COMMONWEALTH of VIRGINIA

Department of Health

Office of Licensure and Certification

M. Norman Oliver, MD, MA
State Health Commissioner

TYY 7-1-1 OR
1-800-828-1120
9960 Mayland Drive, Suite 401
Henrico, Virginia 23233-1485
Fax (804) 527-4502

July 24, 2019

Beverly

Ms. ~~Bethany~~ Greene, Administrator
Brookside Rehab & Nursing Center
614 Hastings Lane
Warrenton, VA 20186

RE: Brookside Rehab & Nursing Center
Provider Number 495267

Dear Ms. Greene:

An unannounced standard survey, ending July 10, 2019, was conducted at your facility by staff from the Virginia Department of Health's Office of Licensure and Certification (the State Survey Agency) to determine if your facility was in compliance with Federal long term care participation requirements for the Medicare and/or Medicaid programs and, if applicable, State licensure regulations. One complaint was investigated during the survey, and was substantiated, with deficiencies.

All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

Survey Results

The results of this survey are reflected on the enclosed Statement of Isolated Deficiencies, "A" Form and/or the Statement of Deficiencies and Plan of Correction, CMS 2567. All survey findings generated on these forms (including the most recent standard survey and any subsequent revisits or complaint investigations) constitute the facility's current survey report. In accordance with §483.10(g), the current survey report must be made available for examination in a place readily accessible to residents and is disclosable to all interested parties.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 07/10/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated survey was conducted on 7/9/2019 through 7/10/2019. One complaint was investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. The census in this 130 bed facility was 118 at the time of the survey. The survey sample consisted of three current resident reviews (Residents #2, #3, and #4) and one closed record review, Resident #1.	F 000	The completion and submission of this credible allegation of compliance does not constitute an admission that the facility agrees with the allegations in the 2567. The facility is completing the allegation of compliance because it is required by State and Federal law. The facility disagrees with and disputes the deficiencies as stated and the scope and severity at which they are cited. Further, the facility disputes and disagrees with the accuracy of statements and other information relied upon in support of the stated deficiencies. The facility reserves its right to dispute, appeal and contest the stated deficiencies and take any action related to or arising therefrom in any other forum as needed.	
F 600 SS=E	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, clinical record review, and in the course of a complaint investigation the facility staff failed to provide an environment free from abuse for three of four residents in the survey sample, Residents	F 600	F 600 (483.12(a)(1)) It is the practice of this facility to provide an environment free from abuse 1. Resident #1 was discharged from the facility under the third facility-initiated ECO Order on June 27, 2019 and will not be re-admitted to the facility. Resident's # 2, #3, & #4 have no lasting effect from the incidents.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: BA Greene | TITLE: Administrator | (X6) DATE: 08/13/19

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 07/10/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 1 #2, #3, and #4. The findings include: Facility Progress Notes and FRI's (Facility Reported Incidents) to the State Agency detailed Resident #1's abuse of Residents #2, #3, and #4. Resident #1, a 70 year old male, was admitted to the facility on 4/26/2019. Diagnoses for Resident #1 included dementia with behavioral issues, anxiety, and alcohol and substance abuse. Resident #1's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 6/4/2019 was coded as a quarterly assessment. Resident #1 was coded with a BIMS (Brief Interview of Mental Status) score of 3 out of 15 indicating severe cognitive impairment. He was coded as needing extensive assistance of one person for most activities of daily living. He was coded as being able to eat without assistance and as ambulating throughout the facility without assistance. He was coded as being always incontinent of bowel and frequently incontinent of bladder. 1. Resident #3, an 81 year old female, was admitted to the facility on 1/25/2018. Resident #3 had a history of delirium and depression. Her most recent MDS with an ARD of 5/4/2019 was coded as a quarterly assessment. Resident #3 was coded a BIMS score of 3/15, indicating severe cognitive impairment. Resident #3 needed only supervision in her activities of daily living. On 5/26/2019 at 15:15 Resident #1 hit Resident #3, pushing her to the floor, twisting her right arm.	F 600	2. Referrals for potential admission to the secure dementia unit, with a history of aggressive (physical) behaviors, will have an on-site assessment / evaluation conducted by a member of the facility team, to determine appropriateness for the facility's secure dementia unit. Residents who present with aggressive behaviors will be provided one-to-one supervision immediately until medically and psychiatrically cleared by his or her attending physician or the attending psychiatrist. 3. The facility Administrator / designee conducted education for the admissions / marketing team regarding the need for completing an onsite evaluation of referrals with behaviors to determine appropriateness for admission to the facility secure dementia unit. 4. The facility Administrator / designee will monitor all new admissions to the secure dementia unit to ensure no aggressive behaviors are being displayed. The audit will take place 5 days per week, during AM clinical meetings. Any discrepancy noted in the audit will be corrected at that time. Results of the audit will be submitted by the Administrator monthly to the QAPI committee for its review and recommendations	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 07/10/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 2 Resident #3 was noted to have a hematoma to the front right side of her head. Neurochecks were conducted and ice was applied to the head. Resident #1 was redirected to his room. 2. Resident #2, a 73 year old male, was admitted to the facility on 3/9/2019. Resident #2 had a history of seizures and cognitive impairment. His most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 4/27/2019 was a quarterly assessment. Resident #2 was coded a BIMS (Brief Interview of Mental Status) score of 9/15, indicating moderate cognitive impairment. Resident #2 needed only supervision in his activities of daily living. On 6/3/2019 at 19:00 Resident #1 was observed in Resident #2's bed with the middle finger of Resident #2 in Resident #1's mouth. Upon removal of the finger, Resident #2 was observed to have an open area to the right middle finger consistent with a bite mark. Wound care was provided to Resident #2. Resident #1 was redirected to his room. 3. Resident #4, an 81 year old male, was admitted to the facility on 1/21/2018. Resident #4 had a history of subarachnoid hemorrhage and dementia. His most recent MDS with an ARD of 4/16/2019 was coded as a quarterly assessment. Resident #4 was coded as having severe cognitive impairment via staff assessment. Resident #4 needed the assistance of 2-3 people in his activities of daily living. On 6/12/2019 at 19:20 Resident #1 was found in the room of Resident #4. Resident #4 non-	F 600	5. Corrective measures to keep residents #2, #3 and #4 from abuse by resident #1was completed on June 27, 2019 upon resident's #1's discharge from facility. Corrective measures (as described in #4) to ensure all residents are free from abuse has been implemented and the facility dutifully alleges compliance by August 7, 2019.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 07/10/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 3 verbally communicated that Resident #1 struck him in his face. Resident #4 was seen to have a discoloration below his right eye as well as a scratch on his face. Wound care was provided to the open area and Resident #1 was redirected to his room. No further information was provided.	F 600	F603 (483.12(a)(1)) It is the practice of this facility that residents are free from involuntary seclusion 1. The employment of the employee LPN "A" who allegedly isolated resident #1 on June 17, 2019 was terminated immediately after the DON received evidence displaying cause for termination. 2. Behavior notes will be audited each day by the unit manager/nursing supervisor to determine if any resident on the secure unit is displaying aggressive behaviors so that charge nurse can closely monitor employee interaction. Facility staff will report resident to resident events as soon as possible to allow for immediate intervention and review by the management team 3. All staff have been re-in serviced on the complete definition of abuse, what constitutes abuse and the reporting requirements of suspected abuse. Any staff member who was on MLOA, LOA, vacation or other will receive this education upon return to work. The education material will be added to the new hire orientation.	
F 603 SS=D	Free from Involuntary Seclusion CFR(s): 483.12(a)(1) §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, clinical record review, and in the course of a complaint investigation the facility staff failed to provide an environment free from seclusion for one on three residents in the survey sample, Resident #1. Resident #1 was kept behind a locked half door for approximately two hours. The findings include:	F 603		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 07/10/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 603	Continued From page 4 Resident #1, a 70 year old male, was admitted to the facility on 4/26/2019. Diagnoses for Resident #1 included dementia with behavioral issues, anxiety, and alcohol and substance abuse. Resident #1's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 6/4/2019 was coded as a quarterly assessment. Resident #1 was coded with a BIMS (Brief Interview of Mental Status) score of 3 out of 15 indicating severe cognitive impairment. He was coded as needing extensive assistance of one person for most activities of daily living. He was coded as being able to eat without assistance and as ambulating throughout the facility without assistance. He was coded as being always incontinent of bowel and frequently incontinent of bladder. On 7/9/2019 at 3:00 PM, an interview was conducted with Employee A, Administrator who stated that Resident #1 exhibited combative, dangerous, and bizarre behavior shortly after his admission on 4/26/2019. It continued until his discharge on 6/27/2019. On 7/10/2019 at 9:30 AM an interview was conducted with Employee B, Director of Nursing. She stated that the staff were frightened of Resident #1. On 6/16/2019 in the afternoon, LPN A placed Resident #1 behind a locked half door on the side of the nurses' station. The area was approximately 8' x 10", and Resident #1 was contained to that area for multiple hours. LPN A gave a shift report regarding Resident #1 to an oncoming CNA who immediately reported the situation to the DON (Director of Nursing). Employee B stated that she terminated LPN A	F 603	4. The DON, ADON, Unit Manager or Nursing supervisor will round the units daily to ensure employees are providing an environment free from abuse and seclusion. The audit will take place each day during walking rounds at random times during the day. Any discrepancy noted in the audit will be corrected at that time. Results of the audit will be submitted by the DON to the QAPI committee for its review and recommendations. 5. Re-education of all facility staff will dutifully allege compliance by August 7, 2019.	