired by the residunder paragraph (c)(E) Aresident has not days. §483.15(c)(5) Content notice specified in paragraph (c)(ii) The reason for the fill of the following the fol	ns for the transfer or dent's medical record in agraph (c)(2) of this section; ice the items described in his section. I of the notice. I of the notice of transfer or nder this section must be at least 30 days before the dor discharged. I do discharged. I do as soon as practicable in the facility would be paragraph (c)(1)(i)(C) of a continuous in the facility would be paragraph (c)(1)(i)(D) of a continuous in the facility would be paragraph (c)(1)(i)(D) of a continuous in the facility would be paragraph (c)(1)(i)(D) of a continuous in the facility would be paragraph (c)(1)(i)(D) of a continuous in the facility would be paragraph (c)(1)(i)(D) of a continuous in the facility would be paragraph (c)(1)(i)(D) of a continuous in the facility for 30 be and the facility for 30 be a continuous in the facility for 30 be a continuous i	F	623 Transfe 1.	Notice Requirements Beforer/Discharge The facility failed to prove written notification to the resident representative an ombudsman for a facility transfer to the hospital for following residents, Resident #76 on 7/7/18 Resident #75 on 8/1/18 Resident #40 on8/9/18 Resident #61on 8/30/18 Notification was mailed of Director of Social Work to Ombudsman for the Mondon July, August and Septemble All transfers out of the factor of t	ide resident, d initiated the the the the the thick will on to the comply culated in twill cial with ansfers to Worker otification ceducated entation onnel record-	
	transferred or discha	rged;					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER		X2) MULTIPLE CONSTRUCTION 1. BUILDING			(X3) DATE SURVEY COMPLETED	
		495267	B. WING			C 09/13/2018		
NAME OF PROVIDER OR SU	iPPI IFR		<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1	10/2010	
NAME OF FROMBLINGING	JI I LILIN				14 HASTINGS LANE			
BROOKSIDE REHAB &	NURSING	CENTER		٧	VARRENTON, VA 20186			
PREFIX (EAC)	DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E	(X5) COMPLETION DATE	
					F 623 Notice Requirements Before			
and telephoreceives su to obtain an completing hearing rec (v) The nart telephone is Long-Term (vi) For nur and develod disabilities, telephone is the protect developme C of the De and Bill of codified at (vii) For nur disorder or email addragency result addragency result addragency result and the informet feeting the must update as practice becomes a §483.15(c) In the case the adminity written not	ne name, a cone number of the form quest; me, addressing facility pmental of the mailing pmental disable evelopmer Rights Act 42 U.S.C. rsing facility related disess and tesponsible for individual under the possible of individual under the possible of facility (6) Changmation in the transfer test the recipible once evailable.	address (mailing and email), er of the entity which sts; and information on how form and assistance in and submitting the appeal ass (mailing and email) and if the Office of the State budsman; ty residents with intellectual disabilities or related and email address and if the agency responsible for dvocacy of individuals with all disabilities Assistance at of 2000 (Pub. L. 106-402, and 15001 et seq.); and ity residents with a mental disabilities, the mailing and elephone number of the for the protection and als with a mental disorder e Protection and Advocacy	F		F 623 Notice Requirements Before Transfer/Discharge continued from a decident of the charts of the charts of the hospital to ensure compliance. This will be conducted by the Unit Mana Education of nursing by Oct 28th, 2018. Daily audits by director of social services x month (October) Deficienci would be identified and conweekly audits x 3 months bunit managers. Reports will analyzed, deficient practice corrected, and the findings presented at the QA monthl meetings. 5. The facility dutifully allege compliance of these tasks of before 10/28/18.	nsferred ngers. tober the 1 es rected. y the l be		

PRINTED: 09/25/2018 FORM APPROVED OMB NO. 0938-0391

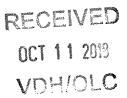
AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED					
				-	С			
NAME OF P	ROVIDER OR SUPPLIER	495267	B. WING	REET ADDRESS, CITY, STATE, ZIP CODE	09/13/2018			
BROOKS	DE REHAB & NURSI	NG CENTER	Į.	614 HASTINGS LANE WARRENTON, VA 20186				
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F 623	State Long-Term the facility, and the well as the plan for relocation of the red 483.70(I). This REQUIREMED by: Based on staff intreview, and clinical determined that the written notification representative, and the hospital for fives sample; Residents of the red facility initiated the representative and facility initiated the representative and facility initiated to Resident #75. 3. The facility staff documentation to representative and facility initiated to Resident #75. 3. The facility staff documentation to representative and facility initiated to Resident #40. 4. The facility staff and or resident rewith written documentation to resident rewith written documentation to resident rewith written documentation on 8/6/18	Care Ombudsman, residents of a resident representatives, as in the transfer and adequate esidents, as required at § ENT is not met as evidenced derview, facility document all record review, it was are facility staff failed to provide in the resident, resident in the survey as #76, #75, #40, #113, and #61. If failed to provide written the resident and/or resident in notify the ombudsman for a insfer to the hospital on 7/7/18 If failed to provide written the resident and/or resident in notify the ombudsman for a insfer to the hospital on 8/1/18 for If failed to provide written the resident and/or resident in notify the ombudsman for a the hospital on 8/1/18 for If failed to provide written the resident and/or resident in notify the ombudsman for a the hospital on 8/9/18 for If failed to provide the resident in notify the ombudsman for a the hospital on 8/9/18 for If failed to provide the resident presentative and ombudsman mentation of a facility initiated in for Resident #113. Iff failed to provide written	F 623					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: OTHR11

Facility ID: VA0178

If continuation sheet Page 75 of 146



STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED					
		40.5007	B WING			С	
		495267	B. WING_			09/	13/2018
	ROVIDER OR SUPPLIER DE REHAB & NURSING	CENTER		STREET ADDRESS, CITY, S 614 HASTINGS LANE WARRENTON, VA 2019			
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F 623	notification to the res (RP) and the ombude transfer to the hospit 61. The findings include: 1. Resident #76 was 10/17/16, with a mos 7/11/18, with diagnor not limited to: heart a blood pressure, mus (1) (A type of lung die the air sacs (alveoli) body does not get the hard to catch one's to the most recent MD assessment, a quart assessment reference resident as scoring a interview for mental thas no cognitive important making. The nurse's note dat documented in part, transport agency sta was noted with diaplicalled and patient waname]3:39 p.m.: P	ident and responsible party sman of a facility initiated all on 08/30/18 for Resident # admitted to the facility on a sees that included but were attack, respiratory failure high cle weakness, emphysema sease involving damage to in the lungs. As a result, the e oxygen it needs, making it	F	523	DEFICIENCY		
	family is at hospital a situation, message le regarding patients [s (medication adminis	tration record), labs d DNR (do not resuscitate)					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED C		
		495267	B. WING			09/13/2018		
	ROVIDER OR SUPPLIER DE REHAB & NURSIN	IG CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186				
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F 623	Continued From pa	age 69	F 62	3				
	conducted with LPI LPN #3 stated she representatives wh the hospital but she	0 p.m., an interview was N (licensed practical nurse) #3. calls residents' en residents are transferred to e does not provide written ransfers to residents'						
	conducted with AS member) #1, the adstaff member), the the admissions directly responsible for not facility-initiated trainot aware we were	0 p.m., an interview was M (administrative staff dministrator, OSM #1 (other social worker and OSM #2, ector. When asked who was ifying the ombudsman of a nsfer, OSM #1, stated, "I was a supposed to do that." OSM o't do it", and ASM #1 stated he t it was required.						
	director of nursing, above findings on	nistrator, and ASM #2, the , were made aware of the 9/13/18 at 4:55 p.m. tion was provided prior to exit.						
	National Institutes	was obtained fromthe of Health at s.gov/emphysema.html						
	National Institutes	was obtained from the of Health at .gov/ency/article/000666.htm	- Approximate Annual An					
	heart muscle has be with a heart attack the heart, the grea	ein that is released when the been damaged, such as occurs . The more damage there is to ter the amount of troponin e blood. This information was						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBERS		TIPLE CONSTRUCTION NG		CX3) DATE SURVEY COMPLETED	
		495267	B. WING_			09/13/2018	
	ROVIDER OR SUPPLIER DE REHAB & NURSING	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186			
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F 623	2. The facility staff fa documentation to the representative and n facility initiated to the Resident #75.	ational Institutes of Health at ov/pressuresores.html iled to provide written a resident and/or resident otify the ombudsman for a hospital on 8/1/18 for	F	623			
	7/20/18, with a most 8/3/18, with diagnose limited to: confusion, (1) (A degenerative to lack of thiamine (vita dependence, genera	Imitted to the facility on recent readmission of less that included but were not wernicke's encephalopathy orain disorder caused by the min B1), history of alcoholulized weakness, difficulty in anxiety, restlessness, and					
	assessment, a five d with an assessment coded the resident a (brief interview for m	S (minimum data set) ay Medicare assessment, reference date of 8/7/18, s scoring a "12" on the BIMS ental status) score, indicating we impairment for daily					
	p.m., documents in p staff asked to see pa afternoonAssessn (laceration) after fall; department) eval (ev (Computed tomograf (laceration)."	• •					

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ITIEICATION NI IMPED:			(X3) DATE SURVEY COMPLETED	
	495267	B. WING	B. WING		C 09/13/2018	
	CENTER	1	1			
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		1	PREFIX (EACH CORRECTIVE ACTION SHOUL			(X5) COMPLETION DATE
The nurse's note date documented in part, 'falling stiffly backward station. He was unresseconds then was absected the was appropriate (family nurse practitic assess resident new resident to ED (emer (evaluate) and treat. called by [RN (registe called to [hospital's not department." On 9/13/18 at 12:40 conducted with LPN (LPN #3 stated she carepresentatives when the hospital but she conducted with ASM member) #1, the admissions directed with a staff member), the set the admissions directed with a staff member), the set the admissions directed with a staff member), the set the admissions directed with a staff member), the set the admissions directed with a staff member), the set the admissions directed with a staff member), the set the admissions directed was not aware that it was not aware that it	ed 8/1/18 at 3:52 p.m. 'Resident was witnessed dis to the floor at the nursing sponsive for a [sic] 10 ble to answer staff's ely. Vitals obtained FNP oner) [FNP's name] to orders received to send gency department) to evalRP (responsible party) ered nurse) #2]Report ame] ED (emergency p.m., an interview was (licensed practical nurse) #3. alls residents are transferred to does not provide written insfers to residents' p.m., an interview was (administrative staff ininistrator, OSM #1 (other ocial worker and OSM #2, tor. When asked who was ring the ombudsman of a fer, OSM #1, stated, "I was upposed to do that." OSM do it", and ASM #1 stated he was required.	F	62			
_	·					
	SUMMARY ST (EACH DEFICIENCY REGULATORY OR Continued From page The nurse's note date documented in part, ' falling stiffly backwan station. He was unre- seconds then was ab- questions appropriate (family nurse practitio assess resident new resident to ED (emer (evaluate) and treat. called by [RN (registe called to [hospital's n department." On 9/13/18 at 12:40 conducted with LPN (LPN #3 stated she car representatives when the hospital but she can representatives. On 09/13/18 at 1:10 conducted with ASM member) #1, the adm staff member), the so the admissions direct responsible for notify facility-initiated trans- not aware we were s #2 stated, "We don't was not aware that it ASM #1, the adminis director of nursing, v above findings on 9/1	A95267 ROVIDER OR SUPPLIER DE REHAB & NURSING CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 treatRP (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'	A BUILD ROVIDER OR SUPPLIER DE REHAB & NURSING CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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. 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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.	A BUILDING A95267 A BUILDING ROVIDER OR SUPPLIER DE REHAB & NURSING CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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. 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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.	CONTIDUENT OR SUPPLIER 485267 BY WARE STREET ADDRESS, CITY, STATE, 2IP CODE 614 HASTINGS LANE WARRENTON, VA 20185 SUMMANY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WISTER EPRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 treatRP (responsible party) 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), the social worker and OSM #2, the administors 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 we were supposed to do that." OSM #2 stated, "We don't do it", and ASM #1 stated he 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.	COMPERENTIAL NUMBER: 495267 A BUILDING 5. WIND STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE SUMMARY STATEMENT OF DEPICIENCIES (EACH DEPICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 71 The nurse's note dated 8/1/18 at 3:52 p.m. documented in part, "Resident was witnessed failing 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) [FINP's name] to assess resident new orders received to send resident to EQ (evaluate) and treat. AP (responsible party) called by [RN (registered nurse) #2]Report called to (hospital's name] ED (emergency department). On 9/13/18 at 1:2:40 p.m., an interview was conducted with LPN (licensed practicula nurse) #3. LPN #3 stated she calls residents are transferred to the hospital but she does not provide written notification of the transfers to residents are representatives. On 09/13/18 at 1:10 p.m., an interview was conducted with ASM (administrative staff member), the social worker and OSM #2, the administrative of the other provides with responsible for notifying the ormbudsman 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, 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.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
		495267	B. WING				C 13/2018
	ROVIDER OR SUPPLIER DE REHAB & NURSING	CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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 PREFI TAG	C	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 623	Continued From page 1) This information w		F	523			
	National Institutes of https://www.ninds.nih						
	documentation to the representative and no	Health at					
	5/18/18 and readmitt diagnoses that includ anemia, enlarged he						
	day assessment, with reference date) of 9/4 having a 13 out of 15	S (minimum data set), a five on an ARD (assessment 4/18 coded the resident as ion the BIMS (brief interview licating the resident was make daily decisions.					
	"Recheck vss (vital s degrees) - 117 (pulse (respirations) - 192/1 (oxygen saturation) s remains alert and orio of) not feeling well. (I notified and NP (nurs patient to ER [emerg	nurse's note documented, igns) 102.3 (temperature in a) and irregular 18 00 (blood pressure) and sat 25 (percent) room air. Patient ented x3 but c/o (complained Name of doctor) office the practitioner) stated to send ency room]. Patient aware."					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
		495267	B. WING			C 09/13/2018	
	ROVIDER OR SUPPLIER DE REHAB & NURSING			6	STREET ADDRESS, CITY, STATE, ZIP CODE 314 HASTINGS LANE WARRENTON, VA 20186	1 031	10/2010
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE A TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED T		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 623	documentation regar the ombudsman receithe transfer in writing. An interview was corp.m. with LPN #3, refollows to notify the nation when a resident was stated, "We call them given any written not unless they come in usually they're not he with a management of the combudsman for a cost of the	ding the responsible party or eiving notification regarding inducted on 9/13/18 at 12:40 garding the process staff esident's representative sent to the hospital. LPN #3 n." When asked if they were iffication, LPN #3 stated, "Not and request something but ere." Inducted on 09/13/18 at 1:10 inistrative staff member) # 1, # 1 (other staff member), SM # 2, admissions director. Its responsible for notifying a facility initiated transfer was not aware we were "OSM # 2 stated, "We don't eated he was not aware that it .m. ASM #1, the SM #2, the director of nursing	F	623			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	1 - '	PLE CONSTRUCTION G		COMPLETED				
		495267	B. WING _			09/13/2018		
	ROVIDER OR SUPPLIER DE REHAB & NURSING	3 CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186				
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
F 623	and or resident reprivith written docume transfer on 8/6/18 for Resident #113 was 5/21/18 and readmincluded but were not disorder caused by brain that control larger for you to read, write say.)(1), cerebral in (A condition in whice blood to meet the botton of the most recent MI quarterly assessme reference date) of 8 having a score of 96 for mental status) in unable to complete was coded as mode skills for daily decision. Review of Resident revealed a nursing documented the foll this nurse on bed happroximately 2 min Remained unrespond following seizure. Viplaced to (Name of send resident to ER becoming responsite	ailed to provide the resident esentative and ombudsman entation of a facility initiated or Resident #113. admitted to the facility on ted on 8/9/18. Diagnoses of limited to: aphasia (A damage to the parts of the nguage. It can make it hard a, and say what you mean to farction (stroke), heart failure in the heart can't pump enough ody's needs.) (2) OS (minimum data set), a ant, with an ARD (assessment /18/18 coded the resident as 9 on the BIMS (brief interview dicating the resident # 113 erately impaired for cognitive	F 6	23				
	Responsible party r	to (Name of hospital). notified with each event." al record failed to evidence						

	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED			
					С		
		495267	B. WING		09/13/2018		
	ROVIDER OR SUPPLIER	NG CENTER	614	STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION		
F 623	that the resident/re ombudsman were the facility- initiated Resident #113. An interview was on p.m. with LPN #3, follows to notify the when a resident we stated, "We call the given any written re unless they come usually they're not On 09/13/18 at ap interview was constaff member) #1, admissions director responsible for not facility-initiated tranot aware we were 2 stated, "We don' was not aware that On 09/13/18 4:50 and ASM #2, the caware of the findir No further information website: https://medlineplus.5. The facility staff.	esident representative and the provided written notification of d transfer on 8/6/18 for conducted on 9/13/18 at 12:40 regarding the process staff e resident's representative as sent to the hospital. LPN #3 em." When asked if they were notification, LPN #3 stated, "Not in and request something but here." proximately 1:10 p.m. an ducted with ASM (administrative the administrator, OSM (other social worker and OSM # 2, or. When asked who was tifying the ombudsman for a nsfer OSM # 1, stated, "I was a supposed to do that." OSM # 1 do it" and OSM # 1 stated he at it was required.	F 623				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	4 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C			
		495267	B. WING		09/13/2018			
	ROVIDER OR SUPPLIER DE REHAB & NURSIN	IG CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION			
F 623	Resident # 61 was 05/30/2017 and a r diagnoses that incl atrial fibrillation (1), disease (3) and hy Resident # 61's moset), a quarterly as (assessment refere Resident # 61 as s interview for mentarial fibrillations. Resident independent for acceptable of the "Nurse's Note" 19:30 (7:30 p.m.) r floor in her room where the compact of the early AM scan neg (negative bruising and assess have therapy screed doctor) and RP (resident # 100 p.m.) and RP (resident # 100 p.m.) resident # 100 p.m.) resident went to (100 p.m.) resident went	admitted to the facility on readmission of 07/23/2018 with uded but were not limited to: dementia (2), Parkinson's pertension (4). The set recent MDS (minimum data sessment with an ARD ence date) of 06/26/18, coded coring a 14 on the brief all status (BIMS) of a score of 0 gnitively intact for making daily at # 61 was coded as being tivities of daily living. The for Resident # 61 dated, "IDT eam) NOTE: On 08/30/18 at esident was observed on the eith bleeding noted from [sic] ener) made aware and ordered room) for eval. (evaluation). Name of Hospital) ER. The CT (computed tomography) es). Will monitor for latent is for pain or discomfort. Will en. Will keep MD (medical sponsible party) updated." The first clinical record and ealth record) failed to evidence to the ombudsman, Resident # 61's responsible party were	F 623					

	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	COMPLETED
					С
		495267	B. WING		09/13/2018
	ROVIDER OR SUPPLIER DE REHAB & NURSIN	IG CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
F 623	Continued From particles of the provide something On 09/13/18 at 12:4 conducted with LPN regarding written not Resident # 61's resistated, "We call the provide something On 09/13/18 at 1:10 conducted with ASI member) # 1, admin member), social word admissions director responsible for notifacility initiated train not aware we were 2 stated, "We don't was not aware that On 09/13/18 at ap (administrative staff administrator and A were made aware was not further information."	age 77 40 p.m., an interview was N (licensed practical nurse) # 3 otification to Resident # 61 and sponsible party. LPN # 3 e responsible party. We only written if they request it." 10 p.m., an interview was M (administrative staff inistrator, OSM # 1 (other staff orker and OSM # 2, r. When asked who was ifying the ombudsman for a nesfer OSM # 1, stated, "I was a supposed to do that." OSM # t do it" and ASM # 1 stated he t it was required. 12 proximately 5:55 p.m., ASM ff member) # 1, the ASM # 2, director of nursing	F 623		
	heartbeat. This info the website: https://www.nlm.nil on.html. (2) A loss of brain f diseases. It affects judgment, and beh obtained from the	the speed or rhythm of the ormation was obtained from h.gov/medlineplus/atrialfibrillati function that occurs with certain memory, thinking, language, navior. This information was website: s.gov/ency/article/000739.htm.			

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1''	PLE CONSTRUCTION G	SURVEY .ETED		
		405007	B WING		_	С	
WALE OF D		495267	B. WING	OTDEET ADDRESS CITY STATE 719 CODE	09/1	13/2018	
	ROVIDER OR SUPPLIER DE REHAB & NURSING	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION DATE	
F 623	obtained from the we https://www.nlm.nih.g essure.html. (4) A type of moveme information was obtai https://www.nlm.nih.g sease.html.	ure. This information was bsite: ov/medlineplus/highbloodpr ent disorder. This ined from the website: ov/medlineplus/parkinsonsdi	F6				
SS=D	CFR(s): 483.21(b)(1) §483.21(b) Comprehe §483.21(b)(1) The far implement a comprehe care plan for each re- resident rights set for §483.10(c)(3), that in objectives and timeframedical, nursing, and needs that are identifal assessment. The cor describe the following (i) The services that a or maintain the reside physical, mental, and required under §483. (ii) Any services that under §483.24, §483 provided due to the r under §483.10, include treatment under §483 (iii) Any specialized s rehabilitative services provide as a result of recommendations. If	ensive Care Plans cility must develop and nensive person-centered sident, consistent with the th at §483.10(c)(2) and cludes measurable ames to meet a resident's dimental and psychosocial fied in the comprehensive inprehensive care plan must g- are to be furnished to attain ent's highest practicable I psychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required .25 or §483.40 but are not esident's exercise of rights ding the right to refuse 3.10(c)(6). ervices or specialized s the nursing facility will FPASARR a facility disagrees with the RR, it must indicate its	F 6	F 656 Develop/Implement Com Care Plan 1. Resident #5's care plan adjusted to include his take the dialysis book f facility to the dialysis of Resident #8 care plan to include the use of the meet her needs Resident #102 care plan adjusted to address the oxygen as prescribed by	n was refusal to rom the enter was adjusted e call bell to un was use of		

PRINTED: 09/25/2018 FORM APPROVED OMB NO. 0938-0391

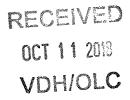
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED		
		495267	B. WING				C 13/2018
	ROVIDER OR SUPPLIER DE REHAB & NURSING	CENTER	, · · · · · · · · · · · · · · · · · · ·	6	STREET ADDRESS, CITY, STATE, ZIP CODE 114 HASTINGS LANE NARRENTON, VA 20186		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE NATE	(X5) COMPLETION DATE
F 656	(iv) In consultation wiresident's representate (A) The resident's go desired outcomes. (B) The resident's profuture discharge. Fact whether the resident community was asselected contact agencial entities, for this purporate, for this purporate, requirements set for section. This REQUIREMEN' by: Based on resident in facility document review, it was determ failed to develop and comprehensive care in the survey sample 102. 1. The facility staff facomprehensive care 5's refusal of taking the book back and forth dialysis center. 2. The facility staff facomprehensive care call bell to meet their survey care.	th the resident and the tive(s)- als for admission and eference and potential for silities must document as desire to return to the essed and any referrals to and/or other appropriate ose. In the comprehensive care in accordance with the hin paragraph (c) of this If is not met as evidenced evidenced enterview, staff interview, itew and clinical recorded inted that the facility staff element the plan for three of 37 residents elements, Residents # 5, # 8 and # alled to develop a plan to address Resident # he dialysis communication from the facility to the elements.	F		F 656 Develop/Implement Compres Care Plan continued from page 84 2. The MDS coordinator will all care plans to ensure that care planned with appropria interventions that are specimesidents who reside at Brown all care plans to ensure the compliance. 3. The MDS coordinator/desime review all care plans to ensure the MDS department an nursing to identify and add all dialysis patients and the require oxygen are care plath and the require oxygen are care plath and the who require call bells to maneds. Weekly audits to be completed by the MDS department of the MDS department and the analysis of results and the analysis of results are corrective measures employing reported monthly to the Queen compliance of these tasks of the plant of the pl	review they are ate fic to the okside. gnee will ure ducted d ress that se who nned. esidents eet their artment al month mber, y 2019 and yed	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: OTHR11

Facility ID: VA0178

If continuation sheet Page 87 of 146



STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	IPLE CONSTRUCTION		COMPLETED	
		495267	B. WING _			9/13/2018
	ROVIDER OR SUPPLIER DE REHAB & NURSIN	G CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 656	5's refusal of taking book back and forth dialysis center. Resident # 5 was a 06/03/2016 with dia not limited to: end sanemia (2), diabete hypertension (4). Resident # 5's mos set), a quarterly as: (assessment refere Resident # 5 as so interview for menta - 15, 15 - being coordecisions. Resident independent and reassistance of one saily living. Section Procedures and Pras receiving dialysis The POS (physicial September 2018 for "Dialysis Monday," Date: 12/06/2017.	failed to develop a e plan to address Resident # the dialysis communication from the facility to the dmitted to the facility on ignoses that included but were stage renal disease (1), is mellitus (3) and t recent MDS (minimum data sessment with an ARD ince date) of 09/03/18, coded oring a 15 on the brief I status (BIMS) of a score of 0 initively intact for making daily it # 5 was coded as being equiring only set up to the staff member for activities of io 0 "Special Treatments, ograms" coded Resident # 5	F 6	556		
	book failed to evide between the facility 09/05/18. On 09/12/18 at 4:3	ence communication sheets and the dialysis center after 0 p.m., an interview was				
	conducted with LP	N (licensed practical nurse) #				

	(X2) MULTIPLE CONSTRUCTION A. BUILDING		
495267 B. WING		C 09/13/2018	
BROOKSIDE REHAB & NURSING CENTER	EET ADDRESS, CITY, STATE, ZIP CODE HASTINGS LANE RRENTON, VA 20186		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	1 5475	
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			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING	(X3) DATE SURVEY COMPLETED		
		495267	B. WING		C 09/13/2018
	ROVIDER OR SUPPLIER DE REHAB & NURSING	CENTER	6	TREET ADDRESS, CITY, STATE, ZIP CODE 114 HASTINGS LANE VARRENTON, VA 20186	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E COMPLETION
F 656	body's needs. This in from the website: https://medlineplus.gd (2) Low iron. This information. This information was obtained from the amount of information was obtained from the wehttps://www.nlm.nih.gd 001214.htm. (4) High blood pressobtained from the wehttps://www.nlm.nih.gd essure.html. 2. The facility staff fail 8's comprehensive cacall bell to meet their Resident # 8 was add 06/01/18 with diagnornot limited to cerebra (2), and hypertension Resident # 8's most rest), an admission as (assessment reference Resident # 8 as scori interview for mental serior 15, 13 - being cognidecisions. Resident # 8	formation was obtained by/ency/article/000500.htm. bymation was obtained from in which the body cannot bymation the blood. This ned from the website: bymation was bsite: bymation was bymation was bsite: bymation was bsite: bymation was bymation was bsite: bymation was by	F 656		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			1''	PLE CONSTRUCTION 3		COMPLETED	
		495267	B. WING		0	9/13/2018	
	DER OR SUPPLIER	3 CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
On cor Repositive flat the flat the Ob hair Repositive for the positive flat the control over with act extractions. Why was a property of the property for the property flat flat flat flat flat flat flat flat	nducted with Resident # 8 was ly sition, with her fee bed and her heat on the mattress to the liservation of the conging over the left sident # 8's bed ward the inside of the room reveale sitioned parallel to the room reveale sitioned parallel to the water in each of the room reveale sitioned parallel to the water in each of the treach of the call bell tended her right a lit's always difficulties asked if she of the treach it." During the left in the was located the bed in front one was located the bed in front onen asked if she one, Resident # 8 oblem. I can't get one was located the treach it yell or I hat the time to put he ade her feel to ha	co.m., an interview was ident # 8 in her room. Ing in her bed in a diagonal et at the bottom left corner of ad, in upper right corner lying. Two pillows were directly on eft of Resident #8's head. It is leel revealed it was it side of the head board of with the activation switch the bed. Further observation of the over-the-bed table, was to the left side of the bed. The contained three water bottles of them. When asked to Resident # 8 partially arm and stated, "I can't reach all to reach the call bell." It to reach the call bell." It to reach the call bell. "I could reach and obtain the over-the-bed table, Resident # her right arm and stated, "I ag the course of the interview, Resident # 8's room. When are phone ringing Resident # 8 none." Resident # 8's cell on a bedside table at the foot of the window in the room. I wanted to answer her cell a stated, "That's another to my cell phone to answer it ow she gets assistance when he call bell, Resident # 8 not call bell, Resident # 8 not call bell, Resident # 8 not call bell on." When how it ve to yell to get assistance east to her personal cell phone,	F 6	56			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIENCLIA IDENTIFICATION NUMBER:			NG		COMPLETED	
		495267	B. WING			C 09/13/2018
	ROVIDER OR SUPPLIER DE REHAB & NURSII	NG CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 614 HASTINGS LANE WARRENTON, VA 20186		
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F 656	about being put to was assisted by or seemed to be in a	age 84 bed Resident # 8 stated she ne staff member and "'They hurry." When asked about dent # 8 stated, "It makes me	F	656		
	conducted of Resident observation of the hanging over the le Resident # 8's bed toward the inside of the room reveal position parallel to over-the-bed table with water in each for and activate the "I can't reach it." Cell phone reveale table at the foot of the room, out of R	dent # 8 and her room, # 8 was lying in bed. An call bell revealed it was eft side of the head board of it with the activation switch of the bed. Further observation ed the over-the- bed- table the left side of the bed. The contained three water bottles of them. When asked to reach e call bell, Resident # 8 stated, observation of Resident # 8's id it was located on a bedside the bed in front the window in esident # 8's reach. Resident # unable to reach her water				
	and her room revel bed. An observation was hanging over of Resident # 8 be toward the inside of of the room reveal position parallel to over-the-bed table with water in each for and activate th "I can't reach it."	n., observation of Resident # 8 paled Resident # 8 was lying in on of the call bell revealed it the left side of the head board and with the activation switch of the bed. Further observation led the over-the-bed-table of the left side of the bed. The electronament contained three water bottles of them. When asked to reach the call bell, Resident # 8 stated, observation of Resident # 8's and it was located on a bedside				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG	E SURVEY PLETED		
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		495267	B. WING		09	/13/2018	
	ROVIDER OR SUPPLIER DE REHAB & NURSING	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		OULD BE	(X6) COMPLETION DATE	
F 656	table at the foot of the the room out of Reside 8 stated she was unabottles. The comprehensive dated 06/11/2018 do resident has alteration Under "Interventions and meet needs. Be and respond prompti assistance." On 09/13/18 at approinterview and observed was conducted with nurse) # 3. While observed was conducted with nurse) # 3. While observed was unable to respond to the over-the personal cell phone. Cell phone and water Resident # 8's reach the over-the-bed tab put her cell phone with access it after asking would prefer to have within Resident # 8's On 09/13/18 at approinterview was condupractical nurse) # 3 rasked to describe the LPN # 3 stated, "The	e bed in front the window in dent # 8's reach. Resident # able to reach her water care plan for Resident # 8 cumented, "Focus: The in musculoskeletal status." It documented, "Anticipate sure call light is within reach y to all requests for eximately 11:00 a.m., an ation of Resident # 8's room LPN (licensed practical serving the placement of the s, and cell phone in Resident surveyor, Resident # 8 stated each the call bell, the water ine-bed table and her LPN # 3 stated the call bell, it should have been within a LPN # 3 then rearranged le closer to Resident # 8 and there Resident # 8 could g Resident # 8 where she it and moved the call bell	F	656			
	we should be followi	ated, "If it's on the care plan ng it." After being informed care plan for Resident #8					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	G		COMPLETED	
		495267	B. WING _			C 09/13/2018
	ROVIDER OR SUPPLIER DE REHAB & NURSIN	IG CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186		, tester to month
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 656	LPN # 3 was asked followed for Reside needs. LPN # 3 state of the control of the	of if the care plan was being ent # 8's call and meeting her lated, "No." proximately 5:55 p.m., ASM if member) # 1, the ASM # 2, director of nursing of the findings. It ion was provided prior to exit. Indeed that affect a person's and mation was obtained from the mation was obtained from the mation was obtained from the mation to find the blood. This present the blood in the stained from the website: In gov/medlineplus/ency/article/ In source. This information was website: In gov/medlineplus/highbloodpr	F 6	56		
	04/04/18 and read diagnoses that incl	s admitted to the facility on mitted on 08/07/18 with luded but were not limited to: ailure (CHF), high blood				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		COMPLETED	COMPLETED			
		495267	B. WING _		09/13/20	018
,,,,,,	ROVIDER OR SUPPLIER DE REHAB & NURSING	CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COM	(X5) IPLETION DATE
F 656	pressure, diabetes, (A condition in which from your lungs into The most recent MD quarterly assessmer reference date) of 8/having a 14 out of 1/for mental status) incognitively intact to 1/for mental status) incognitively intact to 1/for mental status) incognitively intact to 1/for mental status) incognitively intact to 1/for mental status) incognitively intact to 1/for mental status) incognitively intact to 1/for mental status) incognitively intact to 1/for mental status) incognitively intact to 1/for mental status) incognitively intact a mintact (a) (a) (b) (b) (c) (c) (c) (c) (c) (c) (c) (c) (c) (c	and acute respiratory failure in not enough oxygen passes your blood.) (1) S (minimum data set), a nt, with an ARD (assessment (21/18 coded the resident as 5 on the BIMS (brief interview dicating the resident was make daily decisions. St recent POS (physician ed 04/04/18 documented in (minute) via nasal cannula i) Sat's. (oxygen saturation) RN (as needed) every shift for structive pulmonary #102's comprehensive care is revision dated 09/04/18 in reference to oxygen use by roximately 11:29 a.m., observed wearing a nasal in being delivered at 2 if on oxygen flow meter of the r. roximately 9:36 a.m., an incted with LPN (Licensed regarding when a care plan if LPN #1 stated when inges with the resident like a shavior. LPN #1 was asked if oxygen would be care	F 6	56		

A95267 B. WING	STATEMENT OF DEFICIENCIES () AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG		E SURVEY APLETED
BROOKSIDE REHAB & NURSING CENTER (CA) ID PREFIX INC. (CA) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 was then asked to find oxygen on Resident #102's care plan. LPN #2 stated, "If don't see it." On 09/13/18 at approximately 4:50 p.m., ASM (administrative staff member) #1, the administrative staff member) #1, the administrative and ASM #2, the DON (Director of Nursing) were made aware of the above concern. No further information was obtained prior to exit. Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans		495267 B. WING		0	l - I		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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. Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans			CENTER		614 HASTINGS LANE		
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. Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF!)	(EACH CORRECTIVE ACTION SHOULD BE COM CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
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	On 09/13/18 at approinterview was conductive was conductive was conductive asked if a reside be included on their of "Yes." When asked wincluded on the compatated, "If they try to would put that on the want to know the am was then asked to fir #102's care plan. LPI On 09/13/18 at appro (administrative staff radministrator and AS Nursing) were made No further information Care Plan Timing and CFR(s): 483.21(b)(2) §483.21(b) Compreh §483.21(b)(2) A combedity of the comprehensive at (ii) Prepared by an inincludes but is not limin (A) The attending ph (B) A registered nurs resident. (C) A nurse aide with resident. (D) A member of foo (E) To the extent prathe resident and the rad an explanation must	eximately 12:18 p.m., an obted with LPN #7. LPN #7 and uses oxygen should that care plan, LPN #7 responded why oxygen should be prehensive care plan, LPN#7 wean themselves off we care plan and we would ount (Of oxygen). LPN #7 and oxygen on Resident N #2 stated, "I don't see it." Eximately 4:50 p.m., ASM member) #1, the SM #2, the DON (Director of aware of the above concern. In was obtained prior to exit. In the difference of the above concern. In was obtained prior to exit. In the side of the above concern. If days after completion of assessment. Iterdisciplinary team, that the inited to yysician. Iterdisciplinary team, that the inited to ysician. Iterdisciplinary team, that the inited to yysician. Iterdisciplinary team, that the inited to yysician. Iterdisciplinary team, that inited to yysician. Iterdisciplinary team, that inited to yysician. Iterdisciplinary team, that inited to yysician. Iterdisciplinary team, that inited to yysician. Iterdisciplinary team, that inited to yysician. Iterdisciplinary team, that inited to yysician. Iterdisciplinary team, that inited to yysician.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED	
		495267	B. WING_				, 13/2018
	ROVIDER OR SUPPLIER	CENTER		STREET ADDR			
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F 657	and their resident renot practicable for the resident's care plan. (F) Other appropriated disciplines as determor as requested by the (iii)Reviewed and resteam after each assonated comprehensive and assessments. This REQUIREMENT by: Based on observation document review, as was determined that and revise the compost of 35 residents in the #113. The facility staff failed comprehensive care seizure on 8/6/18. The findings included Resident #113 was 5/21/18 and readmit that included but no disorder caused by brain that control lart for you to read, write say.) (1), cerebral in (A condition in which blood to meet the best of the most recent ME quarterly assessme reference date) of 8	presentative is determined the development of the set aff or professionals in mined by the resident's needs the resident. Vised by the interdisciplinary the essment, including both the quarterly review. T is not met as evidenced on, staff interview, facility and clinical record review, it it facility staff failed to review the esurvey sample, Resident the esurvey sample, Resident the resident had a set admitted to the facility on a tited on 8/9/18 with diagnoses it limited to: aphasia (Adamage to the parts of the inguage. It can make it hard a, and say what you mean to infarction (stroke), heart failure in the heart can't pump enough	F	1. R u C C C C C C C C C C C C C C C C C C	Resident #113 care plan ward polated to include aphasia and derebral infarct. The Assistant Director of Name of the Core of the residents as a linically indicated. The daily morning clinical meetings will include immediate and care plans to reflect any characterings will include immediate and the early of the care of the residents as a linically indicated. The daily morning clinical meetings will include immediate and care plans are flected on the 24hr report Management meetings. A daily audit of care plans all changes of conditions the reflected and updated in the resident's care plans. Daily by Nurse Unit Managers structured to the This practice of formally integrated into morning clinical meetings. Compliance and analysis of the formally x 6months Octobe November, December 2018 anuary, February and Martine facility dutifully alleges compliance of these tasks of the facility dutifully alleges to the plans and the facility dutifully alleges to the facility dutifully allege	lursing list all langes in lediate that are lat occur in the laudits larting list wember list wember list wember list wember list list list list list list list list	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION		E SURVEY PLETED	
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	ROVIDER OR SUPPLIER DE REHAB & NURSING			STREET ADDRESS, CITY, STATE, ZIP CO 614 HASTINGS LANE WARRENTON, VA 20186			
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F 657	unable to complete the was coded as modern skills for daily decision. Review of Resident is revealed a nursing not documented the follothis nurse on bed has approximately 2 minus Remained unresponsion following seizure. Vita placed to (Name of Disend resident to ER (becoming responsive Medical Service) arrival. Resident sent to Responsible party not Review of Resident is a hospital discharge documented Resider facility following a neseizure (3) that laster postictal. Of 10-15 m section documented on Keppra (Levetirac medication) during the Resident #113's mosorder summary) date "Levetiracetam table tablet through G- tub times a day for seizu. The medication admidated August and Se "Levetiracetam table: "Levetiracetam	icating the resident was the interview. Resident # 113 ately impaired for cognitive on making. #113's clinical record the dated 8/6/18 that wing: "Resident observed by ving grand mal seizure for tites. Observed throughout. Sive for several minutes al signs unremarkable. Call foctor); orders received to (emergency room). Resident to when EMS (Emergency ved; exited facility at 0940 to (Name of hospital). #113 clinical record included summary dated 8/9/18, that th #113 presented from the tw onset "tonic-clonic d "2-3 minutes than a inutes". The reviewed plan Resident #113 was started tetam, an anti-seizure tils admission. #1 recent POS (physician tild 8/9/18 documented tils 500 mg (milligrams) give 1 te (Gastrostomy tube) two	F	657			

PRINTED: 09/25/2018 FORM APPROVED OMB NO. 0938-0391

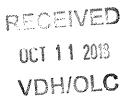
STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
		495267	B. WING_			C 09/13/2018
	ROVIDER OR SUPPLIER DE REHAB & NURSING	CENTER		STREET ADDRESS, CITY, STATE, 2 614 HASTINGS LANE WARRENTON, VA 20186	IP CODE	
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F 657	Continued From page	e 91	F	657		
	quarterly revision dat any reference to Res of seizure or the new prescribed for Reside prevention.					
	interview was conduct Practical Nurse) #1. It care plans are update anything major change new diagnosis or behalf resident transfer to	eximately 9:36 a.m., an exted with LPN (Licensed LPN #1 was asked when ed. LPN #1 stated when ges with the resident like a navior. LPN #1 was asked if the hospital for a seizure lan, LPN #1 stated, "Yes."				
	interview was conductive was asked if a resider plan should be updated as eizure, LPN #7 stated locate seizures on Reference.	eximately 12:18 p.m., an octed with LPN #7. LPN #7 and's comprehensive care sed after a new diagnosis of ed, "Yes." When asked to esident #113's plan, LPN #7 stated, "I don't				
	Discharge Planning" comprehensive personeviewed and revised	ed, "Care Planning and documented, "The on- centered care plan will be d as appropriate after each dget Reconciliation Act)				
	(administrative staff)	SM #2, the DON (Director of				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: OTHR11

Facility ID: VA0178

If continuation sheet Page 99 of 146



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X'		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	C3) DATE SURVEY COMPLETED
		495267	B. WING		09/13/2018
	ROVIDER OR SUPPLIER DE REHAB & NURSING	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186	
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F 657	Continued From pag No further informatio	e 92 n was presented prior to exit.	F 657	7	
F 658 SS=E	2. This information we website: https://medlineplus.gr 3. Generalized tonic- seizure that involves called grand mal seiz convulsion, or epilep- with generalized tonic- information was obtate website:https://medlings.htm Services Provided M. CFR(s): 483.21(b)(3) \$483.21(b)(3) Compound The services provide as outlined by the comust- (i) Meet professional This REQUIREMEN' by: Based on observation document review, ar was determined the professional standar residents in the surve #117, #115 and #77. 1. The facility staff far #39's physicians ord.	neplus.gov/epilepsy.html. as obtained from the by/heartdiseases.html. clonic seizure is type of the entire body. It is also zure. The terms seizure, sy are most often associated by are most	F 658	F 658 Services Provided Meet Professtandards 1. Resident #117- The physical order for pain medication we clarified Resident 115- The physical order for pain medication we rectified Resident #39 The order for work was rectified Resident #77 The physician for the two pain medication clarified 2. All facility residents' e-man reviewed for accuracy of pain medications by Nurses recent the order	ian's ras an's ras lab n's order s were s will be iin

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED		
		495267	B. WING			09/	C 13/2018
	ROVIDER OR SUPPLIER DE REHAB & NURSING	G CENTER		614 HAS	ADDRESS, CITY, STATE, ZIP CODE TINGS LANE INTON, VA 20186	•	
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F 658	1. The facility staff orders for pain med 2. The facility staff forders for two pain of two pain of two pain of two pain of two pains o	rmine when and which as ation should be administered. failed to clarify the physician's ication for Resident#115. ailed to clarify thephysician medications for Resident # a: ailed to transcribe Resident # a: ailed to transcribe Resident der for laboratory (lab) work. admitted to the facility on sees that included but were not noid hemorrhage orrhage (SAH) is bleeding into stured cerebral aneurysm or is a form of a stroke. (1)], tia, and history of falling. DS (minimum data set) relatively assessment, with an nee date of 7/14/18, coded the both short and long-term The resident was coded as assistance of one staff s activities of daily living ich he required supervision		658 Stand	All new orders will be reviewed at the morning climed transcription of physician's Physicians and Nurse pract will be informed of the expectation. All new orders that in different dosages for pain medication. All new orders reviewed by the ADONs at morning clinical meetings. resident's chart will be browned on the accurate transcription of physician's physicians and Nurse pract will be informed of the expectation. All new orders reviewed by the ADONs at morning clinical meetings. resident's chart will be browned information. A facility wide review of a for accuracy will be conducted by October 28th The result of this audit will reviewed at the QA month meeting. The facility dutifully allegation of the compliance with these task before 10/28/18	ewed by inical ons will report Il be orders itioners ectations clude will be The aght to accuracy Il orders cted and a, 2018 be ly	
	documented, "Na+ BID (twice a day) d (lower than normal	ian order dated, 7/9/18, (sodium) tabs (tablets) 1 gram x [diagnosis] - hyponatremia concentration of sodium in the asic metabolic panel (2)] in 1					

AND DUAN OF CODDICATION HOLDERS HOLDERS HAVE BEEN		A. BUILDING	E CONSTRUCTION	COMPLETED				
		495267	B. WING		09/13/2018			
•••	ROVIDER OR SUPPLIER	IG CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186				
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F 658	week." There was a line, "Signature of I Review of the clinic the laboratory test by the physician. Review of the com 3/17/18, revised or documentation of to On 9/13/18 at appr (other staff membershe had access to computer. She programmer is a laboratory website laboratory website laboratory results for would have been as On 9/13/18 at appr (licensed practical locate the laboratory weren't done. On 9/13/18 at 10:00 manager, reviewed surveyor and state it was taken off." A this concern, LPN have anything (laboratory) and state it was taken off." A this concern, LPN have anything (laboratory) and state it was taken off." A this concern, LPN have anything (laboratory) and state it was taken off." A this concern, LPN have anything (laboratory) and state it was taken off." A this concern, LPN have anything (laboratory) and state it was taken off." A this concern, LPN have anything (laboratory) and state it was taken off." A this concern, LPN have anything (laboratory) and state it was taken off." A this concern, LPN have anything (laboratory) and state it was taken off." A this concern, LPN have anything (laboratory) and state it was taken off." A this concern, LPN have anything (laboratory) and state it was taken off." A this concern, LPN have anything (laboratory) and state it was taken off." A this concern, LPN have anything (laboratory) and state it was taken off." A this concern, LPN have anything anything (laboratory) and laboratory is a laboratory taken anything (laboratory) and laboratory taken anything (laboratory) and laboratory taken anything (laboratory) and laboratory taken anything (laboratory) and laboratory taken anything (laboratory) and laboratory taken anything (laboratory) and laboratory taken anything (laboratory) and laboratory taken anything (laboratory) and laboratory taken anything (laboratory) and laboratory taken anything (laboratory) and laboratory taken anything (laboratory) and laboratory taken anything (laboratory) and laboratory taken anything (laboratory) and laboratory taken anyth	nothing documented on the Nursing Receiving Order." cal record failed to evidence results for the BMP as ordered prehensive care plan, dated a 7/20/18, failed to evidence the hyponatremia. roximately 9:45 a.m., OSM er) #5, the ward clerk stated the laboratory results on the ceeded to access the and could only locate the for 7/6/18 and 8/16/18. There is one week after 7/9/18, which	F 65					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G		TE SURVEY MPLETED	
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		495267	B. WING _			9/13/2018	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI	Ē		
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BKOOKSI	DE RENAD & NOROING	CENTER		WARRENTON, VA 20186			
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F 658	Continued From pag	e 95	F 6	58			
	administrator and AS were made aware of 9/13/18 at 4:56 p.m. On 9/13/18 at 6:21 p	ative staff member) #1, the SM #2, the director of nursing the above concern on .m., ASM #2, the director of cility follows their policy and					
	procedures as their s						
	following website: https://www.ncbi.nlm m=Subarachnoid+he (2) The basic metabolism blood tests that provided by metabolism. E Terms for the Non-M Rothenberg and Che (3) This information of following website:	olic panel (BMP) is a group of ides information about your Barron's Dictionary of Medical edical Reader, 5th edition,					
	orders for Resident and determine which, and medication should be Resident #117 was a 12/6/17 with a readn diagnoses that include	admitted to the facility to nission on 1/25/18 with ded but were not limited to: r, depression, high blood					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION		TE SURVEY MPLETED
		10.700	B WING			C
		495267	B. WING			9/13/2018
	ROVIDER OR SUPPLIER IDE REHAB & NURSING	CENTER		STREET ADDRESS, CITY, STATE, ZIP C 614 HASTINGS LANE WARRENTON, VA 20186	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 658	characterized by rap the atria of the heart the ventricles and re- output and frequently (1)], and malnutrition The most recent MD	id and random contraction of causing irregular beats of sulting in decreased heart y clot formation in the atria i. S (minimum data set)	F 6	558		
	assessment reference resident as scoring a interview for mental was moderately important decisions. The reside periods of inattention Resident #117 was of	taff member for all of her				
	"Acetaminophen (Ty relieves minor aches (milligrams); Give 3 hours as needed for 12/12/17. The physic "Tramadol Tablet [Umoderately severe pby mouth every 6 ho	summary documented, rienol) [Tylenol temporarily s and pains (2)] 325 MG tablets by mouth every 6 pain." This order was dated cian orders documented, sed to relieve moderate to pain. (3)] 50 MG; Give 50 mg purs as needed for s order was dated 6/11/18.				
	record) documented Tylenol was docume a pain level of "6." T documented as give 8/3/18 at 9:51 a.m. f 8/9/18 at 9:28 p.m. f 8/18/18 at 7:59 p.m. 8/26/18 at 8:03 a.m.	AR (medication administration the above medications. The ented as given on 8/13/18 for the Tramadol was on on the following dates: for a pain level of "9." for a pain level of "6." for a pain level of "7." for a pain level of "7."				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	E CONSTRUCTION	COMPLETED				
		495267	B. WING		C 09/13/2018			
	ROVIDER OR SUPPLIER DE REHAB & NURSING	G CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLÉT			
F 658	Continued From pa	ge 97	F 65	3				
	•	8 MAR documented the eive any Tylenol or Tramadol .						
	on 9/11/18, docume #117) is at risk for p documented in part, need for pain relief any complaint of pa previous pain histor pain and impact on response to analges effect and impact or	care plan dated as revised anted i part, "Focus: (Resident ain." The "Interventions", "Anticipate the resident's and respond immediately to in. Identify and record y and management of that function. Identify previous sia including pain relief, side in function. Monitor/document of each pain episode.						
	practical nurse) #2, at 3:08 p.m., LPN # above orders for Ty asked how staff know medication should to stated she would stated she working I'd over the grams per should state moders.	onducted with LPN (licensed the unit manager; on 9/12/18 2 was asked to review the lenol and Tramadol. When ow which as needed pain oe administered, LPN #2 art with the Tylenol and if d call the doctor so I don't go day." LPN #2 stated the order ate or mild pain. I would need or clarify the order."						
	Orders," documente medications must ir a. Name and streng b. Number of doses specific duration of c. Dosage and frequent. d. Route of adminis	oth of the drug. , start and stop date, and/or therapy. uency of administration. tration. or symptoms for whichthe						

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- · · · · · · · · · · · · · · · · · · ·		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G		OATE SURVEY COMPLETED
		495267	B, WING			C 09/13/2018
	ROVIDER OR SUPPLIER DE REHAB & NURSING	CENTER	•	STREET ADDRESS, CITY, STATE, ZIP COI 614 HASTINGS LANE WARRENTON, VA 20186	DE	
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 658	Continued From pag	e 98	F 6	58		
	edition Potter and Permedication order is rebe administered by a order is incomplete, if prescriber and ensur carrying out any med. The administrator and made aware of the administrator and made aware of the administrator and made aware of the administrator and made aware of the administrator and made aware of the administrator and made aware of the administrator and made aware of the administrator and following information of the administrator and made aware of the administrator and following website: https://dailymed.nlm.gxsl.cfm?setid=16220ecfb7 (3) This information of the administrator and following website: https://medlineplus.gml.	and director of nursing were bove concern on 9/13/18 at an was provided prior to exit. Try of Medical Terms for the control of the control o				
	orders for two as nee Resident #115 to de	ailed to clarify the physician's eded pain medication for termine when and which as tion should be administered.				
	8/18/18 with diagnos limited to: pancreatit heart failure and end	admitted to the facility on ses that included but were not is, diabetes, hypertension, sephalopathy [a disease of cts the brain's ability to				

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Event ID: OTHR11

Facility ID: VA0178

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	СОМІ	E SURVEY PLETED
		495267	B. WING		1	/13/2018
	ROVIDER OR SUPPLIER DE REHAB & NURSING	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 658	assessment, a Medic with an assessment of coded the resident at (brief interview for me he has no cognitive is making. The resident extensive assistance members for bed mo toileting, and persona Medications, the resi opioids during the local The physician order analgesics (pain relie reducers). It is used to pain. (1)] Tablet 650 by mouth every 4 hordiscomfort." The phydocumented: "Oxyco 5-325 [a hydrocodon combination product moderate-to-severe medications called of (2)] mg: Give 1 tables needed for pain." Newhich pain medication the resident's pain let	S (minimum data set) sare 14 day assessment, reference date of 9/1/18, s scoring a "14" on the BIMS ental status) score, indicating impairment for daily decision is was coded as requiring of at least one staff bility, transfers, dressing, al hygiene. In Section N - dent was coded as using ok back period. dated, 8/19/18, documented, elass of medications called evers) and antipyretics (fever to relieve mild to moderate ing (milligram): Give 650 mg ins as needed for general sician order dated 8/31/18, done-Acetaminophen Tablet e and acetaminophen used to relieve pain. It is in a class of piate (narcotic) analgesics to by mouth every 6 hours as ither order documented on should be used based on vel. B MAR (medication I) documented the above	F 654			
	documented as having 9/1/18 at 8:55 a.m. for	ng been administered on or a pain level of 8 and at evel of 9; on 9/2/18 at 4:30				Control

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	COMPLETED			
		495267	B. WING		09/13/2018			
	ROVIDER OR SUPPLIER DE REHAB & NURSIN	IG CENTER	6	STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186				
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION			
F 658	a.m. for a pain level pain level of 8 and at 11 on 9/6/18 at 1:13 at 8:20 p.m. for a pain level pain level of 9; on level of 4; on 9/11/of 7; and on 9/12/1 of 7. The September 20 above physician or documented as hat 9/1/18 at 6:50 a.m. The comprehensive a most recent revised ocumented in pair risk for pain." The part, "Anticipate the and respond immer pain". An interview was opractical nurse) #3 When asked how medication to give has multiple order medications, LPN pain level or to nur When asked to revolve the doctor to clarif which pain medications which pain medications which pain medications which pain medications is a pain level or to nur when asked to revolve the doctor to clarif which pain medications which pain medications which pain medications is a pain level or to nur when asked to revolve the doctor to clarif which pain medication m	el of 9 and at 4:59 p.m. for a 9/3/18 at 1:24 a.m. for a pain 1:00 a.m. for a pain level of 7; a.m. for a pain level of 6 and at a level of 5; on 9/7/18 at 4:05 el of 7 and at 11:30 p.m. for a pain level of 7 and at 11:30 p.m. for a pain 18 at 5:01 p.m. for a pain level 18 at 11:30 a.m. for a pain level 18 at 11:30 a.m. for a pain level 18 at 11:30 a.m. for a pain level 19 at 11:30 a.m. for a pain level 19 at 11:30 a.m. for a pain level 19 at 11:30 a.m. for a pain level 19 at 11:30 a.m. for a pain level 19 at 11:30 a.m. for a pain level 19 at 11:30 a.m. for a pain level 19 at 11:30 a.m. for a pain level 19 at 11:30 a.m. for a pain level 19 at 11:30 a.m. for a pain level of 6. The care plan dated 8/21/18, with sion date of 9/11/18, at "Interventions" documented in the resident's need for pain relief ediately to any complaint of 19 at 12:40 p.m. staff determine which pain 19 at a resident when the resident 19 at 12:40 p.m. staff determine which pain 19 at 12:40 p.m. staff determine which pain 19 at 12:40 p.m. staff determine when the resident 19 at 12:40 p.m. staff determine which pain 19 at 12:40 p.m. staff determine when the resident 19 at 12:40 p.m. staff determine when the resident 19 at 12:40 p.m. staff determine when the resident 19 at 12:40 p.m. staff determine when the resident 19 at 12:40 p.m. staff determine when the resident 19 at 12:40 p.m. staff determine when the resident 19 at 12:40 p.m. staff determine which pain 19 at 12:40 p.m. staff determine which pain 19 at 12:40 p.m. staff determine which pain 19 at 12:40 p.m. staff determine which pain 19 at 12:40 p.m. staff determine which pain 19 at 12:40 p.m. staff determine 19 at 12:40 p.m. staff determine which pain 19 at 12:40 p.m. staff determine which pain 19 at 12:40 p.m. staff determine which pain 19 at 12:40 p.m. staff determine which pain 19 at 12:40 p.m. staff determine which pain 19 at 12:40 p.m. staff determine which pain 19 at 12:40 p.m. staff determine which pain 19 at 12:40 p.m. staff determine which pain 19 at 12:40 p.m. staff determine	F 658					
ļ	1 ,	ve staff member) #1, the ASM #2, the director of						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ı		NSTRUCTION	СОМ	(X3) DATE SURVEY COMPLETED C	
		495267	B. WING				/13/2018	
	ROVIDER OR SUPPLIER DE REHAB & NURSING			STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	κ	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 658	on 9/13/18 at 4:55 p. According to "Lipping Practice", Eighth Edi Wilkins, pg. 87 read: dosages or unfamilia confirmed with the hipharmacist before at following is documer Orders: 2. Although follow an order you to just ignore a medical attending physician, him, obtain appropri	aware of the above findings	F	658				
	1) This information we National Institutes of https://medlineplus.gtml 2) This information we National Institutes of https://medlineplus.gtml 4. The facility staff for orders for Resident medications to determine medication to administration of the product o	vas obtained from the f Health at pov/druginfo/meds/a601006.h ailed to clarify the physician's # 77's two as needed pain mine when and which						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495267	B. WING		0	C 9/13/2018	
	ROVIDER OR SUPPLIER DE REHAB & NURSING	3 CENTER		STREET ADDRESS, CITY, STATE, ZIP COE 614 HASTINGS LANE WARRENTON, VA 20186			
(X4) ID PREFIX TAG	(EACH DEFICIENCE	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 658	set), a quarterly ass (assessment referer Resident # 77 as so interview for mental - 15, 14 - being cogi decisions. Resident independent and recone staff member for Section J0400 "Pair # 77 as "Almost con The POS (physician 07/01/2018 - 09/30/documented, "Hydro/Apap (Hydro [5]) 5-325MG (millig every 4 (four) hours Status: Active. Order "Ibuprofen (6) TAB	st recent MDS (minimum data essment with an ARD nee date) of 08/04/18, coded oring a 14 on the brief status (BIMS) of a score of 0 nitively intact for making daily #77 was coded as being quiring limited assistance of or activities of daily living . In Frequency" coded Resident estantly." It's order sheet) dated 2018 for Resident #77 Decodone and acetaminophen pram). Give one tablet orally as needed for pain. Order or Date: 02/01/2018." (tablet) 400MG. Give 1 (one) (six) hours as needed for	F	558			
	record) dated July 2 physician's orders. Further review of th Ibuprofen 400MG w 07/01/18 through 07/01/18 at 9:49 p. 07/05/18 at 6:50 p.r 07/06/18 at 1:36 p.r 07/08/18 at 8:31 p.r	nic medication administration 2018 documented, the above e July eMAR revealed vas not administered from 7/31/18 and Hydro/Apap inistered on the following m. with a pain level of 3. m. with a pain level of 5. m. with a pain level of 7. m. with a pain level of 7. m. with a pain level of 7. m. with a pain level of 5. m. with a pain level of 5.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			STRUCTION	(X3) DATE SURVEY COMPLETED	
			1				С
		495267	B. WING			0	9/13/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET	ADDRESS, CITY, STATE, ZIP CODE		
BROOKS	DE REHAB & NURSING	CENTER			STINGS LANE ENTON, VA 20186		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 658	07/11/18 at 7:00 p.m 07/14/18 at 2:00 p.m 07/14/18 at 2:00 p.m 07/15/18 at 6:34 p.m 07/17/18 at 12:59 a.r at 2:54 p.m. with a pa 07/18/18 at 5:15 p.m 07/19/18 at 1:53 p.r 07/20/18 at 1:15 p.m 8:22 p.m. with a pain 07/21/18 at 9:22 a.m 6:56 p.m. with a pain 07/22/18 at 4:10 p.m 07/23/18 at 10:19 a.r 07/24/18 at 10:33 a.r at 4:24 p.m. with a pain 07/25/18 at 3:45 p.m 07/26/18 at 10:25 a.r 07/29/18 at 11:53 a.r at 1:30 p.m. with a pain 07/30/18 at 11:53 a.r at 5:12 p.m. with a pain 07/31/18 at 11:55 p.r The eMAR (electronic record) dated Augus above physician's or August eMAR reveal administered on 08/3 Hydro/Apap 5-325M following dates: "08/01/18 at 1:14 p.r 08/02/18 at 2:38 p.m 8:38 p.m. with a pain 08/03/18 at 1:25 p.m 08/05/18 at 1:25 p.m 08/06/18 at 1:53 a.r at 4:08 p.m. with a p	with a pain level of 3. with a pain level of 5. with a pain level of 5. with a pain level of 8 and ain level of 6. with a pain level of 2. with a pain level of 8. with a pain level of 7 and at level of 5. with a pain level of 4 and at level of 5. with a pain level of 5. with a pain level of 6. with a pain level of 5. nd ain level of 5. with a pain level of 6. with a pain level of 5. with a pain level of 5. with a pain level of 6. with a pain level of 5. with a pain level of 5. with a pain level of 6. with a pain level of 6. with a pain level of 6.	F	658			

STATEMENT OF DEFICIENCIES (X' AND PLAN OF CORRECTION	I DELITICIOATION NI BIRED.		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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	495267	B. WING_		01	9/13/2018	
NAME OF PROVIDER OR SUPPLIER BROOKSIDE REHAB & NURSING CE	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186			
PREFIX (EACH DEFICIENCY M	EMENT OF DEFICIENCIES IUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
record) dated September above physician's order August eMAR revealed administered from 09/01 Hydro/Apap 5-325MG with following dates: "09/02/18 at 5:27 a.m. with 09/03/18 at 9:59 p.m. with 09/10/18 at 5:20 a.m. with 09/11/18 at 3:24 p.m.	with a pain level of 8. with a pain level of 5. with a pain level of 10. with a pain level of 6." medication administration er 2018 documented the rs. Further review of the lbuprofen 400MG was not 1/18 through 09/12/18 and was administered on the with a pain level of 3. with a pain level of 5. m., an interview was rensed practical nurse) # ribe the procedure for eeded) pain medication, e location of the pain, the ign out the medication, he resident's pain in 30 hen asked about the regarding two prn pain rameters, LPN # 3 stated, n from the physician." S and EMARs for Resident t and September 2018, here were parameters for 3 stated, "No." When nedication should be tated, "The order should	F 6	58			

	OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING		COMPLETED		
		495267	B. WING _		09/13/2018
	ROVIDER OR SUPPLIER DE REHAB & NURSING	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186	
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F 658	Continued From pag were made aware of		F6	558	
	References:	n was provided prior to exit. il, you need treatment to			
	replace the work they options are dialysis of treatment has benefit which treatment you some changes in you and plan your activities health care providers	y normally do. The treatment or a kidney transplant. Each its and drawbacks. No matter choose, you'll need to make our life, including how you eat les. But with the help of s, family, and friends, most	10.		
	lives. This informatio website: https:	ailure can lead full and active in was obtained from the pov/kidneyfailure.html.			
	obtained from the we	order. This information was absite: gov/medlineplus/swallowingdi			
	the website:	formation was obtained from gov/medlineplus/anemia.html			
	website:	ation was obtained from the gov/medlineplus/anxiety.html			
	other ingredients, an products are prescril hydrocodone combin relieve moderate-to-	available in combination with ad different combination bed for different uses. Some nation products are used to severe pain. Other nation products are used to			

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''	IPLE CONSTRUCTION IG	COMPLETED
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	ROVIDER OR SUPPLIER DE REHAB & NURSING	3 CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186	
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F 658	medications called and in a class of medications called and in a class of medication and in a class of medicativity in the part of coughing. This information website: https://medlineplus.gtml. (6) Prescription iburtenderness, swelling osteoarthritis (arthrithe lining of the join (arthritis caused by joints). It is also use pain, including mendefore or during a minformation was obthettps://medlineplus.tml. Quality of Care CFR(s): 483.25 § 483.25 Quality of Quality of care is a applies to all treatmer facility residents. Be assessment of a rethat residents received accordance with propractice, the comprise plan, and the interest that the comprise plan, and the interest that the comprise plan, and the interest that the comprise plan, and the interest that the comprise plan, and the interest that the comprise plan, and the interest that the comprise plan, and the interest that the comprise plan, and the interest that the comprise plan, and the interest that the comprise plan, and the interest that the comprise plan, and the interest that the comprise plan and the intere	procedone is in a class of oppiate (narcotic) analgesics edications called antitussives. es pain by changing the way as system respond to pain. es cough by decreasing if the brain that causes mation was obtained from gov/druginfo/meds/a601006.h profen is used to relieve pain, g, and stiffness caused by tis caused by a breakdown of its) and rheumatoid arthritis swelling of the lining of the id to relieve mild to moderate strual pain (pain that happens henstrual period). This ained from the website: gov/druginfo/meds/a682159.h care fundamental principle that lent and care provided to ased on the comprehensive sident, the facility must ensure we treatment and care in ofessional standards of ehensive person-centered	F	F 684 Quality of Care 1. Resident #39— The faci follow physician's order the laboratory tests' Resident # 60- The faci to obtain the laboratory 2. A facility wide audit of received, and identificat deficient practice will b by October 28th 2018	s to obtain lity failed tests lab orders ion of any

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Event ID: OTHR11

Facility ID: VA0178

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION ING		LETED
		495267	B. WING			C 13/2018
	ROVIDER OR SUPPLIER DE REHAB & NURSIN	G CENTER	_ !	STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		HOULD BE	(X5) COMPLETION DATE
F 684	and clinical record reacility staff failed to ordered by the physical the survey sample, 1. The facility staff forders to obtain the #39. 2. The facility staff forders to obtain the #60. The findings include 1. The facility staff forders to obtain the #60. Resident #39 was a 1/21/18 with diagnoral limited to: subarach [subarachnoid hem the brain from a ruphead trauma. SAH pneumonia, demented trauma. SAH pneumonia, demented trauma the brain from a ruphead trauma. The most recent MI assessment, a qualessessment references ident as having memory difficulties. The requiring extensive member for all of hiexcept eating in whafter set up help was set to obtain the #39.	eview, it was determined the obtain laboratory tests as sician for two of 37 residents in Resident #39 and #60. Failed to follow physician laboratory tests for Resident failed to follow physician laboratory tests for Resident failed to follow physician laboratory tests for Resident failed to follow physician laboratory tests for Resident failed to follow physician laboratory tests for Resident failed to the facility on sees that included but were not sees that included but	F	F 684 Quality of Care continued 112 3. The revision of the policy for the management of lab or collaboration with the Lab we completed by the ADON 4. Development of a lab bool addresses and rectifies all the practices will be initiated by of Nursing. An audit of lab or month starting October 1st, 2 months. Results and correction practice reported to the QAC monthly. 5. The facility dutifully alleged of these tasks on or before 100 months.	and procedure ders in ill be that edeficient the Director rders daily x 1 2018 and x3 on of deficient committee es compliance	
I		ian order dated, 7/9/18, (sodium) tabs (tablets) 1 gram				**************************************

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	COMPLETED			
		495267	B. WING	·····	09/13/2018			
	ROVIDER OR SUPPLIER DE REHAB & NURSIN	G CENTER	(STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION			
F 684	BID (twice a day) of (lower than normal blood) (2). BMP [baweek." There was a line, "Signature of I Review of the clinic the laboratory test by the physician. Review of the compa/17/18, revised or documentation of the computer. She proposed in the laboratory website laboratory website laboratory results for would have been a computer. She proposed in the laboratory results for would have been a computer. She proposed in the laboratory results for would have been a computer. She proposed in the laboratory results for would have been a computer. She proposed in the laboratory results for would have been a computer. She proposed in the laboratory results for would have been a computer of the laboratory results for words and the laboratory reviewed an	ix [diagnosis] - hyponatremia concentration of sodium in the asic metabolic panel (2)] in 1 nothing documented on the Nursing Receiving Order." cal record failed to evidence results for the BMP as ordered or the hyponatremia. coximately 9:45 a.m., OSM or) #5, the ward clerk stated the laboratory results on the ceeded to access the and could only locate the or 7/6/18 and 8/16/18. There one week after 7/9/18, which iround 7/16/18. coximately 9:50 a.m., LPN nurse) # 4 stated she could not ry test results and that they	F 684					
	this concern, LPN have anything (lab order. The facility policy, Orders" failed to e	t 10:17 a.m., after researching #2 stated it doesn't look like I oratory results) related to that "Medication and Treatment vidence the steps to take to ian order. The facility policy,						

ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		COMPLETED			
495267	B. WING		C 09/13/2018		
	6	STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186			
Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	D BE COMPLÉTION		
Test Results - Clinical d in part, "2. The staff will ons and arrange for tests. tive staff member) #1, the M #2, the director of nursing the above concern on d director of nursing were cove concern on 9/13/18 at m., the director of nursing ows their policy and tandard of practice. Nursing" 6th edition, 2005; I Anne Griffin Perry; Mosby, physician is responsible for atment. Nurses are ysician's orders unless they e in error or would harm in was provided prior to exit. I was obtained from the mih.gov/pubmedhealth/?termorrhage ry of Medical Terms for the 5th edition, Rothenberg and	F 684				
	ATEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) Test Results - Clinical d in part, "2. The staff will ons and arrange for tests. tive staff member) #1, the M #2, the director of nursing the above concern on d director of nursing were bove concern on 9/13/18 at .m., the director of nursing ows their policy and tandard of practice. Nursing" 6th edition, 2005; A Anne Griffin Perry; Mosby, physician is responsible for atment. Nurses are ysician's orders unless they e in error or would harm In was provided prior to exit. was obtained from the .nih.gov/pubmedhealth/?ter emorrhage ry of Medical Terms for the , 5th edition, Rothenberg and .was obtained from the	A95267 B. WING CENTER ATEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) Test Results - Clinical din part, "2. The staff will ons and arrange for tests. tive staff member) #1, the M #2, the director of nursing the above concern on did director of nursing were cove concern on 9/13/18 at	A 495267 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186 D. PROVIDERS PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOULD LISC IDENTIFYING INFORMATION) D. 109 Test Results - Clinical di in part, "2. The staff will ons and arrange for tests. tive staff member) #1, the M #2, the director of nursing the above concern on di director of nursing were pove concern on 9/13/18 at , the director of nursing ows their policy and tandard of practice. Nursing" 6th edition, 2005; I Anne Griffin Perry, Mosby, physician is responsible for atment. Nurses are ysician's orders unless they e in error or would harm In was provided prior to exit. was obtained from theinin.gov/pubmedhealth/?termorrhage yr of Medical Terms for the ,5th edition, Rothenberg and was obtained from the		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		COMPLETED			
		495267	B. WING		C 09/13/2018
	ROVIDER OR SUPPLIER DE REHAB & NURSIN	G CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186	
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F 684	Continued From pa	ge 110	F 68	4	
		failed to follow physician a laboratory tests for Resident			
	4/26/18 with diagnor limited to Schizoph disorders character reality, withdrawal operception and ementia, high blood Disorder [a mental	admitted to the facility on oses that included but were not renia [Any of a group of mental rized by gross distortions of of thought, language, otional response. (1)], od pressure, and Bipolar disorder characterized by and depression. (2)].			
	The most recent M assessment, a qua assessment referer resident as scoring interview for menta was moderately im decisions. The resi periods of inattentic verbal behavior directored every one was coded as requione or more staff in daily living except e	DS (minimum data set) rterly assessment, with an once date of 7/30/18, coded the a "9" on the BIMS (brief of the paired to make cognitive daily dent was coded as having on and having episodes of ected toward others that the to three days. Resident #60 iring extensive assistance of the paired to			
	"CBC [A complete following: The num count) the number count) (3)] + (plus) week d/t (due to) D	or dated, 6/1/18, documented, blood count test measures the ber of red blood cells (RBC of white blood cells (WBC VPA (valproic acid) level in 1 depakote (valproic acid) [used ipolar Disorder and prevent es (4)].			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '			COMP	LETED
		495267	B. WING _				3
	ROVIDER OR SUPPLIER DE REHAB & NURSING		B. WING	STI	REET ADDRESS, CITY, STATE, ZIP CODE 4 HASTINGS LANE ARRENTON, VA 20186	09/	13/2018
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	•	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From pag	ge 111	F	684			
	part, "1. Two view C (altered mental state ASAP (as soon as pretabolic panel). [T (BMP) is a group of information about your Review of the clinical documentation of the laboratory tests orded laboratory report with CBC and VPA level the order was written."	ered on 6/1/18. There was a th the above ordered tests, dated, 6/22/18, 21 days after n. 5 a.m., LPN (licensed					
	a "Laboratory Service documented the rest A "Missed Draw She for Missed Draw," rechecked." The form re-draw: 6/11/18." N	the unit manager, presented ces Log" dated 6/8/18 that ident refused the blood draw. eet" documented the "Reason efused and combative were documented "Will Return for lo further documentation was es of 6/11/18 until the results		and the second s			
	test results dated, 8 ordered by the phys note dated, 8/3/18 a part, "CBC, BMP ex draw blood resched no other notes docuphysician ordered is order of 8/1/18 and An interview was co	al record revealed a laboratory 1/6/18 with the test results sician on 8/1/18. A nurse's at 3:55 p.m. documented in very shift for 1 day unable to luled on Monday." There were amented related to the aboratory tests between the the results of 8/6/18.		1. I CONTRACTOR OF THE PERSON			

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED C			
		495267	B. WING				13/2018
	ROVIDER OR SUPPLIER DE REHAB & NURSING	CENTER		614 H	EET ADDRESS, CITY, STATE, ZIP CODE Hastings Lane Rrenton, va 20186		
(X4) ID PREFIX TAG			ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 684	laboratory tests are of are drawn on a Mone Fridays." When asked tests were drawn accorder, LPN #2 stated can't find anything the When asked what it orders labs ASAP, Lochecked with the host drawn there but I haprovide to you." The facility policy, "Lochecked with the host drawn there but I haprovide to you." The facility policy, "Lochecked with the host drawn there but I haprovide to you." The facility policy, "Lochecked with the host drawn there but I haprovide to you." The facility policy, "Lochecked with the host drawn there but I haprovide to you." The facility policy, "Lochecked with the facility policy, "Lochecked with the host drawn there but I haprovide to you." The facility policy, "Lochecked with the facility policy," Lochecked with the host drawn there but I haprovide to you." The facility policy, "Lochecked with the host drawn there but I haprovide to you." The facility policy, "Lochecked with the host drawn there but I happrovide to you." The facility policy, "Lochecked with the host drawn there but I happrovide to you." The facility policy, "Lochecked with the host drawn there but I happrovide to you." The facility policy, "Lochecked with the host drawn there but I happrovide to you." The facility policy, "Lochecked with the host drawn there but I happrovide to you."	drawn, LPN #2 stated they day, Wednesday and dif the above laboratory cording to the physician l, "No, they weren't and l at states why they were late." meant when the physician PN #2 stated, "Right away. I spital to see if they were we no further information to ab and Diagnostic Test otocol" documented in part, cess test requisitions and director of nursing were above concern on 9/13/18 at an was provided prior to exit. In yof Medical Terms for the r, 5th edition, Rothenberg and control of the dition, Rothenberg and control of the many of Medical Terms for the r, 5th edition, Rothenberg and control of the dition, Rothenberg and control of the dition, Rothenberg and control of the many of Medical Terms for the r, 5th edition, Rothenberg and control of the dition, Rothenberg and control of the many of Medical Terms for the r, 5th edition, Rothenberg and control of the dition, Rothenberg and control of the many of Medical Terms for the r, 5th edition, Rothenberg and control of the dition, Rothenberg and control of the dition of the many of the dition of the many of the dition of the many of the dition of the many of the dition of the many of the dition of the many of the dition of the many of the dition of the many of the dition of the many of the dition of the many of t	F	584			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION IG	(X3) DATE (
		495267	B. WING_		09/1	; 3/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1	
BBOOKEI	BROOKSIDE REHAB & NURSING CENTER			614 HASTINGS LANE		
BROOKSI	BROOKSIDE REHAB & NURSING CENTER			WARRENTON, VA 20186		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC ((EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	(X5) COMPLETION DATE
F 697 F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Man The facility must ensi- provided to residents consistent with profet the comprehensive p and the residents' go This REQUIREMENT by: Based on staff interv review, it was determ ensure a comprehen program for two of 3's sample, Resident #1 1. The facility staff fa non-pharmacologica administration of pain #117. 2. The facility staff fa non-pharmacologica administration of as Resident # 77. The findings include: 1. The facility staff fa non-pharmacologica administration of pain #117. Resident #117 was a 12/6/17 with a readn diagnoses that included	agement. ure that pain management is who require such services, ssional standards of practice, person-centered care plan, hals and preferences. If is not met as evidenced view, and clinical record nined the facility staff failed to sive pain management resident in the survey 17 and Resident # 77. alled to attempt I interventions prior to the nomedication for Resident for the needed pain medication for the needed pain medication for the nomedication for Resident in the survey 18 interventions prior to the needed pain medication for the needed pain medication for the nomedication for Resident in the survey 19 interventions prior to the nomedication for Resident interventions prior to the nomedication for Reside	1	F 697 Pain Management 1. Resident #117- The facility failed to attempt non-pharmacological intervent to the administration of particular failed to attempt non-pharmacological intervent to the administration of as pain medication 2. Review of 100% of the Edetermine the % of resident have pain medications or who will be potentially after the same deficient practice will be developed for audication by the Assistance Director of Nursing on who constitutes a non-pharmacon intervention and the document of these interventions and prior to the administration medications.	ions prior in staff ions prior needed Mars to nts who hered and feeted by e. A list ting. Int nat cological nentation outcomes	
	pain in right shoulde pressure, atrial fibrill	r, depression, high blood ation [a condition		State States to the States of	77 100000	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495267	B. WING			09/) 13/2018
NAME OF P	ROVIDER OR SUPPLIER			8	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00,	10,2010
				6	14 HASTINGS LANE		
BROOKSI	DE REHAB & NURSING	CENTER		٧	VARRENTON, VA 20186		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E	(X5) COMPLETION DATE
E 007		- 444			F 697 Pain Management continued	rom	
F 697			F	697	page 119		
	characterized by rapi the atria of the heart the ventricles and res output and frequently (1)], and malnutrition The most recent MDS assessment, a quarte assessment reference resident as scoring a interview for mental s was moderately impa decisions. The reside periods of inattention Resident #117 was of supervision of one st activities of daily livin The physician orders	d and random contraction of causing irregular beats of sulting in decreased heart of clot formation in the atria. S (minimum data set) erly assessment, with an erly assessment, and erly assessment,			4. Audits of the e-mar on the pidentified as routinely receive pain medications will be comby the Unit Managers or destruction of the in-service education by the ADON will presented at the October QAMeeting and at monthly QAMeetings x 3 months November, December and J 2018 Facility-wide audit of e-marked to ensure that are documenting non-pharmacological intervention to the administration of pair To be Completed by October	ving inducted signee. the libe anuary swill nurses ons prior n meds.	
	minor aches and pair Give 3 tablets by more for pain." This order of physician orders doc (Used to relieve mod pain. (3) 50 MG; Give hours as needed for was dated 6/11/18. The August 2018 MA record) documented Tylenol was docume 8/13/18 for a pain lev documented as having following dates: 8/3/18 at 9:51 a.m. fc 8/9/18 at 9:28 p.m. fc 8/18/18 at 7:59 p.m.	or a pain level of "9."			2018. 5. The facility dutifully allege compliance with these tasks before 10/28/18	S	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION UMBER:		1''	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495267	B. WING	B. WING		C /13/2018
NAME OF P	ROVIDER OR SUPPLIER	789201		STREET ADDRESS, CITY, STATE, 2		113/2016
				614 HASTINGS LANE		
BROOKSIDE REHAB & NURSING CENTER			WARRENTON, VA 20186			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN ((EACH CORRECTIVE CROSS-REFERENCED DEFICII	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 697	Continued From page	a 115	F	697		
	8/27/18 at 4:15 p.m.	for a pain level of "7."				
		MAR documented the ve any Tylenol or Tramadol .	A TO THE REAL PROPERTY OF THE PARTY OF THE P			
	on 9/11/18, documen #117) is at risk for pa documented in part, need for pain relief at any complaint of pair previous pain history pain and impact on for esponse to analgesi effect and impact on for probable cause of Remove/limit causes. The nurse's notes we September 2018 and documentation of the	and management of that unction. Identify previous a including pain relief, side function. Monitor/document f each pain episode. where possible."				
	administration of the An interview was cor 9/12/18 at 5:20 p.m. process staff follows of pain, LPN #6 state pain, do a touch asse what medications the have anything ordere an order. I'd call the order." LPN #6 state would try to redirect see if that helps." Wh attempted before add are documented, LPI	pain medications. Iducted with LPN #6 on LPN #6 was about the when a resident complains id, "I first would assess the essment, then check to see by have ordered. If they don't id I'd call the doctor and get family if there was a new id, "If they can't tell me I ithem or reposition them to nen asked where the things ministering the medication N #6 stated, "In the nurse's notes for Resident # 117				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	co	X3) DATE SURVEY COMPLETED C		
		495267	B. WING		0	9/13/2018		
NAME OF PROVIDER OR SUPPLIER BROOKSIDE REHAB & NURSING CENTER			ا	STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186				
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doce interest adm An imai proof of proof	nterview was conager, on 9/12/18 cess staff follows ain. LPN #2 state at tion, intensity aringe in their face it signs. If there are tries anything was attempted pridication are documented, it's not administrator and aware of the action of as sident #77.	attempted prior to the in medication. Inducted with LPN #2, the unit 8 at 5:27 p.m., regarding the s when a resident complains red, "I assess the pain, and look for verbalizations or grimacing, and take their are no orders for pain to the standing orders, then cotor if I feel it is more severe on could handle." When asked prior to giving a medication, ries relaxation, repositioning them. When asked where the for to administering the armented, LPN #2 stated, "In reat's nursing 101. If it's not to done." Indicator of nursing were above concern on 9/13/18 at	F 697					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l · ·	IPLE CONSTRUCTION IG		C				
		495267	B. WING _			09/13/2018			
	NAME OF PROVIDER OR SUPPLIER BROOKSIDE REHAB & NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186	S LANE				
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION: CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE			
F 697	(assessment references Resident # 77 as sinterview for mentall - 15, 14 - being condecisions. Resident independent and mone staff member of Section J0400 "Pall # 77 as "Almost condecisions. The POS (physicial 07/01/2018 - 09/30 documented, "Hydro/Apap (Hydro/Apap (Hydro/Apap (Hydro/Apap (Hydro/Apap (Hydro/Apap (Four) hour Status: Active. Ord "Ibuprofen (6) TAB tablet orally every pain. Order Status 11/16/2017." The eMAR (electro record) dated July The above physicial the July eMAR revent administered for the single pain.	ence date) of 08/04/18, coded coring a 14 on the brief all status (BIMS) of a score of 0 gnitively intact for making daily at # 77 was coded as being equiring limited assistance of for activities of daily living .	F	697					
	the following dates "07/04/18 at 9:49 p 07/05/18 at 6:50 p 07/06/18 at 1:36 p 07/08/18 at 8:31 p 07/09/18 at 1:22 p 07/11/18 at 7:00 p 07/14/18 at 2:00 p 07/15/18 at 6:34 p	s: c.m. with a pain level of 3. c.m. with a pain level of 5. c.m. with a pain level of 7. c.m. with a pain level of 7. c.m. with a pain level of 5. c.m. with a pain level of 3. c.m. with a pain level of 5. c.m. with a pain level of 8 and							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''		E CONSTRUCTION	(X3) DATE COMPI	SURVEY LETED
		495267	B. WING	B. WING		C 09/13/2018	
	ROVIDER OR SUPPLIER DE REHAB & NURSING	CENTER		6	STREET ADDRESS, CITY, STATE, ZIP CODE 514 HASTINGS LANE WARRENTON, VA 20186		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E	(XS) COMPLETION DATE
F 697	07/19/18 at 11:53 p.m 07/20/18 at 1:15 p.m 8:22 p.m. with a pain 07/21/18 at 9:22 a.m 6:56 p.m. with a pain 07/22/18 at 4:10 p.m 07/23/18 at 10:19 a.m 07/24/18 at 10:33 a.m at 4:24 p.m. with a pain 07/25/18 at 3:45 p.m 07/26/18 at 10:25 a.m 07/29/18 at 12:09 a.m at 1:30 p.m. with a pain 07/30/18 at 11:53 a.m at 5:12 p.m. with a pain 07/31/18 at 11:55 p.m. The eMAR (electroni record) dated August above physician's on August eMAR reveal administered on 08/3 Hydro/Apap 5-325MG following dates: "08/01/18 at 1:14 p.m 08/02/18 at 2:38 p.m. 8:38 p.m. with a pain 08/03/18 at 1:25 p.m 08/05/18 at 1:53 a.m at 4:08 p.m. with a pain 08/03/18 at 1:53 a.m at 4:08 p.m. with a pain 08/07/18 at 1:53 a.m at 4:08 p.m. with a pain 08/07/18 at 1:53 a.m at 4:08 p.m. with a pain 08/07/18 at 1:55 p.m 08/07/18 at 10:17 a.m 08/21/18 at 7:59 p.m 08/24/18 at 7:59 p.m 08/24/18 at 8:43 p.m	with a pain level of 2. n. with a pain level of 8. with a pain level of 7 and at level of 5. with a pain level of 4 and at level of 2. with a pain level of 5. n. with a pain level of 6. n. with a pain level of 6 and ain level of 3. with a pain level of 6. n. with a pain level of 6. n. with a pain level of 5 and ain level of 5. n. with a pain level of 5 and ain level of 5. n. with a pain level of 5 and ain level of 5. n. with a pain level of 5. n. with a pain level of 5. c medication administration at 2018 documented, the ders. Further review of the level of 5. c medication administration at 2018 at 5:20 p.m. and 3 was administered on the 1. n. with a pain level of 5. with a pain level of 5. with a pain level of 5. with a pain level of 5. with a pain level of 6. with a pain level of 5. m. with a pain level of 8.	F	697			

NAME OF PROVIDER OR SUPPLIER BROOKSIDE REHAB & NURSING CENTER COMPLETE STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE CANCELLONGE CONTROL CANCELLONGE CONTR	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	G	COMPLETED		
MAKE OF PROVIDER OR SUPPLIER BROOKSIDE REHAB & NURSING CENTER WARRENTON, V.A 20166 PRISTON REGULATORY OR LSC IDENTIFYING INFORMATION) 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: 10/10/2018: "Ibuprofen (6) TAB (tablet) 400MG. Give 1 tablet orally every 6 hours as needed for pain. Order Status. Active. Order Date: 11/10/2017: "Further review of the August eMAR revealed louprofen 400MG was not administred from 09/01/18 through 09/12/18 and Hydro/Apap 5-325MG was administered from 09/01/18 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. 09/11/18 at 3:24 p.m. with a pain level of 5. 09/11/18 at 3:20 p.m., reparding the process the staff follows when a resident complains of pain. LP N/6 stated, "If its 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 doctor and get an order. I'd call the doctor and get an order. I'd call the doctor and get an order. I'd call the doctor and get an elected period and an elected period and an order. I'd call the doctor and get an order. I'd call the doctor and get an order. I'd call the doctor and get an order. I'd call the doctor and get an order." I'd call the doctor and get an order. I'd call the doctor and get an order. I'd call the doctor and get an order. I'd call the doctor and get an order. I'd call the doctor and get an order." I'd was a definition of an needed pain medication are documented, I PM Se stated, "If they can't tell medication are documented, I PM Se stated, "If they can't tell medication are documented, I PM Se stated, "If they can't tell medication are documented, I PM Se stated, "If they can't tell medication are documented, I PM Se stated, "If I PM Se stated, "If I PM Se stated, "If I PM Se st				1		c		
BROOKSIDE REHAB & NURSING CENTER D(A)) ID SUMMARY STATEMENT OF DEFICIENCIES CACH CORRECTIVA A 20156			495267	B. WING		09/13/2018		
F 697 F 697 Continued From page 119 The eMAR (electronic medication administration record) dated September 2018 documented, "Hydro/Apap 5-325MC. Give one tablet orally every 4 (four) hours as needed for pain. Order Status: Active. Order Date: 11/16/2017." Further review of the August eMAR revealed lbuprofen (9) TAB (tablet) 400MC. Give 1 tablet orally every 4 (four) hours as needed for pain. Order Status: Active. Order Date: 21/16/2017." Further review of the August eMAR revealed lbuprofen 400MC was not administered from 09/10/18 at 5:27 a.m. with a pain level of 8. 09/10/18 at 5:27 a.m. with a pain level of 5. 09/11/18 at 3:24 p.m. with a pain level of 5. 09/11/18 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 heips." When asked where the things attempted, before the administration of as needed pain medication of or sended pain medication of or sended pain medication of or sended pain medication of as forced pain.					614 HASTINGS LANE			
The eMAR (electronic medication administration record) dated September 2018 documented, "Hydro(Apap 5-255MG. 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 lbuprofen 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 5:27 a.m. with a pain level of 5. 09/11/18 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. Neview 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 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." LPN #6 stated, "If first would assess a new order." LPN #8 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 a needed pain medication or are documented, LPN #8 stated, "In medication are documented, LPN #8 stated, "In medication are documented, LPN #8 stated, "In medication are documented, LPN #8 stated, "In medication are documented, LPN #8 stated, "In medication are documented, LPN #8 stated, "In medication are documented, LPN #8 stated, "In medication are documented, LPN #8 stated, "In	PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP	OULD BE COMPLÉTION		
An interview was conducted with LPN #2, the unit	F 697	The eMAR (electrorecord) dated Sept record) dated Sept "Hydro/Apap 5-325 every 4 (four) hour Status: Active. Ord "Ibuprofen (6) TAB orally every 6 hour Status: Active. Ord Further review of tilbuprofen 400MG 09/01/18 through 05-325MG was adm "09/02/18 at 5:27 a 09/03/18 at 9:59 p 09/10/18 at 5:20 a 09/11/18 at 3:24 p Review of the nurs through 09/12/18 f documentation not were attempted princeded pain medications they is anything ordered I order. I'd call the file. LPN #6 stated, "If redirect them or rehelps." When asked before the administ medication are do the nurse's notes."	principle of the process the aresident complains the process the administration of the process the aresident complains of pain. Order left Date: 02/01/2018." If (tablet) 400MG, Give 1 tablet is as needed for pain. Order left Date: 11/16/2017." If he August eMAR revealed was not administered from 109/12/18 and Hydro/Apaphinistered on: a.m. with a pain level of 3. a.m. with a pain level of 5. are some dated 07/10/18 is alled to evidence any in-pharmacological interventions in to the administration of as cation for Resident # 77. Conducted with LPN #6 on in., regarding the process the aresident complains of pain. First would assess the pain, do a in, then check to see if what in ave ordered. If they don't have it'd call the doctor and get an in amily if there was a new order." If they can't tell me I would try to be position them to see if that end where the things attempted, stration of as needed pain cumented, LPN #6 stated, "In in the content of the pain cumented, LPN #6 stated, "In in the content in the pain cumented, LPN #6 stated, "In in the content in the pain cumented, LPN #6 stated, "In in the content in the pain cumented, LPN #6 stated, "In in the pain cumented, LPN #6 stated, "In in the pain cumented, LPN #6 stated, "In in the pain cumented, LPN #6 stated, "In in the pain cumented in the pain	F 69	97			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	G	COMPLETED				
		495267	B. WING _		C 09/13/2018			
	NAME OF PROVIDER OR SUPPLIER BROOKSIDE REHAB & NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETION			
F 773 SS=D S(C)	process the staff for complains of pain. I wain, location, interfer change in their fitted signs. If there management, I go give it or call the donar what medication is she tries anything. PN #2 stated she made even reads to chings attempted priceded pain medicated, "In the nurse is not documented by a physician assistant or call the correction of the provide or obtain or call the correction of the physician assistant of provide or clinical rewith facility policies with facility policies with facility policies accordance with so practice laws.	Illows when a resident LPN #2 stated, "I assess the sity and look for verbalization ace, grimacing, and take their are no orders for pain to the standing orders, then octor if I feel it is more severe on could handle." When asked g prior to giving a medication, tries relaxation, repositioning them. When asked where the rior to the administration of as action are documented, LPN #2 e's note. That's nursing 101. If d, it's not done." proximately 5:55 p.m., ASM if member) # 1, the ASM # 2, director of nursing of the findings. ion was provided prior to exit. In Order/Notify of Results (2)(i)(ii)	F 6					

Event ID: OTHR11

practitioner.

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '	LE CONSTRUCTION	COMPLETED			
		495267	B. WING		1	, 13/2018		
	NAME OF PROVIDER OR SUPPLIER BROOKSIDE REHAB & NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_DBE	(X5) COMPLETION DATE		
F 773	physician's orders. This REQUIREMEN by: Based on staff inter and clinical record of facility staff failed to laboratory tests were two of 37 residents Resident #39 and # 1. The facility staff failed to laboratory tests were two of 37 residents Resident #39 and # 1. The facility staff failed to laboratory tests as ordered by #39. 2. The facility staff failed to laborate labora	IT is not met as evidenced rview, facility document review eview, it was determined the ensure physician ordered e obtained as ordered for of in the survey sample, 60. alled to obtain the laboratory the physician for Resident alled to obtain the laboratory the physician for Resident alled to obtain the laboratory the physician for Resident alled to obtain the laboratory the physician for Resident admitted to the facility on ses that included but were not	F 77	F 773 Lab Services Physician Orc Results continued from page 127 3. The entire administration of services will be reviewed by It Administration by October 28 Deficient practices will be considered on diagnostics tests laboratory services. Lab proceed documentation will be audited accuracy by ADON /nursing and compliance and analysis reported to the QA committed x 6months October, November 2018 January, Februarch 2019. 5. The facility alleges compathese tasks on or before 1	f lab Nurse Sth, 2018. rrected. Dee and dess and d daily for supervisor of the data e monthly er, ruary and			
	assessment, a qual assessment referer resident as having I memory difficulties. requiring extensive	rterly assessment, with an nce date of 7/14/18, coded the						

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES	F	ORM APPROVED NO. 0938-0391
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	AN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING				LETED		
		495267	B. WING			1	C 13/2018
NAME OF PROVIDER OR SUPPLIER BROOKSIDE REHAB & NURSING CENTER			1	6	TREET ADDRESS, CITY, STATE, ZIP CODE 14 HASTINGS LANE VARRENTON, VA 20186		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 773	except eating in whice after set up help was A telephone physicial documented, "Na+ (BID (twice a day) dx (lower than normal or blood) (2). BMP [bas week." There was not line, "Signature of Ni Review of the clinical the laboratory test reby the physician. Review of the compression of the compression of the compression of the compression of the computer. She proceed to the physician of the computer. She proceed to the physician of the computer. She proceed to the physician of the computer of the computer of the physician of the computer of the physician of the computer of the physician of the p	ch he required supervision is provided. an order dated, 7/9/18, sodium) tabs (tablets) 1 gram [diagnosis] - hyponatremia concentration of sodium in the sic metabolic panel (2)] in 1 othing documented on the tursing Receiving Order." all record failed to evidence esults for the BMP as ordered rehensive care plan, dated 7/20/18, failed to evidence e hyponatremia. eximately 9:45 a.m., OSM of #5, the ward clerk stated he laboratory results on the eeded to access the and could only locate the refronce week after 7/9/18, which	F.	773			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION 3	COMPLETED				
		495267	B. WING		09/13/2018			
	NAME OF PROVIDER OR SUPPLIER BROOKSIDE REHAB & NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION			
F 773	order. The facility policy, "I Orders" failed to evitranscribe a physicis "Lab and Diagnostic Protocol" document process test requisi The ASM (administrator and A were made aware of 9/13/18 at 4:56 p.m. The facility policy, "I Orders" failed to evitranscribe a physici "Lab and Diagnostic Protocol" document process test requisi The administrator a made aware of the 4:56 p.m. On 9/13/18 at 6:21 stated the facility fo procedures as their According to "Fund Lippincott, Williams" After you receive a transcribe it onto a by your health care carefully, concentra check it when you'r	Medication and Treatment idence the steps to take to an order. The facility policy, corest Results - Clinical ted in part, "2. The staff will itions and arrange for tests. Trative staff member) #1, the LSM #2, the director of nursing of the above concern on the F 77	73					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
					С			
		495267	B. WING			0	9/13/2018	
	ROVIDER OR SUPPLIER DE REHAB & NURSIN	G CENTER		614 H	ET ADDRESS, CITY, STATE, ZIP CODE ASTINGS LANE RENTON, VA 20186			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
F 773	Continued From pa	ge 124	F	773				
	following website: https://www.ncbi.nir m=Subarachnoid+h (2) Barron's Diction Non-Medical Reade Chapman, page 28 (3) This information following website: http://www.nlm.nih.s 03462.htm 2. The facility staff of tests as ordered by #60. Resident #60 was a 4/26/18 with diagnoral limited to Schizoph disorders character reality, withdrawal of perception and emodementia, high blood Disorder [a mental episodes of mania The most recent M assessment, a qua assessment referencesident as scoring interview for mental was moderately im decisions. The resi periods of inattentic verbal behavior dire occurred every one was coded as requi	ary of Medical Terms for the er, 5th edition, Rothenberg and						

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1, ,	NG		COMPLETED		
			1,30,100		c	;	
		495267	B. WING_		09/1	3/2018	
NAME OF PROVIDER OR SUPPLIER BROOKSIDE REHAB & NURSING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186			
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG		SHOULD BE	(X5) COMPLETION DATE	
F 773	daily living except of supervision after supervision after sures. The physician order "CBC [A complete following: The number count) (3)] + (plus) week d/t (due to) Down to treat seizures, Be migraine headached. The physician order part, "1. Two view (altered mental states ASAP (as soon as metabolic panel). [(BMP) is a group of information about to the complete order was writted to the order was writted order was writted order was writted order was writted order was writted order was sured ocumented the read "Missed Draw," checked." The form re-draw: 6/11/18." provided for the day of 6/22/18.	eating in which he only required et up assistance was provided. er dated, 6/1/18, documented, blood count test measures the aber of red blood cells (RBC of white blood cells (WBC VPA (valproic acid) level in 1 depakote (valproic acid) [used dipolar Disorder and prevent es (4)]. er dated, 8/1/18, documented in CXR (chest x-ray) - fever/AMS (tus). 3. Labs (laboratory tests) possible): CBC, BMP (basic The basic metabolic panel of blood tests that provides your body's metabolism (5)]. cal record failed to evidence the physician ordered dered on 6/1/18. There was a with the above ordered tests, el dated, 6/22/18, 21 days after	F	773			

		IDENTIFICATION NUMBER:				COMPLETED		
		495267	B. WING _			1	C /13/2018	
	ROVIDER OR SUPPLIER	G CENTER		614	EET ADDRESS, CITY, STATE, ZIP CODE HASTINGS LANE RRENTON, VA 20186	·		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	,	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 773	test results dated, ordered by the phynote dated, 8/3/18 part, "CBC, BMP edraw blood resched no other notes door physician ordered lorder of 8/1/18 and An interview was confered laboratory tests are drawn on a Mo Fridays." When ask drawn a order, LPN #2 state can't find anything to When asked what in orders labs ASAP, checked with the hidrawn there but I hiprovide to you." The facility policy, "Results - Clinical Piez. The staff will provide to you." The administrator a made aware of the 4:56 p.m. No further informat (1) Barron's Diction Non-Medical Read Chapman, page 52 (2) Barron's Diction	3/6/18 with the test results sician on 8/1/18. A nurse's at 3:55 p.m. documented in very shift for 1 day unable to duled on Monday." There were umented related to the aboratory tests between the the results of 8/6/18. Inducted with LPN #2 on m. When asked how often or drawn, LPN #2 stated they anday, Wednesday and sed if the above laboratory ecording to the physician and, "No, they weren't and I shat states why they were late." It meant when the physician LPN #2 stated, "Right away. I pospital to see if they were ave no further information to "Lab and Diagnostic Test rotocol" documented in part, pocess test requisitions and and director of nursing were above concern on 9/13/18 at the ser, 5th edition, Rothenberg and	F7	773				

PRINTED: 09/25/2018 FORM APPROVED OMB NO. 0938-0391

(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		(X3) DATE SURVEY COMPLETED	
495267	B. WING			C 13/2018
ENTER		614 HASTINGS LANE		
MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU	LD BE	(X5) COMPLETION DATE
s obtained from the gov/vivisimo/cgi-bin/query- dlineplus&query=CBC&x= s obtained from the h.gov/pubmedhealth/PMH ails. , Palatable/Prefer Temp drink and the facility provides- epared by methods that e, flavor, and appearance; d drink that is palatable, e and appetizing s not met as evidenced , resident interview, staff ment review, and in the nvestigation, it was staff failed to ensure food to serve food at a palatable a., a group interview was idents. A resident voiced		F 804 Nutritive Value/Appear Palatable/Prefer Temp 1. On 9/14/18, Administrat a test tray for each mealt hours for palatability. Of documentation and acknowledgement of documentation from OS the standard guidance fo liquid textures based on American Dietetic Asso posted guidance in the k CHHCM guide/reference and Pureed Tip" posted i as well as reference. Residents will receive fo appropriate temperatures OSM #9 educated on fo- temperature policy inclu food temperatures, servi and taking food Temperatures. 2. All residents dining in the	ime x 24 tained M #4 on food and he iation and tchen and fround n kitchen od at ding proper ng meals	
		### A. BUILDING ### A. BUILDING ### A. BUILDING ### B. WING ### ENTER ### FEMENT OF DEFICIENCIES ### MUST BE PRECEDED BY FULL BE IDENTIFYING INFORMATION) ### FEMENT OF DEFICIENCIES ### MUST BE PRECEDED BY FULL BE IDENTIFYING INFORMATION) ### FEMENT OF DEFICIENCIES ### MUST BE PRECEDED BY FULL BE IDENTIFYING INFORMATION) ### FEMENT OF DEFICIENCIES ### PREFIX TAG ### TAG ### FEMENT OF DEFICIENCIES ### PREFIX TAG ### FEMENT OF DEFICIENCIES ### IDENTIFY IN TAG ### PREFIX TAG ### FEMENT OF DEFICIENCIES ### IDENTIFY IN TAG ### PREFIX TAG ### FEMENT OF DEFICIENCIES ### PREFIX TAG ### PREFIX TAG ### FEMENT OF DEFICIENCIES ### PREFIX TAG ### PR	STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186 EMEMENT OF DEFICIENCIES MINST BE PRECEDED BY FULL IC IDENTIFYING INFORMATION) 127 F 773 F 773 F 804 Nutritive Value/Appear Palatable/Prefer Temp 1. On 9/14/18, Administrate a test tray for each mealti hours for palatability. Ob documentation and acknowledgement of documentation from OSI the standard guidance for liquid textures based on if American Dietetic Assoc posted guidance in the ki CHHCM guide/reference and Pureed Tip" posted in as well as reference. Residents will receive fo appropriate temperatures OSM #9 educated on foo temperature, servir and taking food Temperatures. 2. All residents dining in th have the potential to be a this practice.	STREET ADDRESS, CITY, STATE, ZIP CODE ### HASTINGS LANE WARRENTON, VA 20185 PROWIDERS PRACEDED BY PULL PREPRY TAG PROPORTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: OTHR11

Facility ID: VA0178

If continuation sheet Page 137 of 146

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		495267	B, WING _	NING		C 13/2018	
NAME OF B	DOVERDO OD SLEDDIJED	730201	T	STREET ADDRESS, CITY, STATE, ZIP CO		13/2016	
NAME OF P	ROVIDER OR SUPPLIER			614 HASTINGS LANE	NC.		
BROOKS	IDE REHAB & NURSIN	IG CENTER					
				WARRENTON, VA 20186			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C ((EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
				F 804 Nutritive Value/App	ear		
F 804	Continued From pa	ige 128	F 8	Palatable/Prefer Temp cont 133			
	of the tray line in the complaint investigate. The test tray was a surveyor and OSM cook. The test tray mashed potatoes, I pureed turkey, pure two surveyors tast that the pureed turk broccoli-cauliflower of the "instant food discernable taste of the consistency of gelatinous. On 9/13/18 at 8:25 breakfast foods was following foods and plating are as follow pureed eggs 110 d degrees; sausage to ast 110 degrees degrees. The test the served which was a surveyor was accountary was served in approximately 8:55 temperature of the to OSM #9. The termosmately 8:55 temperature of the to OSM #9. The termosmately 8:55 temperature of the to OSM #9. The termosmately 8:55 temperature of the to OSM #9. The termosmately 8:55 temperature of the to OSM #9. The termosmately 8:55 temperature of the to OSM #9. The termosmately 8:55 temperature of the to OSM #9. The termosmately 8:55 temperature of the to OSM #9. The termosmately 8:55 temperature of the to OSM #9. The termosmately 8:55 temperature of the to OSM #9. The termosmately 8:55 temperature of the to OSM #9. The termosmately 8:55 temperature of the to OSM #9. The termosmately 8:55 temperature of the to OSM #9. The termosmately 8:55 temperature of the to OSM #9. The termosmately 8:55 temperature of the to OSM #9. The termosmately 8:55 temperature of the to OSM #9. The termosmately 8:55 temperature of the to OSM #9. The termosmately 8:55 temperature of the to OSM #9. The termosmately 8:55 temperature of the to OSM #9. The termosmately 8:55 temperature of the to OSM #9. The temperature of the to OSM #9. The temperature of the to OSM #9. The temperature of the to OSM #9. The temperature of the to OSM #9.	a.m., a second test tray of the s requested and started. The their temperature upon ws: pureed ham 120 degrees, egrees, fortified oatmeal 146 patty 121 degrees, French and scrambled eggs 141 ray was taken to the last area the south dining room. The mpanied by OSM #9. The last the south dining room at		3. Dietary staff were before 10/28/18 requality, preparation enhancing enjoyme texture foods. Maintenance Direct Administrator to as following: Steam of warmers assessed a working order. Die in-serviced by Reg Food Service Mana on the food temper including proper for serving meals and temperatures on or 4. Administrator or deaudit test trays of deconsistencies for postal months. The reviewed monthly committee until it determined that the effective. Addition Assurance Committee tools at the schwith recommendat for additional internecessary Addition be provided as inditional properties.	garding food a techniques and ent of modified stor asked by ssess the tables and plate and are in etary staff will be istered Dietician, ager or designee rature policy ood temperatures, taking food before 10/28/18 esignee will different alatability ks, then weekly audits will be by the QA has been e systems are hally, The Quality ttee will review eduled meetings ions as needed ventions as hal education will		

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OLIVILIV	O I OI VIVIL DIONICE OI	ALDIONID OLIVIOLO						
STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
						C		
		495267	B. WING			09/	13/2018	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
		OFNITES		6	14 HASTINGS LANE			
BROOKSI	DE REHAB & NURSING	GENIER		٧	VARRENTON, VA 20186			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	•	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD B		COMPLETION DATE	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	1	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	``F		
					F 804 Nutritive Value/Appear			
F 804	Continued From page	a 129	F		Palatable/Prefer Temp continued fro	m page		
			'		134	P84		
		taste of egg and ham;			137			
ļ		yly tasted of food thickener. o be barely warm. When			The Fred Comice Management	:11		
		o taste the food, he declined.			The Food Service Manager			
	CON TO WAS ASKEU !	o teste trie 1004, lie decilied.			hold Resident Food Council			
	OSM #9 was asked to	o describe the process of			meetings weekly x 4 weeks,	D1-		
		I foods. OSM #9 stated that			weekly x 4 weeks, then			
		that the pureed foods should			monthly thereafter. Addition			
		stency as the mashed			the Food Service Manager/d	esignee		
	potatoes. When aske	•			will audit test tray 5 times a	week		
	•	tio of food to thickener to			in alternating areas x 30 day	s, 3		
	use. OSM #9 stated.	"No, I look at it and compare			times a week x 30 days, 2 times			
		toes". When asked if he	į		week x 30 days, then weekly			
	-	d foods before, he stated			days.			
	"Yes."				The audits will be reviewed			
					monthly by the QA committ	ee until		
	An interview was con	ducted on 9/13/18 at			it has been determined that t			
		.m. with OSM #3, the dietary			systems are effective. Addit			
	<u> </u>	ed to describe the process			1	1		
		food, OSM #3 stated, "You			The Quality Assurance Com	mmuce		
		ureed food if it needs it."			will review the tools at the			
		results of the pureed foods	***		scheduled meetings with			
		vell, as how OSM #9 stated			recommendations as needed	ior		
	l .	thicken the pureed food,			additional interventions as			
		ve only been here three the staff need training on			necessary Further or additio			
	how to thicken food."	rie stali need training on			education will be provided a	IS		
	HOW to tricken lood.				indicated. Auditing for com	pliance		
	An interview was con	ducted on 9/13/18 at 1:15			will occur daily x 3 months,			
		e assistant dietary manager.			October, November and De	cember;		
		ribe how he determines the			and compliance reported mo			
		to add to the pureed food,			the QA committee meetings	-		
	‡	is never instructed on how to			Random audits will be cond			
	•	, but I generally add only			for 3 additional months to M			
	•	r so." OSM #4 further stated			2019.	141Vii		
		he facility for about nine			2019.			
		n he started the facility had a						
		anager running the kitchen.						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: OTHR11

Facility ID: VA0178

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OCT 1 1 2018 VDH/OLC

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER	S FUR WEDICARE & I	MEDICAID SERVICES				<u> </u>	. 0000-0001
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
						(3
		495267	B. WING			09/	13/2018
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
BROOKSI	DE REHAB & NURSING	CENTER			14 HASTINGS LANE		
				V	VARRENTON, VA 20186		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
					F 804 Nutritive Value/ Appear Palat	ì	
F 804	Continued From page	e 130	F	804	Prefer Temp continued from page 13	35	
	An interview was con	ducted on 9/13/18 at 3:15					
		he registered dietitian. OSM			A QA Tool based on CMS "	Kitchen	
		narily responsible for the			Observation" will be		
	•	e food service and that the imarily responsible for the			utilized weekly x 4 weeks in		
		ved. When asked about the			October, monthly x 6 month		
		g pureed food, OSM #13			(November, December 2018	-	
		by the speech therapist in			January, February, March, A		
		ident's individual needs.			2019), and quarterly thereaf		
		all of the pureed foods,			one year with results reporte		
		ent's specific needs, were			Quality Assurance Committ	ee.	
		M #13 stated that it is the sponsibility to train the staff			E The facility dutifully allogo		
		ickening of food. When			5. The facility dutifully alleges compliance of these tasks or		
		od needs to be thickened,			before 10/28/18	101	
	OSM #13 stated, "No	." When asked if pureed			DCIOIC 10/20/16		
	food should be palate	able, OSM #13 stated, "Yes."					
	The feelih maliny "D	internal decomposited in part			F 812 Food Procurement		
		ietary" documented in part, atable, attractive, and at the			Store/Prepare/Serve-Sanitary		
		s determined by the type of					
	food to ensure reside	• •			1. The following staff in-service	ed on	
			ļ		infection control practices w	hen	
	,	staff member) #1, the	-		handling food: CNA #1, CN	IA #4,	
	•	SM #2, the director of			OSM #18, OSM #16		
	nursing, were made a on 9/13/18 at 4:55 p.	aware of the above findings			No specific residents are ide	ntified.	
	Uli 9/13/10 at 4.30 p.	ш.			Bread is being handled		
	No further informatio	n was provided prior to exit.			appropriately and in accorda		
F 812		tore/Prepare/Serve-Sanitary	F	812	with sanitation guidelines. C		
SS=D	CFR(s): 483.60(i)(1)	(2)	L		straws in residents' drinks a	nd the	
					rims of cups being handled		
	§483.60(i) Food safe	ty requirements.			appropriately and in accorda		
	The facility must -				sanitation guidelines in the	-	
	8483 60/i\/1\ - Procu	re food from sources			areas. Policies and procedur		
		red satisfactory by federal,			based on food handling, ass	istance	
	state or local authori						

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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:	1 ' '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		N. DOLDING			C	
	495267	B. WING	<u> </u>	09/	13/2018	
NAME OF PROVIDER OR SUPPLIE	R		STREET ADDRESS, CITY, STATE, ZIP CODE			
BROOKSIDE REHAB & NUR	RING CENTED		614 HASTINGS LANE			
DROOKSIDE KENAD & NOK	SING CENTER		WARRENTON, VA 20186			
PREFIX (EACH DEFIC	RY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL CY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
from local product and local laws of the control of	ude food items obtained directly cers, subject to applicable State regulations. In does not prohibit or prevent ing produce grown in facility to compliance with applicable diffood-handling practices. In does not preclude residents foods not procured by thefacility. Itore, prepare, distribute and cordance with professional od service safety. MENT is not met as evidenced evation, staff interview, facility and clinical record review, it that the facility staff failed to sanitary manner in two of two esouth dining room and the north aff failed to serve bread without their bare hands in the north aff failed to wear gloves while of bread for two residents in the moduring lunch.	F 8	F 812 Food Procurement Store/Prepare/Serve-Sanitary confrom page 137 Auditing for compliance weekly x 3 months, Octo November and Decembe quarterly x 4 (until December and compliance reported the QA committee meeting 5. The facility dutifully allest compliance of these tasks before 10/28/18	will occur ber, r; Then nber 2019) monthly at ngs.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495267	B. WING	B. WING		C 09/13/2018	
	ROVIDER OR SUPPLIER DE REHAB & NURSING			6	TREET ADDRESS, CITY, STATE, ZIP CODE 14 HASTINGS LANE VARRENTON, VA 20186		10.2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E	(X5) COMPLETION DATE
F 812	resident. CNA #4 wa of the juice cups with serving them to the read of the juice cups with serving them to the read of the juice cups with serving them to the read of the juice cups with CNA #1. Wappropriate to touch bare hands, CNA #1 asked why, CNA #1 sinfection control." Whappropriate for staff the propriate for staff the juice. The facility was not available. CNA #4 was not a	bare fingers served it to the sobserved holding the rims her bare fingers and then esidents. Inducted on 9/13/18 at 9:14 then asked when it was a resident's food with their stated, "Never." When stated, "Cross contamination, nen asked if it was to hold cups by the rim, CNA is where they're going to put where they're going to put the stated on 9/13/18 at 10:35 inistrative staff member) #1, if ASM #2, the director of the above observation are bread with their bare the cups by the rim, ASM #2 mination." ASM #1 and ASM is of the findings at that time. It's policy titled, "Assistance address infection control ling of resident's food. In was provided prior to exit, alled to wear gloves while read for two residents in the	F.	812			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED
		495267	B. WING		C 09/13/2018
NAME OF PROVIDER OR SUPPLIER BROOKSIDE REHAB & NURSING CENTER			614	REET ADDRESS, CITY, STATE, ZIP CODE HASTINGS LANE ARRENTON, VA 20186	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 812	At approximately 12: observed seated at a (other staff member) secretary was observed the resident. She placed removed the resident and placed them on resident. OSM # 18 them are and place it on the recourse of the meal, the eating the slice of brown and place it on the recourse of the meal, the eating the slice of brown and placed the tray on the resident's plates, bothem on the table in 16 then removed a spaper wrapping with then spread butter or it on the resident's placed the tray on the resident's plates, bothem on the table in 16 then removed a spaper wrapping with then spread butter or it on the resident's placed the tray on the resident's placed the spread butter or it on the resident's placed the spread butter or it on the stray. On 09/11/18 at approximately 12: on 09/11/18 at approximately interview was condumanager. When ask for handling resident stated, "Bare hands they should be wear the end of the straw.	atable by himself. OSM # 18, south wing unit red bring a lunch tray to the the tray on the table and t's plates, bowls and cups, the table in front of the hen removed a slice a bread apping with her bare hands. d butter on the slice of bread esident's plate. During the he resident was observed ead. 46 p.m., a resident, who was brought to a table by OSM # hal therapist, registered). She te table and removed the was and cups, and placed front of the resident. OSM # lice a bread from a wax her bare hands. OSM #16 In the slice of bread and place tate. OSM # 16 also placed a w into the resident's cup. the straw by placing her bare g end of the straw. During	F 812	RECEIV OCT 11 2	018

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1, ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		495267	B. WING		09/13/2018	
***************************************	ROVIDER OR SUPPLIER DE REHAB & NURSING	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 812	should wear gloves to the end of the straw." On 09/12/18 at approinterview was conductasked to describe proresident's food, OSM everything, take it off food if needed." When she removed the breath 18 stated, "I used nused gloves." On 09/12/18 at approinterview was conductasked to describe proresident's food, OSM touched the food with informed of the observing room the day 18 stated, "I was not fingers on the straw a gloves." On 09/13/18 at approfessions."	eximately 8:27 a.m., an exted with OSM # 18. When eximately 18 stated, "I open the hot plate and cut up the masked to describe how and from the packaging, OSM my bare hands, I should have eximately 10:07 a.m., an exted with OSM # 16. When eximately 16 stated, "You shouldn't make the hands." When eximately 16 stated, "You shouldn't make the hands." When exit on in the south wing eximately 5:55 p.m., ASM member) # 1, the is M # 2, director of nursing	F 81	2		
F 838 SS=F	Facility Assessment CFR(s): 483.70(e)(1) §483.70(e) Facility a The facility must con facility-wide assessmesources are neces		F 83	F 838 Facility Assessment 1. A thorough facility assessment initiated and slated to be Completed on or before 10/2 and will address and determore resources needed to care for residents during day-to-day operations and emergencies.	28/18 nine	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495267	B. WING				09/	3/2018
NAME OF P	ROVIDER OR SUPPLIER			ST	REET AD	DRESS, CITY, STATE, ZIP CODE		
PROOKE	DE REHAB & NURSING	CENTED		61	4 HASTIN	NGS LANE		
BROOKS	DE REHAD & NURSING	CENTER		W	ARREN	TON, VA 20186		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG		C	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E	(X5) COMPLETION DATE
					F 838 F	Facility Assessment continued	1 from	
F 838	Continued From page	e 135	F	838	page 14	41		
	and emergencies. The update that assessment assessment assessment. The fact address or include: §483.70(e)(1) The fact including, but not limit (i) Both the number of resident capacity;	ne facility must review and ent, as necessary, and at acility must also review and ent whenever there is, or the change that would require a conto any part of this ility assessment must cility's resident population, ited to,		a de la companya de l	2.	Current residents in facility risk. 100% audit initiated and be completed on or before 10/28/18. New admissions we evaluated by Interdisciplina Team to ensure facility can their needs. Regional Operations Managed designee will re-educate fact Administrator on Facility	will be ry Care meet ger or ility	
	resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity,		44			Assessment on, or before 10		
	that population; (iii) The staff competer provide the level and resident population; (iv) The physical envices, and other puthat are necessary to (v) Any ethnic, culturn may potentially affect facility, including, but food and nutrition set §483.70(e)(2) The fabut not limited to, (i) All buildings and/of and vehicles; (ii) Equipment (mediculi) Services provides pharmacy, and speciciv) All personnel, including the staff of the staf	encies that are present within encies that are necessary to types of care needed for the ironment, equipment, shysical plant considerations care for this population; and al, or religious factors that t the care provided by the not limited to, activities and rvices. cility's resources, including r other physical structures cal and non-medical); d, such as physicaltherapy, ific rehabilitation therapies; cluding managers, staff (both e who provide services under		An appropriate the second seco	4.	Administrator or designee very complete audit on facility assessment with focus on stream competencies that are necessory provide the level and types an eeded for the resident population the physical environment, equipment services and other physical plant consideration are necessary to care for the population, ethical, cultural religious factors that may at care provided by the facility. Furthermore, other factors addressed such as the facility and community-based risk assessment utilizing an all-lapproach using audit tools very design and the population of the facility and community and the facility and community and the facility and community and the facility and community and the facility assessment utilizing an all-lapproach using audit tools very design and the facility approach using audit tools very design and the facility approach using audit tools very design and the facility approach using audit tools very design and the facility approach using audit tools very design and the facility approach using audit tools very design and the facility approach using audit tools very design and the facility approach using audit tools very design and the facility approach using audit tools very design and the facility approach using audit tools very design and the facility approach using audit tools very design and the facility approach using a design and the facility approach using a design and the facility approach using a design and the facility approach using a design and the facility approach using a design and the facility approach using a design and the facility approach using a design and the facility approach using a design and the facility approach using a design and the facility approach using a design and the facility approach using a design and the facility approach using a design and the facility approach using a design and the facility approach using a design and the facility approach and the facility approach and the facility approach and the facility approach and the facility approach and the faci	aff sary to of care ulation; er ss that or effect the ty-based mazards weekly x	

		DESITIE CATION SHIMPED.		MULTIPLE CONSTRUCTION ULDING			(X3) DATE SURVEY COMPLETED	
		495267	B. WING		····		/13/2018	
BROOKSI	ROVIDER OR SUPPLIER DE REHAB & NURSING		STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186					
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE PRIATE	(X5) COMPLETION DATE	
F 838	related to resident ca (v) Contracts, memo or other agreements services or equipme normal operations at (vi) Health informatic such as systems for patient records and of information with other §483.70(e)(3) A facil community-based ris all-hazards approach This REQUIREMEN by: Based on staff inter review, it was determ failed to develop a co The facility assessm competencies that a level and types of ca population, the phys services and other p that are necessary to ethical, cultural, or re potentially affect the facility-based and co assessment, utilizing The findings include	eers, as well as their ining and any competencies are; randums of understanding, with third parties to provide into the facility during both and emergencies; and on technologyresources, electronically managing electronically sharing ar organizations. It is not met as evidenced view and facility document inined that the facility staff complete facility assessment. The inined that the facility staff complete facility assessment. The inined that the facility staff complete facility assessment. The inined that the facility staff complete facility assessment. The inined that the facility staff complete facility assessment. The inined that the facility staff complete facility assessment. The inined that the facility staff complete facility assessment. The inined that the facility staff complete facility assessment.	F	838 page 1	Results of the audits will reported to the QA comm monthly for a period of 4 (October, November, Decand January). Random au be conducted for 3 additionnths to April 2019. The facility dutifully allecompliance of these tasks before 10/28/18	be nittee months cember dits will onal		
	evidence documents are necessary to pro care needed for the	ation staff competencies that byide the level and types of resident population, the nt. equipment services and						

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		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER BROOKSIDE REHAB & NURSING CENTER (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) FROM the 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, administration staff member) # 1, ad			495267	B. WING _			-	
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			CENTER		614 HASTINGS LANE			
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	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A	SHOULD BE	COMPLETION	
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. 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	other physical plant of necessary to care for cultural, or religious of affect the care provided facility-based and consistent assessment, utilizing on 09/13/18 at 3:15 of the facility's assess ASM (administration administrator. ASM # assessment was done of the transfer of the facility assessment was not on 09/13/18 at approximately app	considerations that are the population, ethical, actors that may potentially led by the facility, mmunity-based risk an all-hazards approach. p.m. a review and interview sment was conducted with staff member) # 1, if 1 stated, "The facility lie when I came in July 2018. If ASM # 1 agreed the facility complete. Doximately 5:55 p.m., ASM member) # 1, the ISM # 2, director of nursing the findings. In was provided prior to exit. Is Control (2)(4)(e)(f) Introl ablish and maintain an and control program a safe, sanitary and ment and to help prevent the nsmission of communicable ons. prevention and control ablish an infection prevention (IPCP) that must include, at					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1``	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING		l c	
		495267	B. WING		1	/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
			6	14 HASTINGS LANE		
BROOKSI	DE REHAB & NURSIN	G CENTER	\	VARRENTON, VA 20186		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE ((X5) COMPLETION DATE
F 880	reporting, investigat and communicable staff, volunteers, vis providing services user arrangement based conducted accordinaccepted national s §483.80(a)(2) Writte procedures for the put are not limited to (i) A system of survey possible communicable communicable disereported; (iii) When and to who communicable disereported; (iii) Standard and trace to be followed to provide to provide the procedure of the persons in the facilia (iv) When and how it resident; including the followed to provide the provided, and (B) A requirement to least restrictive positive prohibit employed is ease or infected	tem for preventing, identifying, ting, and controlling infections diseases for all residents, sitors, and other individuals under a contractual upon the facility assessment to \$483.70(e) and following tandards; en standards, policies, and program, which must include, oc: eillance designed to identify able diseases or ey can spread to other ty; om possible incidents of ase or infections should be ansmission-based precautions event spread of infections; isolation should be used for a but not limited to: uration of the isolation, e infectious agent or organism that the isolation should be the sible for the resident under the ces under which the facility byees with a communicable skin lesions from direct ints or their food, if direct	F 880		itored infection e.g. Il be actice ave been deficient rts e if any s of these the DON ction is and her. e findings Control the hds are ken to e "at	
	by staff involved in	ne procedures to be followed direct resident contact.		OCT 11	2018	

Facility ID: VA0178

with Infection Control Policies and

procedures.

PRINTED: 09/25/2018

FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495267	B. WING				C /13/2018
	ROVIDER OR SUPPLIER DE REHAB & NURSING	CENTER	l	STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 880	identified under the facorrective actions take §483.80(e) Linens. Personnel must hand transport linens so as infection. §483.80(f) Annual reverse for the facility will conduct the facility will conduct the facility will conduct the facility staff facility staff facility staff facility staff facility staff facility infection control progincomplete Monthly lied 2018 through Septem follow infection control residents in the surversidents in the surv	decility's IPCP and the en by the facility. Ille, store, process, and a to prevent the spread of view. In the facility document of the review, and the review of its ir program, as necessary. It is not met as evidenced view, facility document of review, it was determined ailed to maintain a complete for an as evidenced by, infection Logs for March of the review	F	880			
	Logs" dated March 2	018 through September 12, ce culture result dates and					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL [*] A. BUİLDI	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED			
		495267	B, WING			09/1:	3/2018
	ROVIDER OR SUPPLIER DE REHAB & NURSING	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	((EACH CORRECT CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD B ICED TO THE APPROPRIA DEFICIENCY)	;	(X5) COMPLETION DATE
F 880	interview was conduct staff member) # 2, direction asked to describe a colog, ASM # 2 stated, infection, date of onstand isolation if requirered the facility's "March 2018 through asked if the logs were "They should have reshould be identified. It education so the logs On 09/13/18 at approximate approximate asked if the logs were made aware of the facility staff resident aware of the facility staff fair between tasks during gastrostomy (PEG) to and failed to ensure the tube feeding was man prevent contamination. Resident #113 was a 5/21/18 and readmitt. Resident #113 includa aphasia [A disorder coparts of the brain that make it hard for your you mean to say. (1) heart failure [A conditions.)	eximately 10:20 a.m., an a sted with ASM (administrative rector of nursing. When complete infection control "It would include the type of et, diagnoses, treatment, ed." ASM # 2 was asked to Monthly Infection Logs"dated September 12, 2018. When excomplete, ASM # 2 stated, esuit dates and pathogens will be conducting will be complete." Eximately 5:55 p.m., ASM member) # 1, the M # 2, director of nursing the findings. In was provided prior to exit. Eled to change gloves a percutaneous endoscopic abe care for Resident #113 the tubing for the residents intained in a manner to	F	380			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
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		495267	B. WING _		09/13/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
				614 HASTINGS LANE		
BROOKSI	DE REHAB & NURSING	CENTER		WARRENTON, VA 20186		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR	(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	COMPLETION DATE	
F 880	Continued From page	e 141	F8	080		
	The most recent MDS	S (minimum data set), a				
		t, with an ARD (assessment	ł			
		8/18 coded the resident as	<u> </u>			
		on the BIMS (brief interview	İ			
	_	icating the resident was				
		ne interview. The resident				
		ately impaired of cognition				
	for daily decision-mai		WARREST PROPERTY OF THE STATE O			
	On 9/12/18 at approx	imately 5:55 p.m., LPN				
	• •	rse) #5 was observed		3. A. C. C. C. C. C. C. C. C. C. C. C. C. C.		
		care for Resident #113.			-	
		terile gloves and proceeded		***************************************		
		nt #113's tube feeding. LPN				
		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 pr	oceeded to leave Resident	ļ			
;	#113's room where the	ne procedure was being				
	performed and walke	d to the treatment cart in the				
	hall while wearing the	e same pair of gloves that		·		
	LPN #5 begun her pr	ocedure with.				
	On 9/12/18 at approx	imately 6:08 p.m., LPN #5				
	(wearing the same page	air of gloves) attempted to				
		on the treatment cart but				
		cart locked. She then walked				
	to central supply roor	n wearing same pair of				
	l —	t approximately 6:10 p.m.,				
	F	a bottle of saline while				
		ir of gloves. She then				
		of sterile gauze and touched				
		the new gauze while still				
	wearing the old glove	es. She crumbled the new		1		
		ght hand and proceeded to			ŀ	
		ing. LPN #5 was observed				
	having difficulty remo	oving the old dressing, she				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			1 ' '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		495267	B. WING_		000	C 13/2018		
NAME OF P	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE	09/	13/2010		
				614 HASTINGS LANE				
BROOKSI	DE REHAB & NURSING	CENTER		WARRENTON, VA 20186				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE		
F 880	Continued From page	e 142	F8	во				
	the resident's abdom dressing. LPN #5 the up from the resident's	esing with the saline on it on en and then removed the old in picked the clean dressing is abdomen and cleaned the be with the same gloves that						
	opened the clean spli apply skin protectant dressing (still wearing LPN #5 then applied reapplied Resident # #5 did not reconnect at this time. LPN #5 s supposed to be off for feeding was observed with the uncapped tu	g the same pair of gloves). the new dressing and 113's abdominal binder. LPN the resident's tube feeding stated, "it's (tube feeding) is or two hours". The tube d left hanging on the pole bing under a pillowcase. d her gloves, washed hands						
	9/12/18 at approxima	educted with LPN #5 on stely 6:13 p.m., regarding the or changing gloves, LPN #5 finished."						
	nurse) #2 on 09/13/1 process of PEG tube gauze here. First, gra towel, knock on door here to do your woun	care. RN #2 "We use a split ab all needed supplies and , introduce self and say I'm ad care, dawn gloves place a						
	clean, also put up a s down. Remove glove take old dressing of, discard old gloves. To apply the dressing. T	ents to keep the resident sterile field to put supplies as then put on new gloves to clean the site, and then hen put on new gloves to three different glovechanges		RE 0C VI	CEIVED T 11 2018 DH/OLC)		
	should be used, date	the new dressing priorto		- I	"""ULL"			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION	COMPLE	COMPLETED		
		495267	B. WING		C 09/13	3/2018	
	ROVIDER OR SUPPLIER DE REHAB & NURSIN	G CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 880	your hands, then de administration reco administration reco should walk to cent gloves on, RN #2 reinfection control protake off gloves to gasked if staff should gloves used to remanswered "No". An interview was co (administrative staff Nursing (DON) on regarding PEG can #2 stated, "Put on good dressing, cleanse to wafer make sure be gloves and put on and applying the nestaff have already go get supplies from removing the old globecause of cross co touch something you this is basic to nurse Don't tell me this work on 09/13/18 04:50 staff member) #1, to (the director of nurse above concern. The facility policy to the tell temployees touching blood, both the staff policy to the tell temployees touching blood, both tell me this work on the staff policy to the tell temployees touching blood, both tell tell temployees touching blood, both tell tell tell tell tell tell tell te	Take off old gloves and wash ocument on MAR (medication rd) or TAR (treatment rd)." When asked if staff tral supply room with dirty eplied, "No, because it's an oblem, you can ask for help or o get new supplies." When d touch new supplies with ove the old dressing, RN #2 onducted with ASM #2 f member) the Director of 09/13/18 at 10:29 a.m., e and changing gloves. ASM gloves to begin, take off old he tube and skin, asses the tumper is flush, then change new gloves before handling ew dressing." When asked if started PEG care, is it okay to m a supply room without loves, ASM #2 responded "No, ontamination, God forbid you ou could make someone sick, sing and should never be done.	F 88				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		495267	B. WING _			C /13/2018	
	ROVIDER OR SUPPLIER DE REHAB & NURSING	CENTER	•	STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186		,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	VE ACTION SHOULD BE ED TO THE APPROPRIATE		
F 880	non-intact skin or who also documents that once and discarded is receptacle located in procedure is being possible. According to Mosby's Care Assistants, 4th "Preventing Infections" "Gloves" was docume between tasks and personremove guncontaminated item. According to the CDC Control), "Hand hygic whether gloves after premove gloves after guildirty" and "clean" both patient must be regain hand-hygiene recommanded.	enever in doubt. The policy "Gloves shall be used only nto the appropriate the room in which the erformed." S Textbook for Long-Term Edition, 2003, pg. 199 ", under the category ented "change gloves rocedures on the same loves before touching	F 8	80			
	Practice", Eighth Edit Wilkins, pg. 723 read (Tube) Feedings: Inte Performance phase: feeding is completed with plug. Rationale: contamination Pre No further information 1. This information website: https://medlir			REGE OCT 1 VDH/	EIVED 1 2018 OLC		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		495267	B. WING			09/	13/2018
NAME OF P	ROVIDER OR SUPPLIER	Description of the second of t			TREET ADDRESS, CITY, STATE, ZIP CODE		
BROOKSI	DE REHAB & NURSING	CENTER			14 HASTINGS LANE		
				V	VARRENTON, VA 20186		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD E TAG CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)			(X5) COMPLETION DATE
F 880	website:	e 145 ov/heartdiseases.html.	F	880			

Printed: 10/02/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED	
49				B. WING		09/20/2018	
					STATE, ZIP CODE		
i i				STINGS LANE ENTON, 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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLDBE COMPLETION	
K 000	ין			K 000	RECEIVE OCT 11 20 VDH/OL	PROPRIATE COMPLETION DATE Discrete Completion Date Completion Date Completion Date Completion Date	
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGN				ATURE	Admen 15 fater	(X8) DATE	

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.