FORM APPROVED

PRINTED: 10/17/2019 DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING . B. WING 10/10/2019 495267 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **614 HASTINGS LANE BROOKSIDE REHAB & NURSING CENTER** WARRENTON, VA 20186 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) E 000 E 000 Initial Comments The completion and submission of this credible allegation of compliance An unannounced Emergency Preparedness does not constitute an admission that survey was conducted 10/08/2019 through the facility agrees with the allegations 10/10/2019. The facility was in substantial in the 25 67. The facility is completing compliance with 42 CFR Part 483.73. the allegation of compliance because Requirement for Long-Term Care Facilities. No

F 000

F 572

An unannounced Medicare/Medicaid standard survey was conducted 10/8/19 through 10/10/19. Four complaints were investigated during the survey. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow.

Emergency Preparedness complaints were

investigated during the survey.

INITIAL COMMENTS

F 000

The census in this 130 certified bed facility was 119 at the time of the survey. The survey sample consisted of 44 current resident reviews and 5 closed record reviews.

F 572 Notice of Rights and Rules SS=D | CFR(s): 483.10(g)(1)(16)

> §483.10(g) Information and Communication. §483.10(g)(1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility.

§483.10(g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay. (i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and

it is required by State and F ederal law. The facility disagrees with and disputes the deficiencies as stated and the scope and severity at which they are cited . F urther , 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 572

It is the practice of this facility to provide residents with information regarding resident rights and rules upon admission.

As indicated in the statement of deficiencies . Resident #73on admission refused to sign the paperwork when presented to him. On October 14,2019 the resident representative was provided with information regarding resident's rights and facility rules on behalf of the resident.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE 101281

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.

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Event ID: R1V111

Facility ID: VA0178

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495267	B. WING		C 10/10/2019	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 10/10/2018	
	SIDE REHAB & NURS	ING CENTER		614 HASTINGS LANE WARRENTON, VA 20186		
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F 572	F 572 Continued From page 1 regulations governing resident conduct and responsibilities during the stay in the facility. (ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any. (iii) Receipt of such information, and any amendments to it, must be acknowledged in writing; This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to evidence that one of 49 residents in the survey sample, Resident #73, was provided with information regarding resident rights and facility rules upon admission.		F 57	Who did this audit and when? On October 22, 2019 the Adm Assistant / Medical Record completed a 100% audit was completed to identify any othe residents with the same deficie practice. Were there any othe residents with an issue? If not please state that no other resid were found to be affected  III On October 22, 2019 the NHA completed education for the Admissions /Marketing perso	er ent r lent	
The findings include:  Resident #73 was admitted to the facility on 6/4/18 with the diagnoses of but not limited to osteomyelitis, dysphagia, herpes viral, mood disorder, anxiety disorder, dementia, neuropathy, pancreatitis, diabetes, peripheral vascular disease, alcohol abuse, adjustment disorder, high blood pressure, and heart disease. The 90 day MDS (Minimum Data Set) assessment with an ARD (Assessment Reference Date) of 9/30/19 coded the resident as being cognitively intact in ability to make daily life decisions. The resident was coded as requiring total care for transfers, toileting, and bathing; extensive transfers for hygiene, dressing, and bed mobility; and supervision for eating.			regarding the regulation and requirement for residents or the Resident representative to receinformation about resident rigand rules upon admission and if a resident refuses to sign admission paperwork, that the paperwork reflects such and the copies of the paperwork is proto the resident despite refusal sign.  RECE	eive ghts I that e hat ovided to		
		ical record failed to reveal any dent #73 had any advance		VDH/	OLC	

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discovery that the resident was provided any arremember that person is out or (Admissions stated that person is out or	investigation then lead to the ne facility had no evidence that the ovided with information regarding		The admissions department designee will maintain a log incoming admissions to entered admissions receive information regarding resident and facility rules.  The administrator or designated conduct audits of the admission paperwent accuracy and complete This audit will take place 5 per week for 2 weeks then we for 4 weeks. Any discrepant noted during the audit will addressed at that time.  Results of the audit will be submitted, by the facility Administrator, to the Qual Assessment Performance Improvement (QAPI) comfor its review and recommendations monthly  V The facility alleges compliate these tasks on or before 11.	g of sure all lent's le	

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<b>495267</b> B. WING	C 10/10/2019
NAME OF PROVIDER OR SUPPLIER  BROOKSIDE REHAB & NURSING CENTER  STREET ADDRESS, CITY 614 HASTINGS LANE WARRENTON, VA 2	
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F 574 SS=D Required Notices and Contact Information CFR(s): 483.10(g)(4)(i)-(vi)  §483.10(g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section; (B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act.  (C) A list of names, addresses (mailing and	In the statement of sesident # 73 on seed to sign the seen presented to him.  6, 2019 the resident was provided with segarding resident's seact information of local widuals and agencies for

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		495267	B. WING		C 10/10/2019		
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F 574	resident advocacy Survey Agency, the State Long-Term O protection and adv services where sta in long-term care for agency for informat community and the and (D) A statement the complaint with the concerning any sur federal nursing fac not limited to resid exploitation, misap in the facility, non- directives requirer information regard (ii) Information and local advocacy not limited to the S Long-Term Care O (established under Americans Act of 1 U.S.C. 3001 et sec advocacy system ( as established under Americans Act of 1 U.S.C. 3001 et sec advocacy system ( as established under Disabilities Assista 2000 (42 U.S.C. 18 (iii) Information reg eligibility and cove (iv) Contact inform Disability Resource Section 202(a)(20) Act); or other No V	d informational agencies, groups such as the State icensure office, the are Ombudsman program, the ocacy agency, adult protective te law provides for jurisdiction acilities, the local contact tion about returning to the Medicaid Fraud Control Unit; at the resident may file a State Survey Agency spected violation of state or illity regulations, including but ent abuse, neglect, propriation of resident property compliance with the advance tents and requests for ing returning to the community. I contact information for State or organizations including but tate Survey Agency, the State imbudsman program section 712 of the Older 965, as amended 2016 (42 a) and the protection and as designated by the state, and ler the Developmental ince and Bill of Rights Act of 5001 et seq.) parding Medicare and Medicaid		574	Who did this audit and when? On October 16, 2019, the Adi Assistant/Medical Records completed a 100% audit was completed to identify any othe residents with the same deficie practice. Were there any othe residents with an issue? If not please state that no other resid were found to be affected  III On October 22, 2019 the NHA completed education for the Admissions /Marketing perso regarding the regulation and requirement for residents or t Resident representative to rec on admission, information regarding pertinent contact information of local and state individuals and agencies and a resident refuses to sign adm paperwork, that the paperwor reflects such and that copies of paperwork is provided to the resident despite refusal to sign	er ent er lent  A  ns he eive  that if ission ck of the	

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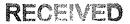
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F 574	grievances or compususpected violation facility regulations, resident abuse, nemisappropriation of facility, non-complicatives requirem information regarding regarding regarding that the that 1 of 49 resident that 1 of 49 resident Hast 1 of 4	d contact information for filing plaints concerning any of state or federal nursing including but not limited to glect, exploitation, fresident property in the ance with the advancements and requests for ing returning to the community. NT is not met as evidenced erview, facility document record review, it was a facility staff failed to evidence this in the survey sample, provided with information to contact information of local its and agencies for the on upon admission.  Ite:  admitted to the facility on gnoses of but not limited to ohagia, herpes viral, mood isorder, dementia, neuropathy, tes, peripheral vascular buse, adjustment disorder, high and heart disease. The 90 day at a Set) assessment with an		574	IV	e all t's of will on to ce. vs per for 4 l	
	coded the resident ability to make dail was coded as requ toileting, and bathi	Reference Date) of 9/30/19 tas being cognitively intact in ly life decisions. The resident uiring total care for transfers, ng; extensive transfers for and bed mobility; and ling.	A THE REAL PROPERTY OF THE PRO		V  The facility alleges compliant these tasks on or before 11/8/		

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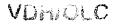
Event ID:R1V111

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F 574	A review of the clinevidence that Residirectives. This relead to the discovere evidence that the rinformation regard and state individual resident's protection Agency complaint. Protective Services admission.  On 10/9/19 at 10:2 Staff Member), the list of multiple residentist of multiple residence admission.  On 10/9/19 at 10:2 Staff Member), the list of multiple residence admission. ASM #1 the information that Advance Directive requested, if he had Admission Contract was provided at the Advance Directive. On 10/10/19 at 3:0 OSM #7, the Busin asked about the exprovided with infor completion of Advance Directive admission. She stand have an admisting that "usually, wher signed they give it	dent #73 had any advance view and investigation then be in the facility had no resident was provided with ing contact information of local its and agencies for the on (i.e., Ombudsman, State and hot line information, Adult is information, etc.) upon a dents, including Resident #73, and the could not provide a dents, including Resident #73, and the page from his could not provide at was requested. A copy of the for Resident #73 was ad any, and the page from his could any, and the page from his could not provide at the treflected that information is including Resident #73 was and any, and the page from his could not provide a time of admission for some was provided.  OPM, in an interview with the sound regarding the ance Directives at the time of the tated that his admission file did a admissions get their contract to me and then I put it in the pusiness office. We give them		74			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
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F 574	provided any and juremember that he is person is out on making the was admitted is if there was anythir reflected he was proposed to his rights, facility ruinformation (i.e., On Agency information information, etc.) should be provided, other that Directives and a black Contract form that information for white Resident #73 was on 10/10/19 at 3:3 Staff Member) the of the findings. No provided by the en Request/Refuse/D CFR(s): 483.10(c)(6) The discontinue treatment to participate in experiment of the findings of the formulate an advantage of the provision of metals.	ust refused to sign it. I just refused. The Admissions aternity leave, but the one nember) that was here when no longer here." When asked at all in his record that rovided with an Admissions included information regarding ales, and pertinent contact inbudsman information, State in, Adult Protective Services he stated there was not. In dures were requested from her ing these concerns. None were in a policy for Advance and copy of an Admission contained the above in there was no evidence provided.  O PM, ASM #1 (Administrative Administrator was made aware of further information was dof the survey, scinting Trimnt; Formite Adv Dir (6)(8)(g)(12)(i)-(v)  right to request, refuse, and/or ent, to participate in or refuse perimental research, and to	E	F 578  It is the practice of the periodically review a directives with reside provide residents with on admission regard Directives.	his facility to Idvanced ents and to th information	n	

NAME OF PROVIDER OR SUPPLIER	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
RECORSIDE REHAB & NURSING CENTER    SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH OFFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)    F 578			495267	B. WING			1	1
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F 578  Continued From page 8 §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).  (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.  (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.  (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.  (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the	BROOKS	BIDE REHAB & NURS	ING CENTER		V	VARRENTON, VA 20186		
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(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.  (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.  (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the								
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(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.  (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the								
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legally responsible for ensuring that the requirements of this section are met.  (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the						advanced directives with Reside	ent	
requirements of this section are met.  (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the				İ		#13 and # 73 on October 28, 20	18.	
(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the						The review has been document	ed in	
time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the				THE WAY TO SEE THE SECOND SECO		_ <del></del>		
information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the						the medical chart.		
has executed an advance directive, the facility may give advance directive information to the				-		<b>Q</b>		
may give advance directive information to the								
						€		
						The Social Services staff comp	eted a	
with State Law. facility wide review of residents to		with State Law.				facility wide review of residents	to	
(v) The facility is not relieved of its obligation to address their Advanced Directive								
provide this information to the individual once he		1 F				1		
Of the leading to receive again information.								
							iicu to	
nutro complete time			ne murridga directly at the			. –		
This REOLIBEMENT is not met as evidenced Woving forward the social services			NT is not met as evidenced			, 0		
by:  department will review and discuss						department will review and dis	cuss	
Based on staff interview, facility document review advance directives with the resident			erview, facility document review	-		advance directives with the res	ident	
and clinical record review, it was determined that representative during the time of		and clinical record	review, it was determined that	W white		representative during the time	of	
the facility staff failed to meet advance directive				Automatia Heore		•		
requirements for two of 49 residents in the survey				***************************************		concusted oute plant to them.		
sample, Residents #13 and #73. The facility staff						·		
failed to evidence that the facility policy for						•		
advanced directives was implemented to review with Resident #13 periodically her Advance								
Directives, to determine if she wanted to change								

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED		
		495267	B. WING				C 1 <b>0/2019</b>
	PROVIDER OR SUPPLIER SIDE REHAB & NURS	ING CENTER		61	REET ADDRESS, CITY, STATE, ZIP CODE 4 HASTINGS LANE ARRENTON, VA 20186		1012010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFI) TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	8E	(X5) COMPLETION DATE
F 578	Resident #73 inforr regarding advance evidence that a per advance directive s resident.	s written. Staff failed to provide nation at the time of admission directives; and failed to iodic review of the resident's status was conducted with the	F 5		III On October 22, 2019 the NHA completed education for the Admissions /Marketing person regarding the regulation and requirement for residents or th Resident representative to rece on admission, information	s e	
	facility policy for ad implemented to rev periodically her Adv	e: failed to evidence that the vanced directives was riew with Resident #13 vance Directives, to determine ange or maintain them as			regarding Advance Directives a that if a resident refuses to sign admission paperwork, that the paperwork reflects such and th copies of the paperwork is prov to the resident despite refusal t	at vided	
	10/25/16 with the d metabolic encepha poisoning, thyrotox Alzheimer's diseas Parkinson's diseas disorder, anxiety di The quarterly MDS ARD (Assessment coded the resident ability to make daily was coded as requi bathing; limited ass	admitted to the facility on iagnoses of but not limited to lopathy, depression, ic crisis, dysphagia, e, neuropathic bladder, e, high blood pressure, bipolar sorder, and kidney fallure. (Minimum Data Set) with an Reference Date) of 7/3/19 as being cognitively intact in y life decisions. The resident iring extensive assistance for sistance for hygiene, toileting, supervision for transfers and			on October 16, 2019 the NHA completed education for the So Services staff regarding periodic review and documentation of advanced directive reviews.	ocial	
	Resident #13 had a 9/15/2001, but no e had been conducte she wished to mak	ical record revealed that an Advance Directive, dated evidence that a periodic review and with the resident regarding if e any changes to the Advance ain them as written.	The state of the s				The state of the s

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		405067	B. WING			С	
		495267	B. WING			V/10/2019	
NAME OF I	PROVIDER OR SUPPLIER		i	STREET ADDRESS, CITY, STATE, Z	IP CODE		
PPAAK	SIDE REHAB & NURS	ING CENTED		614 HASTINGS LANE			
BROOK	HE HEHAD & HORE	MIG OLIVE!		WARRENTON, VA 20186			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 578	Continued From pa	age 10	F 5	78			
	conducted with OS the Director of Soc the facility only sind about completing p advance directives but I can start." W Services Departme reviews of advance wasn't told when I doing one. I was o services director fo slipped her mind."  A review of the fac Directives docume to formulate an Ad refuse, and/or disc treatment4. The the resident for de- approach the healt representative if th have decision mak discussions and ar resident executes resident' medical r planning process, and review with the representative whe changes related to made regarding the research as prefer 7. Decisions regar treatment will be a change or improve	ether they desire to make any Advance Directives, decisions eatments or experimental rences may change over time. ding Advance Directives and ddressed with any significant ement"		OC	in a log of s to ensure all ive ng resident's formation of duals and r designee will e admission caperwork to compliance. place 5 days s then weekly screpancy dit will be		
		3 PM, ASM #1 (Administrative Administrator was made aware				· · · · · · · · · · · · · · · · · · ·	

PRINTED: 10/17/2019 FORM APPROVED OMB NO. 0938-0391 I(X3) DATE SURVEY

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  IDENTIFICATION NUMBER:  A. BUILDING			COMPLETED		
		495267	B. WING		1	C 0/1 <b>0/2019</b>
	PROVIDER OR SUPPLIER SIDE REHAB & NURS	ING CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 614 HASTINGS LANE WARRENTON, VA 20186		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
₽ 578	of the findings. No provided by the end  2. The facility staff Resident #73 was purchased the firme of admission of the staff staff.	further information was don't be survey.  failed to evidence that provided with information at on regarding advance	F 57	The Social Services staff wi maintain an ongoing log of Directive reviews to ensure each resident has at least a review, and documentation review, of their Advance do This review will also have	f Advance that quarterly n of such rective.	egiling de la colonia de la co
	review of the reside was conducted with Resident #73 was a 6/4/18 with the diag osteomyelitis, dysp	ed to evidence that a periodic ent's advance directive status in the resident.  admitted to the facility on process of but not limited to thagia, herpes viral, mood sorder, dementia, neuropathy,	To a supply the supply of the	audit by the facility admin	istrator.	
	disease, alcohol ab blood pressure, and MDS (Minimum Da ARD (Assessment	es, peripheral vascular buse, adjustment disorder, high d heart disease. The 90 day ta Set) assessment with an Reference Date) of 9/30/19 as being cognitively intact in y life decisions.	Add the state of t	these tasks on or before 11		
	interview was cond	oximately 1:30 PM, an ucted with Resident #73. He erns with his stay at the facility ce Directives.				
	evidence that Residence directives or that a conducted with the	ical record failed to reveal any dent #73 had any advance periodic review had been resident regarding whether or evelop any advance directives.				
	conducted with OS the Director of Soc the facility only sind	a.m., an interview was M #3 (Other Staff Member), ial Services, who has been at ce June 2019. When asked periodic reviews of residents'				And and the control of the control o

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495267	B. WING		1	C 0/10/2019
	PROVIDER OR SUPPLIER SIDE REHAB & NURS	ING CENTER		STREET ADDRESS, CITY, STATE, ZIP 614 HASTINGS LANE WARRENTON, VA 20186		710/2013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING (NFORMATION)	ID PREFI TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 578	advance directives, but I can start." WI Services Departme reviews of advance wasn't told when I doing one. I was of services director for slipped her mind."  On 10/9/19 at 10:23 Staff Member), the list of multiple resident for multiple resident to provide asked periodic review of a residents. On 10/9 stated she could not advance directives requested. A copy Resident #73 was represent this Admission Cont Directive information admission. None was completed with information of Advance directive information admission. OSM #7 admission file did not in it. OSM #7 state get their contract sithen I put it in the file office. We give the come in but he refucouple times to significatives was offer the contract was offer the contract was offer the contract to significatives was offer the contract was of	OSM #3 stated, "I have not nen asked if the Social nt has a process for periodic directives, OSM #3 stated, "I same but they could have been nly here with the old social rone day. It could have a could have to a could have a c	F	778		

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)  F 578  Continued From page 13  it. I just remember that he refused. The Admissions person is out on maternity leave, but the one (Admissions staff member) that was here  STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  F 578  F 578  Continued From page 13  it. I just remember that he refused. The Admissions person is out on maternity leave, but the one (Admissions staff member) that was here	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING	COM	E SURVEY MPLETED	
NAME OF PROVIDER OR SUPPLIER  BROOKSIDE REHAB & NURSING CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  F 578  Continued From page 13  it. I just remember that he refused. The Admissions person is out on maternity leave, but the one (Admissions staff member) that was here  STREET ADDRESS, CITY, STATE, ZIP CODE  614 HASTINGS LANE WARRENTON, VA 20186  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  F 578  F 578			495267	B. WING		1	
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 578  Continued From page 13  it. I just remember that he refused. The Admissions person is out on maternity leave, but the one (Admissions staff member) that was here  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  F 578  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		ING CENTER		614 HASTINGS LANE		
it. I just remember that he refused. The Admissions person is out on maternity leave, but the one (Admissions staff member) that was here	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFI	(EACH CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPR	JLD BE	(X5) COMPLETION DATE
when he was admitted is no longer here."  A review of the facility's policy on Advance Directives documented, "It is the resident's right to formulate an Advance Directive, to request, refuse, and/or discontinue medical or surgical treatment	F 578	it. I just remember Admissions person the one (Admission when he was admit A review of the faci Directives docume to formulate an Adversuse, and/or discurrentment1. On a determine if the resident would Directive3. The fin a manner easily resident representative if and approach the I representative if the have decision maked discussions and arresident executes resident executes resident medical or surgical advance directive. assess the resident and approach the I representative if the have decision maked discussions and arresident executes resident executes resident medical made regarding transpersentative when the changes related to made regarding transpersentative when the finding in the of the findings. Note that the staff Member is the of the findings. Note that is the staff Member is the of the findings.	Ithat he refused. The is out on maternity leave, but is staff member) that was here ited is no longer here."  Ility's policy on Advance inted, "It is the resident's right wance Directive, to request, ontinue medical or surgical admission, the facility will sident has executed an and if not, determine whether like to formulate an Advance facility will provide information understood by the resident or ative about the right to refuse I treatment and formulate an 4. The facility will periodically it for decision-making abilities health care proxy or legal e resident is determined not to ting capabilities. Such my advance directive(s) that the will be documented in the ecord6. During the care the facility will identify, clarify, a resident or legal enter they desire to make any advance Directives, decisions eatments or experimental ences may change over time. ding Advance Directives and ddressed with any significant ement"		78		

NAME OF PROVIDER OR SUPPLIER  495267  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE		
	10/10/2019	
BROOKSIDE REHAB & NURSING CENTER  614 HASTINGS LANE WARRENTON, VA 20186		
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM	(X5) COMPLETION DATE	
F 584 SS=E  Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7)  §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.  The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.  (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.  (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or thelt.  §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;  §483.10(i)(3) Clean bed and bath linens that are in good condition;  §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);  §483.10(i)(5) Adequate and comfortable lighting levels in all areas;  §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED			
			A. DOILD			С	
		495267	B. WING			10/10/2019	
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
BROOKS	SIDE REHAB & NURS	ING CENTER		-	14 HASTINGS LANE		
BITOOIS				٧	VARRENTON, VA 20186		
(X4) ID PREFIX TAG				ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		BE	(X5) COMPLETION DATE
F 584	sound levels. This REQUIREMENT by: Based on observated document review an investigation, it was staff failed to maint for one of two units staff failed to maint manner free from opersistent urine odd 10/8/19 and 10/9/19. The findings included A stale, musty, urin throughout the nort and times: 10/8/19 at approximation 10/9/19 at 8:07 a.m surveyor) 10/9/19 at 3:08 p.m surveyor) 10/9/19 at 4:13 p.m	e maintenance of comfortable  NT is not met as evidenced  ion, staff interview, facility and in the course of a complaint determined that the facility ain a homelike environment , the north unit. The facility ain the north unit in a homelike dors. A stale, musty and or was noted on the unit on  e: e odor was observed h unit on the following dates mately 5:00 p.m. h. (confirmed by a second  m. h. (confirmed by a second	F	384	III The environmental services director changed the chemical used on the North Wing to a product that is more effective removing urine odors.  IV The environmental services director or designee will condidaily audits Monday through Friday to ensure maintenance homelike environment free froodors. Any discrepancy noted the audit will be corrected at time. Results of the audit will submitted by the Housekeepir director monthly to the QAPI committee for its review and recommendations.  V The facility dutifully alleges	at  of om l with hat be	
	On 10/9/19 at 4:30 p.m., an interview was conducted with OSM (other staff member) #2 (the environmental services director). OSM #2 was asked what was being done to contain musty				compliance of these tasks on obefore 11/8/2019.		
	"We are making su	north unit. OSM #2 stated, are all of the beds are stripped			RECEIVE	D	
	wiped down and di	rning. Each bed is being sinfected. Bathrooms are			OCT 3 0 20	Q	**************************************
	Floors are scrubbe there (north unit) h	a weekly and daily basis. d twice a day. Some residents ave incontinence issues and bed and on the wall. The other	mayoo aa aa aa aa aa aa aa aa aa aa aa aa a		VDH/OL	C	Analy Construct Adjustment of the Construction

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		COMPLETED	
		495267	B. WING		1	10/2019
	PROVIDER OR SUPPLIER	ING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 584	thing that they do is units. That I really Once the urine goe director) will take the down and try to cle issue." When asked on the north unit, Condiced odors in the particular residents agreed that there we philosophy was not and eliminate the second of the director of nuring the director of nuring the improved.  On 10/10/19 at 10: wax on the floor in stripped during the improved.  The facility document Responsibilities of "To maintain clean patients, staff and potential for crosscie anliness, order, techniques. Odor document specific control.	s urinate in the air conditioning can't do too much about. It is in (name of maintenance the unit out and hose them an them but it's an ongoing and if he had noticed urine odors of the had noticed urine odors of the wall. OSM #3 stated that he had be rooms where a couple of the urinate on the wall. OSM #3 overe odors. OSM #2 stated his to use deodorizers, but to find fource.  p.m., ASM (administrative the administrator), ASM #2 sing) and ASM #3 (the clinical dent) were made aware of the unit had been night and the odor had housekeeping documented, healthful surroundings for visitors. To minimize the infection. To maintain and safety. Basic cleaning control." The document did not information regarding odor		84		
F 609			F	609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED	
		495267	B. WING			10/1	; 0/2019
	PROVIDER OR SUPPLIER	ING CENTER		6	TREET ADDRESS, CITY, STATE, ZIP CODE 14 HASTINGS LANE VARRENTON, VA 20186	123	012013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG				(X5) COMPLETION DATE
F 609 SS=D	CFR(s): 483.12(c)(1) §483.12(c) In responeglect, exploitation must: §483.12(c)(1) Ensurinvolving abuse, nemistreatment, inclusions after the allegithat cause the allegithat cause the allegithat cause that cause that cause and do not rethe administrator of officials (including tradult protective serfor jurisdiction in loaccordance with St procedures. §483.12(c)(4) Repoinvestigations to the designated represes accordance with St Survey Agency, with incident, and if the appropriate correct This REQUIREMED by: Based on clinical redocumentation revifacility staff failed to allegation of abuse 49 sampled resident.	anse to allegations of abuse, in, or mistreatment, the facility are that all alleged violations glect, exploitation or ding injuries of unknown ropriation of resident property, diately, but not later than 2 gation is made, if the events pation involve abuse or result in y, or not later than 24 hours if se the allegation do not involve esult in serious bodily injury, to the facility and to other to the State Survey Agency and vices where state law provides ing-term care facilities) in ate law through established		609	F 609 It is the practice of this facility immediately report allegations abuse to the State Agency.  I As stated in the 2567, the incide was reported on 3/25/19 but nowithin a 2- hour timeframe. Resident # 314 had no injury for the event and no longer resident the facility. Past non-compliant cannot be corrected. Staff responsible for timely reporting the event no longer work at the facility.  II The Director of Nursing compared a review of facility reportable incidents, retro 6 months, to e reporting was within compliant All reports were found to be in compliance.  RECEIVEL OCT 3 0 2019	ent ot rom s in ice g of e	
l	holding a pillow over Resident #314's face. The						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		E CONSTRUCTION	COM	E SURVEY PLETED C	
		495267	B. WING				10/2019
	PROVIDER OR SUPPLIER SIDE REHAB & NURS	ING CENTER		6	TREET ADDRESS, CITY, STATE, ZIP CODE 14 HASTINGS LANE VARRENTON, VA 20186		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 609	facility staff did not to the State Agency The Findings include Resident #314 was 03/10/2016. Her did dysphagia (difficulty disease. Resident Data Set (MDS) as Assessment with a (ARD) of 05/05/201 Mental Status (BIM 4, indicating profou was coded as required one person for bed two or more people dependence on on Resident #10 was 2/11/2013. Diagnos to, Alzheimer's dise depression. The reimpaired of cognitic assessment with a Review of a Facility documented the follocident Date: 3/24 [Name of Resident #314 a Type: Allegation of following was hand Resident." "Descril and action taken: ([Name of Resident #314]'s renurse. He [Resident Resident #314]'s renurse. He [Resident Resident #314]'s renurse. He [Resident Resident  report this allegation of abuse y until 3/25/19.  ded: ded: dadmitted to the facility on agnoses included depression, y swallowing), and Alzheimer's #314's most recent Minimum sessment was a Quarterly in Assessment Reference Date 19. The Brief Interview for IS) scored Resident #314 at a and impairment. Resident #314 iring extensive assistance of mobility, total dependence on for transfers, and total e person for dressing.  admitted to the facility on ses include but are not limited ease, anxiety disorder and isident was coded as severely on on the quarterly MDS		\$09	On 6/17/2019 all staff were reeducated via in-service regard the requirement of abuse report within two hours.  Resources regarding abuse and facility incident reporting were available in the form of a binde each unit.  Any facility reportable incident reported to DON/ADON immediately after occurrence.	made r on		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ' '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495267	B. WING		C 10/10/2019	
	PROVIDER OR SUPPLIER SIDE REHAB & NUR			STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186		
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F 609	residents were se #314] was examin observed." Under taken:" the FRI do protected and ass for injury, Notified Physician for both enforcement and personnel Transferame of hospital], until seen by psyc [evaluation) [Nam transferred out of The incident of ab prior abbreviated was noted that the incident to the State documented the in 03/24/2019 at 9:1 transmission shee was not reported 03/25/2019 at 13: p.m.). Two copies to the State Agency A review of the fact the following: "2.5"	ully pushing down. The parated. [Name of Resident ned for injuries and none were "Employee action initiated or ocumented, "Immediately ressed [Name of Resident #314] RP [responsible party] and residents. Notified law all appropriate administrative erred [Name of Resident #10 to Maintaining 1-1 upon his return chiatrist for further evaluation of the feet of Resident #314] will be unit to [Name of unit]."  Source itself was investigated on a survey. On review of the FRI, it are was a delay in reporting the stee Agency. The FRI incident as occurring on 2p.m. Review of the facsimile ets evidenced that the incident to the State Agency until 29 (1:29 p.m.) and 13:54 (1:54 of the same report were faxed	F 608	On October 14, 2019 the facil Administrator reviewed the regulation F 609 and time fra for reporting with the departs heads and the resources which placed at the nursing units for to utilize.  IV The Facility Administrator of will monitor all allegations of for timely reporting, daily 7 deper week.  Any discrepancy noted during audit / review will be address immediately with a report be filed and action steps taken to ensure compliance.  V The facility alleges compliance these tasks on or before 11/8,	mes ment h were r staff  r DON f abuse lays g the ed ing	
	property) will be re	and misappropriation of resident eported within 2 hours."	Time believe a recommendation of the state o	RECEIVE		
	Administrator, and Nursing, were info reporting of this in meeting on 10/09	aff Member (ASM) #1, the facility d ASM #2, the Director of brind of concerns regarding the holdent at the end of day 1/2019. Neither ASM #1 nor ASM or information regarding the	New Annual Control of	OCT 3 0 201		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING		COM	E SURVEY IPLETED C
		495267	B. WING _		i i	10/2019
	PROVIDER OR SUPPLIER SIDE REHAB & NURS	ING CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 614 HASTINGS LANE WARRENTON, VA 20186		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC 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 609 F 622 SS=D	Continued From paincident. Transfer and Disch CFR(s): 483.15(c)(1) §483.15(c)(1) Facili (i) The facility must remain in the facilit discharge the reside (A) The transfer or resident's welfare a cannot be met in the (B) The transfer or because the reside sufficiently so the reservices provided to (C) The safety of in endangered due to status of the reside (D) The health of in	arge Requirements 1)(i)(ii)(2)(i)-(iii)  r and discharge- ity requirements- permit each resident to y, and not transfer or ent from the facility unless- discharge is necessary for the and the resident's needs the facility; discharge is appropriate ant's health has improved the facility; discharge is appropriate ant's health has improved the facility; dividuals in the facility is the clinical or behavioral ant; adviduals in the facility would	F 60	DEFICIENCY)	ility to entation for le care plan and tion.  not be 80 & # 100. sides at the	
	otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or			that everything that is requested transfer is on the checklist	uired for	

A95267  NAME OF PROVIDER OR SUPPLIER  BROOKSIDE REHAB & NURSING CENTER  C 10/10  STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186	0/2019  (X6)  COMPLETION DATE
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  614 HASTINGS LANE	(X6) COMPLETION
	COMPLETION
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
Gontinued From page 21 discharge notice from the facility pursuant to \$ 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.  §483.15(c)(2) Documentation.  When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.  (i) Documentation in the resident's medical record must include:  (A) The basis for the transfer per paragraph (c)(1)(i) of this section.  (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the receiving facility to meet the need(s).  (ii) The documentation required by paragraph (c)(2)(i) of this section, and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.  (iii) Information provided to the receiving provider must include a minimum of the following:  (A) Contact information of the practitioner reeponsible for the care of the resident.  (B) Resident representative information including	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495267	B. WING		C 10/10/2019
	PROVIDER OR SUPPLIER	ING CENTER	6	TREET 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 SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE COMPLÉTION
F 622	contact information (C) Advance Direct (D) All special instruments on the composition of the resident on the composition of the resident on the composition of the resident of the composition of the resident of the composition of the composit	tive information ructions or precautions for ppropriate. e care plan goals; esary information, including a at's discharge summary, 33.21(c)(2) as applicable, and record review, facility iew, and staff interview, the record review, facility iew, and staff interview, the record review facility iew, and staff interview, the record review facility iew, and staff interview for two of 49 at hospital transfer for two of 49 at #80 and #100.  Ied: failed to ensure Resident #80's re plan goals were provided to ital at the time of transfer on admitted to the facility on agnoses included heart failure ess, and dysphagia (difficulty lent #80's most recent at (MDS) assessment was a ssessment with an Assessment all Status (BIMS) scored 15, indicating no impairment.  Int #80's medical record #80 was transferred to the 2019 following an episode of	F 622	Newly hired Licensed staff will receive this education during orientation.  IV  The DON or ADON will audit transfer checklists, the followin business day to ensure complia with completion and submission necessary documentation on resident transfer. Any discrepanoted with the audit will be corrected by sending the necessinformation to the hospital at time. The checklist will be file the resident's record.  The DON or ADON will monithe daily census report to ident any resident was a direct admitt the hospital to ensure complian with submission of necessary documentation being sent to the hospital. Any discrepancy note with the audit will be corrected sending the necessary information the hospital at that time. The checklist will be filed in the resident's record.	nce on of ancy sary hat d in  tor ify if to nce ne ed l by tion
	hospital on 09/28/2		THE ADMINISTRATION OF THE PROPERTY OF THE PROP	WAY COMMENT OF THE CO	t constitution of the cons

	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	i		C 10/10/2019	
NAME OF I	PROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE	101	10/2010
BBUUK	SIDE REHAÐ & NURS	ING CENTER		-	14 HASTINGS LANE		
BROOK	IDE HEHAD & NOTIC		, L.	V	VARRENTON, VA 20186		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT 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)		(X5) COMPLETION DATE		
F 622	evidence any docur comprehensive car Resident #80 on tra On 10/10/19 at 9:29 manager, was interrun the face sheet, of documentation for folder. There is a chasked if the facility RN #1 stated, "It is nursing)."  On 10/10/19 at 10:3 staff member) #1, the director of nurs concerns. ASM #2 of the checklist from #80's 9/28/19 hosp would have check, regarding the hosp would have check. regarding the hosp the checklist for Reside hospitalization coul stated the checklist. A review of the doc Checklist," reveale form is to be comp transferred to the hoom] or direct ad completed, the nur form will be filed in No further information.	mentation that the e plan goals were sent with ansfer to the hospital.  9 a.m., RN #1, the unit viewed. RN #1 stated, "We med [medication] list, change orm, and put it in the blue heck off list in there." When retains a copy of the checklist, given to the DON (director of  55 a.m., ASM (administrative he administrator, and ASM #2, ing), were informed of these was asked if she had a copy in the blue folder for Resident italization. ASM #2 stated she Policies were requested ital transfer procedure.  05 p.m., ASM #2 stated a ent #80's 9/28/19 id not be located. ASM #2 t was the facility policy.  sument, "Transfer to Hospital d, in part, the following: "This leted for each resident who is iospital (ER [Emergency mission). After each task is se will enter their initials. The the hard chart on the unit."	F	522	Results of the audit(s) will be submitted by the DON month the QAPI committee for its reand recommendations.  V The facility alleges compliance these tasks on or before 11/8/2	of	
	1. Heart failure is a	condition in which the heart					Tadia (Anno

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	IPLE CONSTRUCTION NG		TE SURVEY MPLETED C	
		495267	B. WING		10	/10/2019
	PROVIDER OR SUPPLIER  SIDE REHAB & NURS	ING CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 614 HASTINGS LANE WARRENTON, VA 20186		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 622	needs. Heart failure heart has stopped means that your he the way it should. It of the heart https://medlineplus  2. Resident #100 won 9/5/19. The facil required resident-s resident care, incluinformation and cathe hospital on trans (1/18 and most rewith diagnoses includerebral palsy (1) a disease) (2). On the data set), a significan assessment refinesident #100 was communication difficognitively intact for having scored 15 cointerview for mental A review of Resident #100 was communication difficognitively intact for having scored 15 cointerview for mental A review of Reside revealed the follow 9/13/19: "Resident [name of hospital]. initiation of dialysis (abdomen) soft and Further review of the fany documentation of day documentation of any documentation of any documentation of dialysis (abdomen) soft and Further review of the fany documentation of dialysis (abdomen) soft and Further review of the fany documentation of dialysis (abdomen) soft and Further review of the fany documentation dialysis (abdomen) soft and Further review of the fany documentation dialysis (abdomen) soft and Further review of the fany documentation dialysis (abdomen) soft and Further review of the fany documentation dialysis (abdomen) soft and Further review of the fany documentation dialysis (abdomen) soft and Further review of the fany documentation dialysis (abdomen) soft and fany documentation dialysis (abdomen) soft and fany documentation dialysis (abdomen) soft and fany documentation dialysis (abdomen) soft and fany documentation dialysis (abdomen) soft and fany documentation dialysis (abdomen) soft and fany documentation dialysis (abdomen) soft and fany documentation dialysis (abdomen) soft and fany documentation dialysis (abdomen) soft and fany documentation dialysis (abdomen) soft and fany documentation dialysis (abdomen) soft and fany documentation dialysis (abdomen) soft and fany documentation dialysis (abdomen) soft and fany documentation dialysis (abdomen) soft and fany documentation dialysis (abdomen) soft and fany docu	blood to meet the body's a does not mean that your or is about to stop working. It eart is not able to pump blood a can affect one or both sides a gov/heartfailure.html  as transferred to the hospital lity failed to evidence that any pecific information regarding ding advance directive re plan goals, was provided to sfer.  admitted to the facility on cently readmitted on 9/13/19 uding, but not limited to, and ESRD (end stage renal e most recent MDS (minimum ant change assessment with erence date of 9/20/19, a coded as having no iculties, and as being r making daily decisions, but of 15 on the BIMS (brief				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION  NG		ATE SURVEY OMPLETED C
	495267	B. WING		1	0/10/2019
NAME OF PROVIDER OR SUPPLIER  BROOKSIDE REHAB & NURSI	NG CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 614 HASTINGS LANE WARRENTON, VA 20186		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
nurse) #2 was inten#100 had been dired 9/5/19 so that dialyst asked about the progrelated to the reside receiving hospital, Laface sheet, a mediadvance directive. Variansport, and notify When asked if sheethe information, LPI not usually."  On 10/9/19 at 4:33 #2, the nursing superstated the facility seresident who is being The blue folder inclubed-hold policy, a facondition form, and When asked if staff sent with residents, usually."  On 10/10/19 at 9:25 manager, was intergrunt the face sheet, of documentation for folder. There is a clasked if the facility RN #1 stated, "It is nursing)."  On 10/10/19 at 10:3 staff member) #1, the director of nursing the face of the face	p.m., LPN (licensed practical viewed. She stated Resident city admitted to the hospital on sis could be started. When becess for sending documents ent's care needs to the LPN #2 stated, "We try to send if (medication) list, and the We notify the doctor, call for y the RP (responsible party)." documents that she has send N #2 stated, "To be honest,  p.m., RN (registered nurse) ervisor, was interviewed. She ends a blue folder with the ng transferred to the hospital. udes a notice of the facility ace sheet, a change of an up to date care plan. If document the information RN #2 stated, "No, not a.m., RN #1, the unit eviewed. RN #1 stated, "We med [medication] list, change form, and put it in the blue heck off list in there." When retains a copy of the checklist, given to the DON (director of the sadministrator, and ASM #2, ing), were informed of these was asked if she had a copy	F			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION  NG		TE SURVEY MPLETED
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	PROVIDER OR SUPPLIER	ING CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 614 HASTINGS LANE WARRENTON, VA 20186		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC 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 622	of the checklist fror #100's 9/5/19 hosp would have to look requested regardin procedure.  On 10/10/19 at 12:surveyor she had in Resident #100's 9/5 stated, "This check policy."  A review of the doc Checklist," revealer form is to be compit transferred to the hRoom] or direct adcompleted, the nurform will be filed in No further informat  (1) "Cerebral palsy affect a person's all balance and postur from the website https://medlineplus  (2) "End-stage kidr stage of long-term is when your kidne body's needs. End-called end-stage reinformation is take https://medlineplus  (3) "When your kid your blood. They a	n the blue folder for Resident italization. She stated she to see. Policies were g the hospital transfer  05 p.m., ASM #2 told the tot located the checklist for 5/19 hospitalization. She list is what we have for the sument, "Transfer to Hospital d, in part, the following: "This leted for each resident who is tospital (ER [Emergency mission). After each task is se will enter their initials. The the hard chart on the unit."  ion was provided prior to exit. is a group of disorders that pility to move and to maintain re." This information is taken gov/cerebralpalsy.html.  ney disease (ESKD) is the last (chronic) kidney disease. This ys can no longer support your stage kidney disease is also anal disease (ESRD)." This				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		495267	B. WING		10/10/2019
	ROVIDER OR SUPPLIER	ING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 814 HASTINGS LANE WARRENTON, VA 20186	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DE COMPLÉTION
F 641 SS=D	your kidneys fail, you the work your kidney have a kidney trans treatment called dia types of dialysis. Boyour body of harmfor water. Hemodialysis sometimes called a go to a special clinia a week." This inform website https://med. Accuracy of Assess CFR(s): 483.20(g)  §483.20(g) Accuracy The assessment more resident's status. This REQUIREMED by:  Based on staff interested and facility document that the facility staff MDS (minimum dat 49 residents in the and #46. The facility Resident #73 on the assessment as recorder for and or adanticoagulant. The Resident #46's 8/13 data set) for restrain The findings included 1. Resident #73 we 6/4/18 with the diagonal facility with the diagonal facility with the diagonal facility with the diagonal facility with the diagonal facility with the diagonal facility facility and facility f	bu need treatment to replace by sused to do. Unless you splant, you will need a alysis. There are two main both types filter your blood to rid all wastes, extra salt, and is uses a machine. It is in artificial kidney. You usually it for treatments several times mation was taken from the ellineplus.gov/dialysis.html. It is in artificial kidney. You usually it for treatments several times mation was taken from the ellineplus.gov/dialysis.html. It is not met as evidenced eview, clinical record review, and review, it was determined if alled to accurately code and it a set) assessment for two of survey sample; Residents #73 y staff incorrectly coded to e 9/30/19, 90-day MDS eliving an anticoagulant. For failed reveal a physicians ministration of an facility incorrectly coded (3/19 quarterly MDS (minimum ints.)	F 641	E 6.4.1	ected

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	* ***		E CONSTRUCTION		E SURVEY PLETED
		495267	B. WING	···		10/1	) 10/2019
	PROVIDER OR SUPPLIER SIDE REHAB & NURS	ING CENTER		61	TREET ADDRESS, CITY, STATE, ZIP CODE 14 HASTINGS LANE VARRENTON, VA 20186		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 641	disorder, anxiety dipancreatitis, diabet disease, alcohol ab blood pressure, and MDS (Minimum Da ARD (Assessment coded the resident ability to make daily "Medications" resident ability to make daily "Medications" resident mediperiod.  A review of the phy discontinued, rever prescribe an anticoagulant was resident. The resident. The resident. The resident anticoagulant.  On 10/10/19 at 10:: conducted with LPI stated, "He (Reside a blood thinner, or anticoagulant." Will are used to accura the RAI manual (Reinstrument).  On 10/10/19 at 1:0 Staff Member) the of the findings. No provided by the end	sorder, dementia, neuropathy, es, peripheral vascular puse, adjustment disorder, high dheart disease. The 90 day ta Set) assessment with an Reference Date) of 9/30/19 as being cognitively intact in y life decisions. Section N, ent #73 was coded as on an cation during the look back sician's orders, current and aled that the physician did not agulant for Resident #73 and not administered to the lent was prescribed Plavix (1) nedication was not an 20 AM, an interview was N #4, the MDS nurse. LPN #4 ent #73) was on Plavix which is lered 5/13/19. It is not an nen asked what procedures tely code the MDS, she stated esident Assessment	F6	44	The MDS nurses conducted an audit of residents on Plavix to verify that none of the other residents on Plavix were coded an anticoagulant. Any discrepancy noted during the audit was corrected at that time with submission of a corrected MDS.  The MDS nurses conducted an audit of residents with side rails that are used for positioning, to verify that none of the other residents with side rails were coded as having a restraint. And discrepancy noted during the audit was corrected at that time with submission of a corrected MDS.  The MDS nurses will utilize a drug book to verify therapeutic categories during coding.  If a bed rail is present, MDS nursely will verify that a bed rail/ assist bar evaluation is completed to identify if the side rail is an enabler or a restraint before coding as a restraint.	s ny e	
		may cause a heart attack or					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	! ' '		E CONSTRUCTION		PLETED
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	PROVIDER OR SUPPLIER SIDE REHAB & NURS	ING 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 SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 641	stroke. Information obtaine https://medlineplus tml  According to the R dated October 201  The RAI process h requirements. Fedda 483.20 (b)(1)(xviii), (1) the assessmen resident's status  And on Page 1-8 do in addition, an according informatic some of which are Those sources mudirect care staff on include the resider and family, guardia appropriate or accomplete that informatic same observation items on the assessing validated for accuractual status was aby the IDT complete nursing homes are all participants in the requisite known assessment.  And on Page N-9,	ad from .gov/druginfo/meds/a601040.h  Al manual 3.0 Version 1.16 8, Page 1.7 documented:  as multiple regulatory eral regulations at 42 CFR (g), and (h) require that t accurately reflects the locumented:  urate assessment requires ion from multiple sources, mandated by regulations. Ist include the resident and I all shifts, and should also at 's medical record, physician, an, or significant other as eptable. It is important to note on obtained should cover the period as specified by the MDS sament, and should be acy (what the resident 's during that observation period) ting the assessment. As such, a responsible for ensuring that he assessment process have ledge to complete an accurate documented:		641	The DON or NHA will conduct review of the RAI manual "Definition of physical restraint and RAI definition of an anticoagulants as opposed to an antiplatelet with the MDS nurse or in the alternative, a licensed nurse will conduct audits of anticoagulant restraint coding 5 days per week weeks, then weekly for 4 weeks ensure coding accuracy. Any discrepancy noted during the awill be corrected at that time. The RNAC will submit results a audit monthly to the QAPI committee for its review and recommendations.  V The facility alleges compliance these tasks on or before 11/8/20	s" and c for 2 to udit of the	
	<u> </u>	ch as Target Specific Oral			VDHA	OLC.	0 00-(=0
FORM CMS-2	2567(02-99) Previous Version	ns Obsolete Event ID: R1V1	11	F	acility ID: VA0178 If continue	mon sheet	Page 30 of 76

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		RIPLE CONSTRUCTION  NG		TE SURVEY MPLETED
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	PROVIDER OR SUPPLIER	ING CENTER		STREET ADDRESS, CITY, STATE, ZIP O 614 HASTINGS LANE WARRENTON, VA 20186		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 641	Anticoagulants (TS require laboratory in NO410E, Anticoagu 2. The facility income 8/13/19 quarterly Marestraints.  Resident #46 was a 2/29/16; diagnoses history of a stroke a recent MDS (minimassessment with an of 8/13/19, Resider cognitively intact for having scored 15 or interview for mental requiring staff superand transfers from section P0100A, Reside rails being use	OACs), which may or may not nonitoring, should be coded in alant. rectly coded Resident #46's IDS (minimum data set) for admitted to the facility on include, but are not limited to, and diabetes (1). On the most num data set), a quarterly in assessment reference date in #46 was coded as being in making daily decisions, but of 15 on the BIMS (brief all status). He was coded as ervision only for bed mobility one surface to another. In esident #46 was coded with ed daily as a restraint.	F 6	41		
	#46 was observed room. At both obsethe up position. In a 12:42 p.m., Reside requested the side time" for positioning facility staff had go of the side rail with consent form. Whe his movement at a helps me."  On 10/10/19 at 10: practical nurse) #4 interviewed. When side rail being code	2 p.m. and 3:10 p.m., Resident sitting in a wheelchair in his ervations, one side rail was in an interview on 10/8/19 at an interview on 10/8/19 at an interview on 10/8/19 at an interview on 10/8/19 at an interview on 10/8/19 at an interview on 10/8/19 at an interview on 10/8/19 at an interview on 10/8/19 at an interview on 10/8/19 at an interview on 10/8/19 at an interview of 10/8/19 at an inter				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	•	TIPLE CONSTRUCTION		X3) DATE SURVEY COMPLETED	
		495267	B. WING			C 0/10/2019	
	PROVIDER OR SUPPLIER SIDE REHAB & NURS	ING CENTER		STREET ADDRESS, CITY, STATE, 614 HASTINGS LANE WARRENTON, VA 20186			
(X4) ID PREFIX TAG	(EACH DEFICIENC	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		CTION SHOULD BE OTHE APPROPRIATE	(X5) COMPLETION DATE	
F 655 SS=D	stated, "He is weak He uses that side r was an error. It is n enhancer." When a reference for comp assessments, LPN (resident assessments, LPN (resident assessment) On 10/10/19 at 10: staff member) #1, the director of nurs concerns.  A review of Long-T Assessment Instru Version 1.17.1 Oct the following: "DEF RESTRAINTS Any mechanical device attached or adjace the individual cann restricts freedom of to one's bodyIde were used at any ti 7-day lookback per or not an item liste restraint and was u look-back period, of No further informat (1) "Diabetes (mell blood glucose, or to high." This informat https://medlineplus	ail to get in and out of bed. It tot a restraint. It is an asked what she uses as a leting accurate MDS #4 stated, "I use the RAI ent instrument) manual."  55 a.m., ASM (administrative the administrator, and ASM #2, ing, were informed of these erm Care Facility Resident ment 3.0 User's Manual ober 2019 revealed, in part, "INITION PHYSICAL manual method or physical or, material or equipment at to the resident's body that of remove easily, which of movement or normal access thify all physical restraints that ime (day or night) during the riod. After determining whether d in (P0100) is a physical ised during the 7-day code the frequency of use."  Ition was provided prior to exit.  Itius) is a disease in which your blood sugar, levels are too ation is taken from the website agov/diabetes.html.	F	655			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	COM	E SURVEY PLETED
		495267	B. WING			10/1	) 10/2019
• • • • • • • • • • • • • • • • • • • •	PROVIDER OR SUPPLIER BIDE REHAB & NURS	ING CENTER		6	TREET ADDRESS, CITY, STATE, ZIP CODE 14 HASTINGS LANE VARRENTON, VA 20186		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 655	§483.21 Comprehe Planning §483.21 (a) Baseline §483.21 (a) (1) The fimplement a baseline that includes the interfective and person that meet profession. The baseline care point in the baseline care point in the baseline care point in the baseline care point in the baseline care point in the baseline care (b) Initial goals base (c) Dietary orders. (d) Therapy services (e) Social services (f) PASARR recorrectly for the care plan if the condition (ii) Meets the requiremental care plan if the condition in the baseline care plan if the condition in the baseline care limited to:  (i) The initial goals (ii) A summary of the dietary instructions	e Care Plans facility must develop and ne care plan for each resident structions needed to provide n-centered care of the resident nal standards of quality care. plan must- thin 48 hours of a resident's mum healthcare information rity care for a resident mited to- ed on admission orders. s.  es. facility may develop a re plan in place of the baseline reprehensive care plan- thin 48 hours of the resident's rements set forth in paragraph excepting paragraph (b)(2)(i) of facility must provide the epresentative with a summary e plan that includes but is not of the resident. the resident's medications and		555	It is the practice of this facility to develop baseline care plans per regulation.  I Information regarding communication via Spanish language was added to the care on 10/11/2019. Several staff members in the facility speak fl Spanish and translate her needs A Spanish communication boa was set up for the resident to communicate with non-Spanis speaking staff.  II Base line care plans will include 'native language' if the resident bilingual in their native language well as English.	plan uent s. rd h	

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. DOIL	/m1Q			,	
		495267	B. WING	i		10/	10/2019	
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
BROOKS	SIDE REHAB & NURS	SING CENTER			14 HASTINGS LANE			
Dilouit		, , , , , , , , , , , , , , , , , , ,		V	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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	8E	(X5) COMPLETION DATE	
F 655	Continued From pa	age 33	F	655	The Social Services staff will			
		e facility and personnel acting	A Walleton of the Lorentz of the Lor		complete an audit of residents	in		
	on behalf of the facility.				the facility that may speak in a			
		formation based on the details sive care plan, as necessary.	Arreson		language other than the domir			
		NT is not met as evidenced	-canada (		'English' to determine if they			
	by:		111000000000000000000000000000000000000		require communication			
		tion, family interview, facility	TO THE PERSON NAMED IN COLUMN TWO IS NOT THE PERSON NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS		accommodation. Such			
		and clinical record review, it at the facility staff to develop a			accommodations will be reflec	ted in		
		for one of 49 residents in the			the care plan.			
		sident #264. The facility staff			F			
		baseline care plan for			III			
		ommunication. She speaks only	-		The DON or NHA will comple	ete an		
	Spanish.				educational review for the Lice			
	The findings include	de:			nurses and Interdisciplinary to			
	The state of the s		*		regarding baseline care plan			
	Davidant ADC town				completion. Newly hired Licer	rsed		
		s admitted to the facility on s include, but are not limited to,			staff will receive this education			
		entia (1) and a recent history of			during orientation.	•		
	encephalopathy (2	). She had not been at the			during orientation.			
		h for the completion of an MDS			IV			
	(minimum data se	t) assessment.			The DON/ADON or IDT tear	n		
	On 10/9/19 at 3:45	p.m., Resident #264 was			member will review the baseli		A. C.	
	observed lying in t	ner bed. Her daughter and						
		her bedside. Her daughter	***************************************		Care plan, on the next busines			
		speaks Spanish. We are a little now she will be able to tell the			following admission to ensure	;		
	staff what she nee		TANA AMARINA AVA		language barriers and	!		
	Juli Wild Ollo 1100		the same of the sa		communication accommodate			
		ent #264's admission nursing			are included when applicable.			
		aled, in part, the following:	A-1000-1000					
		N: Other Language: gical: Oriented to Person,			V	•		
	Place, Time, and				The facility alleges compliance			
	, . iiiioj wilo (	ar - 1 ar ar ar 2 ar 2 ar			these tasks on or before 11/8/2	2019.		
	A review of Reside	ent #264's baseline care plan,						

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

Event ID: R1V111

Facility ID: VA0178

If continuation sheet Page 34 of 76 RECEIVED

OCT 3 0 2019

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	DING		СОМІ	E SURVEY IPLETED	
		495267	B. WING				) 10/2019	
	PROVIDER OR SUPPLIER SIDE REHAB & NURS	ING CENTER		6	TREET ADDRESS, CITY, STATE, ZIP CODE 14 HASTINGS LANE VARRENTON, VA 20186			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 655	regarding Resident differences becaus On 10/9/19 at 4:08 assistant) #2 was it she was communic was assigned to he haven't had a conv. Spanish. She does understand her. An though, I think."  On 10/9/19 at 4:18 #1, the unit managithe facility staff wer communicate with "We have an interphave access to an come to us and the On 10/10/19 at 9:3 RN #1, when asker RN #1 stated, "For initial assessment intentions of succe follow where the painterventions." Whe for developing a bastated, "The admitting or me. It wresponsibility." Whishould have been baseline care plan have been included.	d to reveal evidence of #264 communication e she only speaks Spanish.  p.m., CNA (certified nursing nterviewed. When asked how ating with Resident #264, who ar, CNA #2 stated, "I really ersation with her. I don't speak n't understand me and I don't other CNA speaks Spanish,  p.m., RN (registered nurse) er, was interviewed about how er going to be able to Resident #264. RN #1 stated, areter (telephone) line. We interpreter 24/7. The CNAs on nurses access it."  9 a.m., during an interview with dother the patient to the goals and as of the patient. It should attent is at the time, what the und then the goals of those en asked who is responsible aseline care plan, RN #1 stated, in ADON (assistant director of will eventually become my en asked if communication included in Resident #264's, RN #1 stated, "Yes. It should		655				

•	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION  IG	COM	E SURVEY IPLETED
		495267	B. WING _		l l	10/2019
	PROVIDER OR SUPPLIER	ING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 655	Continued From pa	ıge 35	F 65	55		
		the administrator, and ASM #2, ing, were informed of these	A T P P T T T T T T T T T T T T T T T T			
	Standard of Practice following: "The bas promote continuity among nursing hor safety, and safegue that are most likely and to ensure the rapplicable, are info delivery of care and written summary of baseline care plan healthcare information each resident in admission."	dility policy, "Baseline Care Plance," revealed, in part, the seline care plan is intended to of care and communication me staff, increase resident ard against adverse events to occur right after admission, resident and representative, if armed of the initial plan for d services by receiving a f the baseline care planThe must include the minimum tion necessary to properly care mmediately upon their				
	brain function. This It affects memory, and behavior." This website	gradual and permanent loss of a occurs with certain diseases. thinking, language, judgment, is information is taken from the agov/ency/article/000746.htm.	occorporation of the part of the statement of the stateme			
F 656 SS=D	a disease that affer your brain." This in website https://www.healthi alopathy. Develop/Implemen	ny is a general term describing cts the function or structure of formation is taken from the line.com/health/hepatic-enceph of Comprehensive Care Plan (1)	F 6	56		
1		• •				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495267	B. WING			C 10/10/2019	
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 10/10/2013	
BROOKS	IDE REHAB & NURS	ING CENTER			14 HASTINGS LANE		
				¥ı	VARRENTON, VA 20186  PROVIDER'S PLAN OF CORRECTIO	u I	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 656	Continued From pa	nge 36	F	556			
		1 O Diama			It is the practice of this facility to	)	
	§483.21(b) Comprehensive Care Plans				develop and implement a		
	§483.21(b)(1) The facility must develop and implement a comprehensive person-centered				comprehensive plan of care		
	implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -  (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).  (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.  (iv)In consultation with the resident and the resident's representative(s)-				I Past non-compliance cannot be corrected for obtaining monthly weights on Resident # 38. If the weight is stable please include it here.  Resident # 3 was assessed on 10/10/19 and a toileting program is not indicated due to severe cognitive impairment. Her care plan was updated accordingly.		
	(A) The resident's goals for admission and desired outcomes.						
	(B) The resident's preference and potential for				RECE	VED	
	future discharge. Facilities must document whether the resident's desire to return to the						
	community was assessed and any referrals to				OCT 30	ZU19	
	community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.  (C) Discharge plans in the comprehensive care				VDH/(	DLC	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	TIPLE CONSTRUCTION  NG	CON	COMPLETED	
		495267	B. WING		1	/10/2019
	PROVIDER OR SUPPLIER	ING CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 614 HASTINGS LANE WARRENTON, VA 20186		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC 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 656	requirements set for section.  This REQUIREME by: Based on staff interview, and clinical determined that the implement the come two of 49 residents #38 and follow the comprehemently weights for September 2019. The findings included the findin	e, in accordance with the orth in paragraph (c) of this  NT is not met as evidenced erview, facility document a record review, it was a facility staff failed to aprehensive plan of care for a in the survey sample, and the facility staff failed to be ensive plan of care to obtain a resident #38, in August and the facility staff failed to ensive plan of care to obtain a resident #38, in August and the facility staff failed to ensive plan of care to obtain a resident #3's comprehensive care program after the resident fell de:  The facility staff failed to ensive plan after the resident fell de:  The facility staff failed to ensive plan after the resident fell de:  The facility staff failed to ensive plan after the resident fell de:  The facility staff failed to ensive plan after the resident fell de:  The facility staff failed to ensive plan after the resident fell de:  The facility staff failed to ensive plan after the resident fell de:  The facility staff failed to ensive plan and the facility on ensity plan after the resident fell de:  The facility document in the second of the ensity plan after the facility on ensity plan after the resident fell de ensity plan after the resident failed to ensity plan after the resident failed to ensity plan after the resident fell de ensity plan after the resident failed to ensity plan after the resident failed to ensity plan after the resident failed to ensity plan after the resident failed to ensity plan after the resident failed to ensity plan after the resident failed to ensity plan after the resident failed to ensity plan after the resident failed to ensity plan after the resident failed to ensity plan after the resident failed to ensity plan after the resident failed to ensity plan after the resident failed to ensity plan after the resident failed to ensity plan after the resident failed to ensity plan after the resident failed to ensity plan after the resident failed to ensity plan after the resident failed to ensity plan after the resident failed to ensity plan after t	F6	The Assistant DON will an audit of resident care interventions to identify are no longer indicated. discrepancy with the audicorrected at that time with of the care plan.  Care Plan interventions paidle discussed in more meeting to determine appropriateness.  Weights will be obtained order and recorded in the chart.  The DON / ADON will do audit of monthly weights identify any weights not per order	plan any that Any it will be th revision  post fall aing IDT  per MD e medical  conduct an	
		Resident #38's clinical record nce of weights for the resident		Commission of the Property of		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C		
		495257	B. WING				10/2019
	PROVIDER OR SUPPLIER SIDE REHAB & NURS	ING CENTER		61	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 SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<b>«</b>	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	(X5) COMPLETION DATE	
F 656	in August and Sept A review of Reside plan dated 7/15/15 following: [Residen (related to) genera weaknessresider significant weight operiodAssess we On 10/9/19 at 4:08 assistant) #2 was i is responsible for oweights, CNA #2 si day shift. Sometim month."  On 10/9/19 at 4:19 nurse) #2 was inte process for obtaini LPN #2 stated, "The shift. The list goes she gives them our make sure they ge On 10/10/19 at 9:2 #1 was interviewed are responsible to weights. I give the to follow up with the like to have them on month. That way we time still left in the purpose of the car guided direction of patient to the goals the patient. It shout the time, what the	nt #38's comprehensive care of revealed, in part, the st #38] is at nutritional risk r/t lized muscle nt will avoid unintentional change through review sight monthly."  I. p.m., CNA (certified nursing nterviewed. When asked who obtaining residents' monthly tated, "Usually we do it on the e around the first of the lip.m., LPN (licensed practical rviewed. When asked the ing residents' monthly weights, ney are assigned to the day to the unit manager, and then t to the day shift nurses to		56	The DON will complete an educational review for the Unit Managers and ADON to ensure are following up on staff obtain weights on their units per MD. The DON/ADON will re-education staff via in servicing regarding obtaining weights as ordered and updating / revising following care plan intervention. Newly hired Licensed staff will receive this education during orientation.	e they ing order.  ate	

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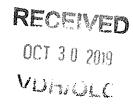
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495267	B. WING	ì		10/1	0/2019
	PROVIDER OR SUPPLIER	ING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 656	responsible for making sure a resident's care plan is followed, RN #1 stated, "The nurse that is taking care of the patient should be looking at the care plan. The responsibility for following up on that is mine."  On 10/10/19 at 10:55 a.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were informed of these concerns.  A review of the facility policy, "Comprehensive Care Plans Standard of Practice," revealed, in part, the following: "Approaches defined in the comprehensive care plan will be implemented unless the resident refuses to allow."  No further information was provided prior to exit.  (1) COPD is "a general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis." Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124.  (2) "Dementia is a gradual and permanent loss of brain function. This occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior." This information is taken from the website https://medlineplus.gov/ency/article/000746.htm.  2. The facility staff failed to implement Resident #3's comprehensive care plan for a toileting program after the resident fell on 6/24/19.			656	The DON/ADON will conduct audit of interventions post resic fall to ensure the intervention heen implemented. This audit was take place, as soon as possible be the latest, on the next business of following the fall. The audit with ongoing audit as part of the AM clinical meeting and fall review discrepancy noted during the awill be corrected at that time. Rof the audit will be submitted be DON or ADON to the QAPI committee for its review and recommendations monthly.	lent as vill ut at day ll be an I Any udit esults	
			Maria in the control of the control		The DON/ADON will conduct audit of monthly weights to ensure that weights are completed time completed. The audit will conduct by the 5th of each month to ensure that each resident has a monthly weight for the month. Any discrepancy noted during the awill be corrected at that time. From the audit will be submitted by DON or ADON to the QAPI committee for its review and recommendations monthly.	sure ely and ucted sure y udit	
	4/11/18. Resident	dmitted to the facility on #3's diagnoses included but high blood pressure, chest			The facility alleges compliance these tasks on or before 11/8/2		

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

Event ID:R1V111

Facility ID: VA0178

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	OF DEFICIENCIES OF CORRECTION	CONFESTION INCIDENCE IN THE INTERNAL PROPERTY OF THE INTERNAL PROPERTY			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495267	B. WING			10/1	0/2019
• • • • • • • • • • • • • • • • • • • •	PROVIDER OR SUPPLIER  SIDE REHAB & NURS	ING CENTER		6	TREET ADDRESS, CITY, STATE, ZIP CODE 114 HASTINGS LANE VARRENTON, VA 20186		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(XS) COMPLETION DATE
F 656	pain and muscle we recent MDS (minimassessment with an date) of 9/30/19, co skills for daily decis impaired. Section sustaining any falls  Review of Resident investigations reversident slid out of to use the bathroor Resident #3's compa/17/18, with a revidocumented, "FALI fallsexplore toilet meals and at bed to Further review of Failed to reveal a boafter 6/24/19 and fathat a toileting programented for Resident's care plan revised after each should include what implemented for the (interdisciplinary teafter each fall and intervention and up was asked to explatoileting programs. programs include in resident every two	ge 40 sakness. Resident #3's most aum data set), a quarterly ARD (assessment reference ded the resident's cognitive ion-making as severely J coded Resident #3 as not since the prior assessment.  If #3's clinical record and fall aled that on 6/24/19 the bed and reported that she had n. No injury was sustained. Orehensive care plan dated sed on date of 6/24/19,S: (Resident #3) is at risk for ing program before and after imes as resident will allow"  It #3's clinical record at the resident #3's clinical record on date of 6/24/19,S: (Resident #3's clinical record owel and bladder assessment alled to reveal any evidence imm had been explored or esident #3 after 6/24/19.  P.m., an interview was (registered nurse) #2 care plans. RN #2 stated an should be reviewed and fall. RN #2 stated the revision date and time of the fall. It the resident. RN #2 stated IDT am) meetings are conducted the team discusses the new odates the care plan. RN #2 ain the facility process for RN #2 stated toileting ounding and toileting a hours. When asked how staff oileting program is being	F	656	The facility alleges compliance these tasks on or before 11/8/2		

	EMENT OF DEFICIENCIES PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILDI	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		495267	B. WING			<b>.</b>	;  0/2019
	ROVIDER OR SUPPLIER	ING CENTER		STREET ADDRESS, CITY, STATE, ZIP 614 HASTINGS LANE WARRENTON, VA 20186	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG		ON SHOULD IE APPROPI	BE	(X5) COMPLETION DATE
F 656	should appear on Cassistant) charting toileting was attempted amount of urine and On 10/9/19 at 6:02 staff member) #1 (the director of nursegional vice presidabove concern.  On 10/10/19 at 9:30 conducted with RN was asked to explae RN #1 stated, "The a guided direction opatient to the goals the patient. A care patient is at the time and then the goals added or encourage was asked who may followed on a daily nurse that is with the looking at that of the responsibility at this new position the on."  The facility docume Revising the Care "4. Any immediate"	stated the toileting program CNA (certified nursing and should document that oted every two hours, the dif the toileting was effective.  p.m., ASM (administrative he administrator), ASM #2 sing) and ASM #3 (the clinical lent) were made aware of the ent) were made aware of the ent) were made aware of the ent) were made aware of the purpose of a care plan in the purpose of a care plan is for of both initial assessment of a and intentions of success of plan should follow what the e, what the interventions are of those interventions that are ed in all disciplines." RN #1 stated, "The nat individual at that day should are plan while she is working. I have currently learned in that is something I will follow up ent titled, "Reviewing and Plan-Guideline" documented, intervention placed on the care		356			
F 657 SS=D	No further informat Care Plan Timing a			657			

NAME OF PROVIDER OR SUPPLIER  BROOKSIDE REHAB & NURSING CENTER  WARRENTON, VA 20188    Continued From page 42   PREST   PROPERTION   PROPRIET OF DEFICIENCES   PROPRIET OF THE APPROPRIATE   DOMESTIC OF THE APPROPRIATE	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
STREET ADDRESS, CITY, STATE, ZIP CODE  \$483.21(b) (20.4) D. (EACH DEFICIENCY MUST BE RECECED BY PLL) REGULATORY OR LISC IDENTIFYING INFORMATION)  F 657  Continued From page 42  \$483.21(b) (2) A comprehensive Care Plans \$483.21(b)(2) A comprehensive care plan must be (i) Developed within 7 days after completion of the comprehensive assessment.  (ii) Prepared by an interdisciplinary team, that includes but is not limited to 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 medical record if the participation of the resident and their resident representative is determined not practicable for fine development of the resident and their resident.  (F) Other appropriate staff or professionals in disciplines as determined by the residents.  (F) Other appropriate staff or professionals in disciplines as determined by the resident and their resident representative is determined by the resident.  (F) Other appropriate staff or professionals in disciplines as determined by the resident and their resident representative is determined by the resident.  (F) Other appropriate staff or professionals in disciplines as determined by the resident and their resident representative is determined by the resident and their resident representative is determined by the resident and their resident representative is determined by the resident and their resident representative is determined by the resident and their resident representative is determined by the resident and their resident representative is determined by the resident representative is determined by the resident and their resident representative is determined by the resident and their resident representative is determined by the resident and their resident representative is determined by the resident and their resident representative is determined by the resident and their resident representative is determined by the resident			495267	B. WING				1
F 657 Continued From page 42  \$483.21(b) (Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary tendical 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 their resident's representative is determined not practicable for the development of the resident representative is determined not practicable for the development of the residents.  (F) Other appropriate staff or professionals in dissiplines as determined by the resident.  (F) Other appropriate staff or professionals in dissiplines as determined by the resident.  (F) Other appropriate staff or professionals in dissiplines as determined by the resident.  (F) Other appropriate staff or professionals in dissiplines as determined by the resident.  (F) Other appropriate staff or professionals in dissiplines as determined by the resident.  (F) Other appropriate staff or professionals in dissiplines as determined by the resident.  (F) Other appropriate staff or professionals in dissiplines as determined by the resident.  (F) Other appropriate staff or professionals in dissiplines as determined by the resident.  (F) Other appropriate staff or professionals in dissiplines as determined by the resident.  (F) Other appropriate staff or professionals in dissiplines as determined by the resident and their resident and their resident.  (F) Other appropriate staff or professionals in dissiplines as determined by the resident and their resident.  (F) Other appropriate staff or professionals in dissiplines as determined by the resident and their resident and their resident.  (F) Other appropriate staff or professionals in disciplines as determined by the resident and their resident.  (F) Other appropriate staff or professionals in disciplines as determined by the resident and their resident.  (F) Other appropr			ING CENTER		61	14 HASTINGS LANE		
\$483.21(b) Comprehensive Care Plans \$483.21(b)(2) A comprehensive care plan must be-  (i) Developed within 7 days after completion of the comprehensive assessment.  (ii) Prepared by an interdisciplinary team, that includes but is not limited to- (A) The attending physician.  (B) A registered nurse with responsibility for the resident.  (C) A nurse aide with responsibility for the resident.  (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative's (S). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.  (F) Other appropriate staff or professionals in disciplines as determined by the resident.  (iii)Reviewed and understative is determined not practicable for the development of the comprehensive and quarterly review assessments.  This REQUIREMENT is not met as evidenced by:  Based on staff interview, facility document review and clinical record review, it was determined that the facility staff falled to review and/or revise the comprehensive care plan as indicated  I The care plan for Resident # 3 was reviewed and updated on 10/23/19 however past non-compliance cannot be corrected. As written in the statement of deficiencies  Resident #3 had no injury associated with this fall.  II Members of the Interdisciplinary team will complete an audit of resident care plans against post fall interventions to identify that the interventions were placed on the care plan and are in place. The review will include determination of any that are no longer indicated which can be resolved. Any discrepancy with the audit will be corrected at that time with revision of the care plan.	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFI	1	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLETION
staff failed to review and/or revise Resident #3's comprehensive care plan after the resident fell on 7/10/19.  RECEIVED  OCT 3 0 2019	F 657	§483.21 (b) Compre §483.21 (b) (2) A corbe- (i) Developed within the comprehensive (ii) Prepared by an includes but is not (A) The attending p (B) A registered nuresident. (C) A nurse aide wiresident. (D) A member of for (E) To the extent properties of the resident and the resident of the resident of the resident of the resident of the resident of the resident of the resident of the sciplines as determined in the sciplines as determined in the sciplines as comprehensive and assessments.  This REQUIREME by:  Based on staff into and clinical record the facility staff failed comprehensive call in the survey samp staff failed to review comprehensive call in the survey samp staff failed to review comprehensive call in the survey samp staff failed to review comprehensive call	chensive Care Plans imprehensive care plan must in 7 days after completion of assessment. interdisciplinary team, that limited to- ohysician. rse with responsibility for the oth responsibility for the od and nutrition services staff. racticable, the participation of e resident's representative(s). st be included in a resident's re participation of the resident epresentative is determined the development of the on. ate staff or professionals in rmined by the resident's needs the resident. evised by the interdisciplinary sessment, including both the d quarterly review  NT is not met as evidenced erview, facility document review review, it was determined that ed to review and/or revise the re plan for one of 49 residents ole, Resident #3. The facility w and/or revise Resident #3's		657	It is the practice of this facility to review and/or revise the comprehensive care plan as indicated  I The care plan for Resident # 3 w reviewed and updated on 10/23 however past non-compliance cannot be corrected. As written the statement of deficiencies Resident #3 had no injury assoc with this fall.  II Members of the Interdisciplinar team will complete an audit of resident care plans against post interventions to identify that th interventions were placed on the care plan and are in place. The review will include determination any that are no longer indicated which can be resolved. Any discrepancy with the audit will corrected at that time with reviso of the care plan.	ras /19 in iated  ry fall e e on of l be sion	

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BROOKS	SIDE REHAB & NURS	ING CENTER		W	/ARRENTON, VA 20186		
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F 657	The findings includ Resident #3 was at 4/11/18. Resident were not limited to pain and muscle were recent MDS (minimassessment with at date) of 9/30/19, conskills for daily decis impaired. Section sustaining any falls Review of Resident investigations reversed wheelchair on 7/10 Further review of Further review of Further review of Further review of Further review days and plan for the 7/10/19 On 10/9/19 at 4:51 conducted with RN regarding falls and resident's care plan revised after each should include the the fall. It should it will be implemented stated IDT (interdisconducted after each conducted after each conducted after each stated IDT (interdisconducted after each stated IDT (in	dmitted to the facility on #3's diagnoses included but high blood pressure, chest eakness. Resident #3's most num data set), a quarterly n ARD (assessment reference oded the resident's cognitive sion-making as severely J coded Resident #3 as not since the prior assessment.  It #3's clinical record and fall aled the resident slid out of the 1/19. No injury was sustained. It lesident #3's clinical record notes, the fall investigation and prehensive care plan dated eveal evidence that the facility for revised the resident's care	F	657	Falls with care plan intervention post fall will be discussed in morning IDT meeting, 5 days proved, Monday through Friday, determine appropriateness and be documented in the care plant.  III  The DON or ADON will compreducation for the licensed nurs how to update / revise a care plepost fall. Newly hired Licensed will receive this education duri orientation.  The DON or NHA will review regulatory requirement for upocare plans with the IDT team.  IV  The DON or ADON or UM or MDS nurse will review care plant days per week in the AM IDT meeting to ensure that a new intervention was placed on the plan post fall and that the apprehas been implemented. Any discrepancy noted in the audit be corrected at that time. Resulting to the plant in the corrected at that time.	er to will a	
	staff member) #1 (the director of nu	p.m., ASM (administrative (the administrator), ASM #2 sing) and ASM #3 (the clinical dent) were made aware of the			the audit will be submitted, by DON, to the QAPI committee monthly for its review and recommendations.		

	OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:		(x2) MULTIPLE CONSTRUCTION  A. BUILDING			COMPLETED	
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	PROVIDER OR SUPPLIER	ING CENTER		61	REET ADDRESS, CITY, STATE, ZIP CODE 4 HASTINGS LANE ARRENTON, VA 20186		
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F 658	above concern.  The facility docume Revising the Care I "2. With a change i the unit manager o will review the care plan is to be update intervention. The comember of the IDT intervention to the No further informat	ent titled, "Reviewing and Plan- Guideline' documented, in condition, the charge nurse, in a member of the IDT team plan and identify which care led with a new or modified tharge nurse/unit manager or team will add the new	F6	557	V The facility alleges compliance these tasks on or before 11/8/recommendations.		
SS=D	CFR(s): 483.21(b)( §483.21(b)(3) Com The services provid as outlined by the or must- (i) Meet profession This REQUIREME by: Based on observat document review, or was determined the follow professional administration of D in the survey samp (licensed practical Resident #34's api to administering Di The findings include Resident #34 was 4/23/19 with the dia	prehensive Care Plans ded or arranged by the facility, comprehensive care plan, all standards of quality. NT is not met as evidenced tion, staff interview, facility and clinical record review, it at the facility staff failed to standards of practice for the igoxin for one of 49 residents de, Resident #34. LPN nurse) #1 failed to auscultate cal pulse for a full minute prior goxin to the resident.		) 	It is the practice of this facility to follow professional standards of practice for the administration of medications to include Digoxin  I Past non-compliance cannot be correct Resident # 34 had no negative outcome the licensed nurse taking the apical pul 15 seconds and multiplying x4 as oppositioning to the apical pulse for a full medical pulse full medical pulse for a full medical pulse full medical	ted. e from se for sed to	

NAME OF PROVIDER OR SUPPLIER  BROOKSIDE REHAB & NURSING CENTER  SUMMARY STATEMENT OF DEFICIENCIES SHAMSTHORY OF LEGICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LISC IDENTIFYING INFORMATION)  F 658  Continued From page 45 disorder, adjustment disorder, high blood pressure, atrial fibrillation, pulmonary edoma, liver cirrhosis, and kidney failure. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 7/31/19 coded the resident as being moderately impaired in ability to make daily life decisions. The resident was coded as requiring limited assistance for dressing and supervision for all other areas of activities of daily living.  On 10/09/19 at 8:15 AM, LPN #1 (Licensed Practical Nurse) was observed preparing medications for administration to Resident #34. She obtained the pulse for 15 seconds, Obtained the number 22 and then multiplied by 4, LPN #1 stated 88. When asked what the resident's pulse was, LPN #1 stated 87. She was then observed preparing medications for Resident #34 which included Digoxin (1) 0.25 mg (milligrams), 1 tablet.  On 10/9/19 at 3:11 PM, in an interview with LPN #1, when asked from the multiplied by 4, LPN #1 stated of professional standard of practice for obtaining the apical pulse for the administration of Obtoxin, LPN #1 stated, "A full minute." When asked if she followed professional standards of practice for obtaining the apical pulse for the administration of Obtaining the apical pulse for the administration of Obtaining the apical pulse for the administration of Obtaining the apical pulse for the administration of Obtaining the apical pulse for the administration of Obtaining the apical pulse for the administration of Obtaining the apical pulse for the administration of Obtaining the apical pulse for the administration of Obtaining the apical pulse for the administration of Obtaining the apical pulse for the administration of Obtaining the apical pulse for the administration of Obtain the apical pulse for the administration of Obtaining the apical pulse for		ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	(2) MULTIPLE CONSTRUCTION  BUILDING		(X3) DATE SURVEY COMPLETED	
STREET ADDRESS, DITY, STATE, ZIP CODE 514 HASTINGS LANE WARRENTON, VA 20186   WARRENTO			495267	B. WING	i			i
F 658 Continued From page 45 disorder, adjustment disorder, high blood pressure, atrial fibrillation, pulmonery edema, liver cirrhosis, and kidney failure. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 73/1/9 coded the resident as being moderately impaired in ability to make daily life decisions. The resident was coded as requiring limited assistance for dressing and supervision for all other areas of activities of daily living.  On 10/09/19 at 8:15 AM, LPN #1 (Licensed Practical Nurse) was observed preparing medications for administration to Resident #34. She obtained an apical pulse for Resident #34. She obtained the pulse for approximately 15 seconds. When asked what the resident's pulse was, LPN #1 stated 88. When asked if she took the resident #34 which included Digoxin (1) 0.25 mg (milligrams), 1 tablet.  On 10/9/19 at 3:11 PM, in an interview with LPN #1, when asked about the professional standard of practice for obtaining the apical pulse for the administration of Digoxin, LPN #1 stated, "4 when asked about the professional standard of practice for obtaining the apical pulse for the administration of Digoxin, LPN #1 stated, "4 when asked about the professional standard of practice for obtaining the apical pulse for the administration of Digoxin, LPN #1 stated, "4 when asked about the professional standard of practice for obtaining the apical pulse for the administration of Digoxin, LPN #1 stated, "4 when asked about the professional standard of practice for obtaining the apical pulse for the administration of Digoxin, LPN #1 stated, "4 when asked about the professional standard of practice for obtaining the apical pulse for the administration of Digoxin, LPN #1 stated, "4 when asked distorted the professional standard of practice for obtaining the apical pulse for the administration of Digoxin, LPN #1 stated, "4 when asked distorted the professional standard of practice for obtaining the apical pulse for the administration of Digoxin, LPN #1 stated, "4 when asked dated				STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE				
disorder, adjustment disorder, high blood pressure, atrial fibrillation, pulmonary edema, liver cirrhosis, and kidney failure. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 7/31/19 coded the resident as being moderately impaired in ability to make daily life decisions. The resident was coded as requiring limited assistance for dressing and supervision for all other areas of activities of daily living.  On 10/09/19 at 8:15 AM, LPN #1 (Licensed Practical Nurse) was observed preparing medications for administration to Resident #34. She obtained an apical pulse for Resident #34. She obtained an apical pulse for Resident #34. She obtained the pulse for approximately 15 seconds. When asked what the resident's pulse was, LPN #1 stated 88. When asked if she took the residents pulse for 15 seconds, obtained the number 22 and then multiplied by 4, LPN #1 stated, "yes." She was then observed preparing medications for Resident #34 which included Digoxin (1) 0.25 mg (milligrams), 1 tablet.  On 10/9/19 at 3:11 PM, in an interview with LPN #1, when asked how she took the apical pulse for Res #34 she stated, "I usually do 15 seconds and multiply it." When asked about the professional standard of practice for obtaining the apical pulse for the administration of Digoxin, LPN #1 stated, "A full minute." When asked if she followed	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLETION
the apical pulse for the administration of Digoxin to Resident #34, LPN #1 stated, "I did not."  A review of the drug information provided by the facility from their drug handbook, "Mosby's 2020 Nursing Drug Reference, Thirty-Third Edition" on	F 658	disorder, adjustme pressure, atrial fibroirrhosis, and kidn (Minimum Data Se Reference Date) of being moderately life decisions. The requiring limited as supervision for all living.  On 10/09/19 at 8:1 Practical Nurse) with medications for acceptanced an apical obtained the pulse When asked what #1 stated 88. Whis residents pulse for number 22 and the stated, "yes." She medications for Redications for Resident #34 she state multiply it." When standard of practifor the administrative redications for Redicational standard of practifor the administrative redications for Redicational standard of practifor the administrative redications for Redicational standard of practifor the administrative redications for Redicational standard of practifor the administrative redications for Redicational standard of practifor the administrative redications for Redicati	ant disorder, high blood rillation, pulmonary edema, liver ey failure. The quarterly MDS of) with an ARD (Assessment of 7/31/19 coded the resident as impaired in ability to make daily e resident was coded as esistance for dressing and other areas of activities of daily as observed preparing iministration to Resident #34. Any medications, LPN #1 pulse for Resident #34. She for approximately 15 seconds. The resident's pulse was, LPN en asked if she took the rational factor obtained the en multiplied by 4, LPN #1 was then observed preparing esident #34 which included any (milligrams), 1 tablet.  1 PM, in an interview with LPN ow she took the apical pulse for ed, "I usually do 15 seconds and asked about the professional ce for obtaining the apical pulse tion of Digoxin, LPN #1 stated, then asked if she followed dards of practice for obtaining or the administration of Digoxin LPN #1 stated, "I did not."		658	The DON or ADON Identified residents receiving digoxin for monitoring.  Additional directions will be act to digoxin orders to prompt the licensed nurse to listen to the apulse for one full minute.  III  The DON/ADON conducted reducation for licensed nurses regarding:  • the professional standard of obtaining an apical pulse prior administration of digoxin  • and medication pass principle Newly hired Licensed staff will receive this education during	future Ided e pical e- to	

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			riPLE NG	(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER BIDE REHAB & NURS		STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186				
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	Assess: Apical pulgiving product; if puadulttake again in call prescriber"  On 10/10/19 at 11:3 Staff Member) was When asked what practice the facility "Lippincott."  According to Funda Williams and Wilkin page 495, "The Apaccurate assessment of a facility of Care CFR(s): 483.25  § 483.25 Quality of Quality of Care CFR(s): 483.25  § 483.25 Quality of Quality of Care CFR(s): 483.25  § 483.25 Quality of Care CFR(s): 483.25  § 483.25 Quality of Care CFR(s): 483.25  § 483.25 Quality of Care CFR(s): 483.25  § 483.25 Quality of Care is a applies to all treatmost facility residents. Be assessment of a retain tresidents receased accordance with productive, the component of the co	nted, "Nursing Considerations. se for 1 min (minute) before alse <60 (less than 60) in 1 hr (hour); if <60 in adult, 33 AM, ASM #2 (Administrative made aware of the findings. professional standard of follows, ASM #2 stated, amentals of Nursing Lippincott as 2007, Lippincott Company, ical pulse provides the most ent of the pulse rate and is the never the peripheral pulses are or the pulse rhythm is minute."	F6		The DON/ADON or designee conduct random competency to flicensed nurses as they obtain apical pulses for digoxin/Lanor administration. Each nurse with have a competency test complet for this audit. Any discrepance noted during the audit will be addressed at that time with reeducation to the licensed nurse DON will submit results of the to the QAPI committee month its review and recommendation.  V The facility alleges compliance these tasks on or before 11/8/2  F 684  It is the practice of this facility ensure treatment and care in accordance with professional standards of practice and the person-centered care plan.  I Past non-compliance cannot be corrected for obtaining month weights on Resident # 38.	esting in xin all eted by e. The e audit ally for ns.	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED	
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F 684	review, and clinical determined that the treatment and care professional standa comprehensive per one of 49 residents Resident #38. The physician's order to monthly weights in The findings includ Resident #38 was a 8/20/13 and most r with diagnoses incl COPD (chronic obs (1), dementia with land heart failure. C (minimum data set an assessment referesident #38 was a cognitively impaired having scored ten cinterview for mental A review of the phy #38 revealed the formal monitor weight monitor weight monitor weight monitor review of Further review of Further review of F	record review, it was a facility staff failed to ensure in accordance with ards of practice, the son-centered care plan for in the survey sample, facility staff failed to follow the obtain Resident #38's August and September 2019.  e: admitted to the facility on ecently readmitted on 1/1/19 uding, but not limited to, structive pulmonary disease) behavioral disturbances (2) on the most recent MDS ), a an annual assessment with erence date of 7/30/19, coded as being moderately d for making daily decisions, out of 15 on the BIMS (brief all status).  esician's orders for Resident following order dated 8/1/19: fonthly."  tesident #38's clinical record	F 6	- 1	Weights will be obtained per MI order and recorded in the medic chart.  The DON / ADON will conduct audit of monthly weights to ident any weights not obtained per order any weights not obtained per order any weights not obtained per order and all complete an educational review for the Unit Managers and ADON to ensure are following up on staff obtaini weights on their units per MD of The DON/ADON will re-educate nursing staff via in servicing regarding obtaining weights as ordered.  Newly hired nursing staff will rethis education during orientation.	an atify der they ng rder.	
	for August and Sep A review of Reside plan dated 7/15/15 following: [Resider (related to) genera weaknessreside	nt #38's comprehensive care o revealed, in part, the at #38] is at nutritional risk r/t	The state of the s		RECEIN OCT 3 0 2 VDH/OI	ED 019 LC	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
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F 684	assistant) #2 was is responsible for oweights, CNA #2 s day shift. Sometimmonth."  On 10/9/19 at 4:19 nurse) #2 was interprocess for obtain LPN #2 stated, "TI shift. The list goes she gives them our make sure they go weights. I give the to follow up with the like to have them month. That way witime still left in the On 10/10/19 at 10 staff member) #1, the director of nur concerns.	eight monthly."  It p.m., CNA (certified nursing interviewed. When asked who obtaining residents' monthly tated, "Usually we do it on the lie around the first of the  It p.m., LPN (licensed practical erviewed. When asked the ling residents' monthly weights, hey are assigned to the day to the unit manager, and then it to the day shift nurses to be done."  It is a manager, and then it to the day shift nurses to be done."  It is a manager, and then it to the day shift nurses to be done. The nurses notify the CNAs to get the list to the nurses, who are then ne CNAs in their section. I would done by the 15th of each we can follow up with plenty of		684		ident ed lit or ee for	
	nonreversible lung combination of en bronchitis." Barro	eneral term for chronic, g disease that is usually a nphysema and chronic n's Dictionary of Medical Terms cal Reader, 5th edition,	The state of the s				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED C		
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F 684	Rothenberg and Ch (2) "Dementia is a charain function. This It affects memory, the and behavior." This website	gradual and permanent loss of occurs with certain diseases. thinking, language, judgment, information is taken from the gov/ency/article/000746.htm.l	F 6	84				
F 686 SS=D	tml Treatment/Svcs to CFR(s): 483.25(b)(  §483.25(b) Skin Int §483.25(b)(1) Pres Based on the compresident, the facility (i) A resident receive professional standard pressure ulcers and ulcers unless the indemonstrates that	tegrity	F 6	F 686 It is the practice of this factorized provide care and services treatment of pressure injustices.  I As indicated in the statem deficiency, the wound for is not a pressure ulcer (be classified as an arterial working caused from lack of circulting statements.	for the cries.  ment of Resident # 3 dsore) and is bound which is			
	necessary treatme with professional s promote healing, p new ulcers from de This REQUIREME by: Based on staff inte and clinical record the facility staff fail for the treatment o residents in the su facility staff failed t physician prescribe	nt and services, consistent tandards of practice, to revent infection and prevent		Past non-compliance for wound treatments cannot corrected. Failure to sign just a failure to sign the tradministration record an necessarily that the treatment completed.  The facility wound team is Resident # 3 on a weekly facility has hired a new w (RN) who will chair the wateam.	signing for the may indicate reatment d not nent was not is following basis. The ound nurse			

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	PROVIDER OR SUPPLIER	ING CENTER		61	TREET ADDRESS, CITY, STATE, ZIP CODE 14 HASTINGS LANE VARRENTON, VA 20186		
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F 686	4/11/18. Resident were not limited to pain and muscle we recent MDS (minimassessment with a date) of 9/30/19, coskills for daily decis impaired. Section having any pressur venous or arterial L. Resident #3's compaired. Section having any pressur venous or arterial L. Resident #3's compaired. Resident #3's compaired to Arterial potential for further mobility and incont. Review of Resident mote signed by the 3/6/19 that docume with an unstageableft heel measuring three centimeters in A physician's order "cleanse the left heapply betadine (2) foam (3) every day. Review of Residen (treatment administrates failed to reverse.	dmitted to the facility on #3's diagnoses included but high blood pressure, chest eakness. Resident #3's most num data set), a quarterly n ARD (assessment reference oded the resident's cognitive sion-making as severely M coded Resident #3 as not re injuries but as having one alcer.  Prehensive care plan dated of on 9/11/19 documented, actual skin impairment r/t wound of the left heel with impairment r/t decreased inence."  It #3's clinical record revealed a wound care physician on ented Resident #3 presented re deep tissue injury (1) on the patree centimeters in length by n width.  It dated 3/6/19 documented, sel with normal saline, pat dry, and cover with hydrocellular		586	II The DON/ADON/ Wound care nurse completed a facility wide sweep to identify if any resident skin areas that the facility was nalready aware of. No new areas concern were identified during audit.  III The DON / ADON has completeducation for licensed nurses of completion of wound care measurements weekly and documentation of completion of treatments.  Newly hired Licensed staff will receive this education during orientation	skin s had ot of the	

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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F 686	3/26/19, 3/29/19 or spaces instead of a initials). This treatr 4/1/19.  A physician's order apply skin prep (4) Review of Resident nurses' notes failed physician ordered to during the night shi order was disconting treatment order was a physician's order apply calcium algin cover with hydroce Review of Resident nurses' notes failed physician ordered to ordered/scheduled 5/30/19.  NOTE: This wound arterial wound by the May 2019.  On 10/9/29 at 4:51 conducted with RN was asked how the treatment has been "They would need treatment on the retime and initials on the TAR and dependent on what in the tark and dependent on what in the tark and dependent in the tark and tark	3/31/19 (as evidence by blank a check mark and nurses' ment was discontinued on dated 4/1/19 documented to to the left heel every shift.  It #3's April 2019 TAR and it to reveal evidence that the reatment was completed fit on 4/7/19. This treatment nued on 4/9/19 and another	F 6	The DON/ ADON will review of the treatment administration record completion, and docu residents with ordered treatments, daily 5 day for 2 weeks then twice weeks then weekly X 4 discrepancy noted dur will be corrected at the re-education will be p nurse to ensure under the need to sign for cotreatments.  V The facility alleges conthese tasks on or before	s to ensure mentation of wound ys per week, a week for 2 d. Any ring the audit at time and rovided to the estanding of ompleted	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING			(X3) DATE SURVEY COMPLETED	
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.,	PROVIDER OR SUPPLIER SIDE REHAB & NURS	ING CENTER		STREET ADDRESS, CITY, STATE, ZIP COL 614 HASTINGS LANE WARRENTON, VA 20186			
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F 686	had any pain. Whe signed off on the Trit's not signed off ye done."  On 10/10/19 at 10:: staff member) #1 (I (the director of nursabove concern.  The facility docume comprehensive as facility must ensure the facility without a develop a pressure clinical condition de unavoidable. 2. A sore receives nece to promote healing new sores from de completed per physical prominence of completed per physical prominence of device. The injury open ulcer and main as a result of intenior pressure in comtolerance of soft tis	en asked what a treatment not AR means, RN #2 stated, "If ou can't evidence that it's 52 a.m., ASM (administrative the administrator) and ASM #2 sing) were made aware of the ent titled, "Skin System anted, "Based on the sessment of a resident, the entat: 1. Residents who enter a pressure sore will not a sore unless the individual's emonstrates it was resident having a pressure assary treatment and services, prevent infection and prevent veloping9. Dressings will be		86			
	perfusion, co-mort tissue.  Deep Tissue Press	sure Injury: Persistent ep red, maroon or purple	A CONTRACTOR OF THE CONTRACTOR				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	L'''	FIPLE CONSTRUCTION		CX3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG	K (EACH COF	ER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD ERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	discoloration Intact localized area of pered, maroon, purple separation revealin filled blister. Pain a precede skin color appear differently in injury results from pressure and sheal interface. The would the actual extent of without tissue loss, subcutaneous tissue muscle or other unthis indicates a full (Unstageable, Stage DTP) to describe vineuropathic, or deinformation was obtitips://cdn.ymaws.ce/resmgr/npuap_s://www.ncbi.nlm.n.  (2) "Betadine (Povantiseptic that provagainst a variety of scrapes, and burns obtained from the color of the colo	or non-intact skin with persistent non-blanchable deep ediscoloration or epidermal ga dark wound bed or blood and temperature change often changes. Discoloration may not darkly pigmented skin. This intense and/or prolonged or forces at the bone-muscle and may evolve rapidly to reveal the tissue injury, or may resolve. If necrotic tissue, are, granulation tissue, fascia, derlying structures are visible, thickness pressure injury ge 3 or Stage 4). Do not use ascular, traumatic, matologic conditions." This obtained from the website: com/npuap.site-ym.com/resour pressure_injury_stages.pdfhttp.iih.gov/pubmed/20081568 idone-iodine) is a topical vides infection protection of germs for minor cuts, s." This information was website: https://betadine.com/oram is a dressing used to treat rmation was obtained from the lm.nih.gov/pubmed/20081568  Image: This information describes the lim.nih.gov/pubmed/20081568  Image: This information describes the lim.nih.gov/pubmed/20081568  Image: This information describes the lim.nih.gov/pubmed/20081568  Image: This information describes to help preserve sking and films." This information		86	REC! OCT 3	0 2019 ULC	

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F 686	Continued From pa	-	F6	686			
	hew-skin-prep.asp)	rkin.com//p-869-smith-and-nep c?gclid=EAlalQobChMl35qLrb cG7EAQYAiABEgK1DPD_BwE					
	This information wa	e is used to treat wounds. as obtained from the website: m.nih.gov/pmc/articles/PMC45	**************************************				
F 689 SS=D	,	azards/Supervision/Devices 1)(2)	Fe	F 689			
	as free of accident §483.25(d)(2)Each supervision and as accidents. This REQUIREME by: Based on staff inte and clinical record the facility staff faile a fall intervention pplan to ensure a saresidents in the sure (6/24/19, Resident resident's compret to explore a toiletin failed to implement resident sustained 7/4/19 and 7/10/19 The findings include Resident #3 was a	resident environment remains hazards as is possible; and resident receives adequate sistance devices to prevent NT is not met as evidenced erview, facility document review review, it was determined that ed to ensure implementation of the comprehensive care afe environment for one of 49 rivey sample, Resident #3. On #3 sustained a fall and the thensive care plan was revised as program. The facility staff this intervention and the three more falls on 7/1/19, i.		Resident # 3 was assessed on 10/10/19 and a toileting progis not indicated due to sever cognitive impairment. Her or plan has been updated accordingly.  Resident #3 did not have an injury related to the falls on 7/1/19, 7/4/19 or 7/10/19. To is nothing to show a correlate between the toileting program and subsequent falls.	gram e are here ion		
		#3's diagnoses included but					

INDUSTRICATION INCOME.	) MULTIPLE CONSTRUCTION BUILDING	(X3) DATE SURVEY COMPLETED C
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NAME OF PROVIDER OR SUPPLIER BROOKSIDE REHAB & NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIF 614 HASTINGS LANE WARRENTON, VA 20186	
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were not limited to high blood pressure, chest pain and muscle weakness. Resident #3's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 9/30/19, coded the resident's cognitive skills for daily decision making as severely impaired. Section J coded Resident #3 as not sustaining any falls since the prior assessment.  Review of Resident #3's clinical record and fall investigations revealed that on 6/24/19 the resident slid out of bed and reported that she had to use the bathroom. No injury was sustained. Resident #3's comprehensive care plan dated 4/17/18 and revised on 6/24/19 documented, "FALLS: (Resident #3) is at risk for fallsexplore toileting program before and after meals and at bed times as resident will allow"  Further review of Resident #3's clinical record failed to reveal a bowel and bladder assessment after 6/24/19 and failed to reveal any evidence that a toileting program had been explored and or implemented after 6/24/19. Resident #3 sustained other falls with no injuries on 7/1/19, 7/4/19 and 7/10/19.  On 10/9/19 at 4:51 p.m., an interview was conducted with RN (registered nurse) #2 regarding falls and care plans. RN #2 stated a resident's care plan should be reviewed and revised after each fall. RN #2 stated the revision should include the date of the fall, the time of the fall, and any new interventions that will be implemented for the resident. RN #2 stated IDT (interdisciplinary team) meetings are conducted after each fall. RN #2 stated the team discusses the new intervention and updates the care plan. RN #2 was asked to explain the facility process	The Assistant DON will audit of resident care printerventions to identify no longer indicated. A discrepancy with the accorrected at that time would find the care plan.  Care Plan intervention be discussed in morning meeting to determine appropriateness.  III  The DON/ADON will nursing staff via in servegarding obtaining wordered and updating following care plan into Newly hired nursing staff via this education during the server of the care plan into Newly hired nursing staff via in servegarding obtaining wordered and updating following care plan into Newly hired nursing staff via the server of the care plan into Newly hired nursing staff via in servegarding obtaining wordered and updating following care plan into Newly hired nursing staff via in server or the care plan into Newly hired nursing staff via in servegarding obtaining wordered and updating following care plan into Newly hired nursing staff via in servegarding obtaining wordered and updating following care plan into Newly hired nursing staff via in servegarding obtaining wordered and updating following care plan into Newly hired nursing staff via in servegarding obtaining wordered and updating following care plan into Newly hired nursing staff via in servegarding obtaining wordered and updating following care plan into Newly hired nursing staff via in servegarding obtaining wordered and updating following care plan into Newly hired nursing staff via in servegarding obtaining wordered and updating following care plan into Newly hired nursing staff via in servegarding obtaining wordered and updating following care plan into Newly hired nursing staff via in servegarding obtaining wordered and updating following care plan into Newly hired nursing staff via in servegarding obtaining wordered and updating following care plan into Newly hired nursing staff via in servegarding obtaining wordered and updating following care plan into Newly hired nursing staff via in servegarding obtaining wordered and updating following care plan into Newly hired nursing staf	lan fy any that are ny udit will be with revision s post fall will ng IDT  re-educate vicing eights as / revising and erventions. taff will receive

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	PROVIDER OR SUPPLIER	ING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186		
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F 689	programs include resident every two evidences that a to completed, RN #2 should appear on assistant) charting toileting was attem amount of urine an On 10/9/19 at 6:02 staff member) #1 (the director of nurregional vice presidabove concern.  The facility policy ti documented, "Morin long term care fadiagnosed condition more than one conrisk. Many of these but relief of symptotaspects may have mobility. Solutions Ambulation: Evaluarestlessness (bladdiscomfort, hunger	ns. RN #2 stated toileting bounding and toileting a hours. When asked how staff ileting program is being stated the toileting program CNA (certified nursing and should document that pted every two hours, the diff the toileting was effective.  p.m., ASM (administrative the administrator), ASM #2 sing) and ASM #3 (the clinical dent) were made aware of the titled, "Fall Prevention" acilities are related to medically ns and many residents have dition that would put them at a conditions are not curable, oms or treatment of reversible significant impact on functional to Prevent Unsafe Transfer or ate and treat causes of motor der or bowel urgency,	F 68	The DON/ADON will conduct audit of interventions post reside fall to ensure the intervention has been implemented. This audit we take place, as soon as possible by the latest, on the next business of following the fall. The audit will an ongoing audit as part of the clinical meeting and fall reviewed discrepancy noted during the away will be corrected at that time. Roof the audit will be submitted by DON or ADON to the QAPI committee for its review and recommendations monthly.  V The facility alleges compliance these tasks on or before 11/8/20	lent as vill ut at day ll be AM Any udit esults y the	
	facility did not have programs.	e a policy regarding toileting				
F 730 SS=C	Nurse Aide Peform	tion was presented prior to exit. n Review-12 hr/yr In-Service (7)	F 73	F 730 It is the practice of this facility have C N A's complete 12 hou	I 3	
	§483.35(d)(7) Reg	ular in-service education.		annual training.	10 01	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING			(X3) DATE SURVEY COMPLETED C	
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F 730	of every nurse aide months, and must peducation based or reviews. In-service requirements of §4 This REQUIREMED by:  Based on staff intered and employee recent that the facility staff out of 5 employee [certified nursing as and CNA #7), received annual training.  The findings included On 10/10/19 at apport the training reconsuring Assistants following was noted. CNA #4 did not he annual training. On as tracked in the esystem. Additional paper and had not and tracked.  - CNA #5 did not he any of the 12 hours documented and tracked and tracked and tracked and second associated and tracked and second associated and tracked an	at least once every 12 provide regular in-service in the outcome of these is training must comply with the 83.95(g).  NT is not met as evidenced inview, facility document review and review, it was determined if failed to evidence that four records reviewed, (CNA esistant] #4, CNA #5, CNA #6 wed the required 12 hours of the it: ave the required 12 hours of all y 9.5 hours was documented itectronic training and education iterating provided were on documented hours associated ave documented evidence of s of annual trainings racked in the electronic training term. Any trainings provided I had no documented hours cked.	F 7	30	The employees affected by the deficient practice will complete required education hours however past non-compliance for the primonths cannot be corrected. The hours of education will be associated and tracked on a perstracking form for each employed the SDC or DON/ADON.  II  The HR director or Staff development of C N A's to identify any employees not in regulatory compliance with the 12 hours or required training. Any discrepain the audit will be corrected with additional hours of education be provided to those employees. Training may be completed by didactic education, via seminars via computer-based trainings.	or 12 conal conal coment % funcy th eing	
	annual training. O	ave the required 12 hours of nly 30 minutes was racked in the electronic training					

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F 730	and education syst were on paper and associated and trace.  - CNA #7 did not he any of the 12 hours documented and traced and education syst were on paper and associated and traced CO 10/10/19 at 9:3 OSM #5 (Other Stateman Resources trainings, OSM #5 set them up in (the education system) to do. Then it is up When asked who	em. Any trainings provided had no documented hours cked.  ave documented evidence of s of annual trainings acked in the electronic training em. Any trainings provided had no documented hours cked.  9 AM, in an interview with aff Member) the Director of s, when asked about the above stated, "When they are hired I electronic training and and tell them what they need to to them to do the modules. follows up to ensure what is	F 73	The DON or ADON or staff development coordinator we provide education to facility aides on the 12 hour /annual education requirement to regulatory compliance to include abuse prevention training and dementia training.  Newly hired C N A staff will this education during orient IV  The Administrator or design conduct monthly audits of education sign in sheets, to education sign in sheets, to the staff of the conduct monthly audits of education sign in sheets, to the staff of the staf	nursing l main in clude nd receive ation.		
	When asked who follows up to ensure what is supposed to be done is completed, OSM #5 stated, "They should go on once a month and do what they have to do. It is their responsibility to complete and to check monthly." When asked who is responsible for monitoring, supervising and tracking that the trainings are being completed, OSM #5 stated, "Managers were supposed to be responsible to ensure that it was being done. They have access to see all of their staff in the system. We have had change over. I guess we need to implement department heads to check." A policy on the required trainings was requested at this time.  On 10/10/19 at 10:40 AM, OSM #5 provided a page from the employee handbook, page 44, which documented, "Learning Requirements: All staff members must attend New Employee Orientation, department orientation, job specific			compliance is met and mair Any discrepancy noted duri audit will be addressed with individual employee. Resul audit will be submitted to the committee by the NHA or Smonthly, for its review and recommendations.  V The facility alleges compliant these tasks on or before 11/2	tained. ing the the ts of the te QAPI DC  ace of 8/2019.		

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NAME OF PROVIDER OR SUPPLIER BROOKSIDE REHAB & NURS	ING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186				
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for all approved co training."  On 10/10/19 at 1:0 Staff Member) the the findings. When regarding required ASM #1 stated tha page from the empinformation was proposed from Unnec FCFR(s): 483.45(c)(3) A particles brain activity processes and below the are not limited categories: (i) Anti-psychotic; (ii) Anti-depressant (iii) Anti-anxiety; and (iv) Hypnotic  Based on a compute resident, the facility \$483.45(e)(1) Responder of the medical specific condition in the clinical recolumn.	mployees will be compensated mpany-specific required  3 PM, ASM #1 (Administrative Administrator, was notified of a sked about a policy staff education and training, there was no policy, just the ployee handbook. No further rovided by the end of the Psychotropic Meds/PRN Use (3)(e)(1)-(5)  ptropic Drugs. Expenditure of the properties associated with mental havior. These drugs include, to, drugs in the following  at;  and  trehensive assessment of a symust ensure that  sidents who have not used are not given these drugs as diagnosed and documented	Martin Alexandra Communication	F 758 It is the practice of this facility ensure that residents remain tun-necessary drugs  I A stop date for the Lorazepar Resident #63 was obtained.  II The DON/ADON or Social S staff completed a review of P psychotropic medications to any that exceed the 14-day rureview by the physician. Any psychotropic medications will 14- day end date, was brough attention of the attending Mireview.	ervices RN identify le for PRN thout a t to the		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED C	
		495267	B. WING	ì		1	10/2019
NAME OF F	PROVIDER OR SUPPLIER			S.	TREET ADDRESS, CITY, STATE, ZIP CODE		
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BHOOKS	SIDE REHAB & NURS	oing center		W	/ARRENTON, VA 20186		
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F 758	Continued From pa	age 60	F	758	III		
	contraindicated, in	an effort to discontinue these		İ	The DON/ADON /SDC /desig	nee	
	drugs;				completed educational review		
					regulation regarding PRN		
	§483.45(e)(3) Res	idents do not receive				tha	
		s pursuant to a PRN order ation is necessary to treat a			psychotropic medications with licensed nurses.	LIIC	
		condition that is documented					
	in the clinical recor				Newly hired Licensed staff will		
			ļ		receive this education during		
		orders for psychotropic drugs			orientation.		
		ays. Except as provided in					
		e attending physician or oner believes that it is			IV		
	prescribing practiti	PRN order to be extended	ļ		Orders for new psychotropic		
		e or she should document their			medications will be reviewed o	laily 5	
	rationale in the res	ident's medical record and	]		days per week in the daily IDT		
	indicate the duration	on for the PRN order.			meeting to ensure there is an e		
	0 (=0 45(-)(5) DD)	1 mala na fan mast manakasta			date for any new PRN psychot		
		N orders for anti-psychotic o 14 days and cannot be			medications or that the MD ha		
		e attending physician or					
		ioner evaluates the resident for			approved the medication to go	,	
	the appropriatenes	ss of that medication.			beyond the 14 days. Any	.11	
		NT is not met as evidenced			discrepancy noted in the audit		
	by:				be corrected at that time. Resu		
		erview, facility document review I review, it was determined that			the audit will be submitted to		
		led to ensure a resident			QAPI committee for its review	and /	
		innecessary medication for one	1		recommendations.		
		the survey sample, Resident	1				
		was prescribed lorazepam			V		
		7/19 with no stop date. The	İ		The facility alleges compliance	e of	
		to ensure the physician luation for the continued use of	ŀ		these tasks on or before 11/8/2		
		eyond 14 days and failed to			these tasks on or before 11/0/2	.517.	1
		ian documented the					
		of the continued use of the					
		ation for the use of the					
I	medication.		1		1		1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	IPLE CONSTRUCTION	(X:	(X3) DATE SURVEY COMPLETED			
				10/10/201	9			
		PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 614 HASTINGS LANE WARRENTON, VA 20186			
	(X4) ID PREFIX TAG	(EACH DEFICIENT	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE		ETION
	F 758	11/16/17. Reside were not limited to and difficulty swal recent MDS (mini assessment with date) of 8/20/19, oskills for daily decimpaired. Section having received a of the last seven of the la	de:  admitted to the facility on the #63's diagnoses included but to heart failure, mood disorder lowing. Resident #63's most mum data set), a quarterly an ARD (assessment reference coded the resident's cognitive ision-making as severely in N coded Resident #63 as inti-anxiety medication seven out days.  Int #63's clinical record revealed or dated 7/8/19 for Hospice review of Resident #63's realed a physician's order dated parm solution, two into the mouth of the mouth		58			
		lorazepam solution continued use of the as needed or Resident #63's continued to the solution of the solution	ted for the continued use of con, the appropriateness for the the medication or a duration for der.  comprehensive care plan dated inted, "PSYCHOTROPIC"		Source incompany and the control of		the matter that annual flavor - of	

	FEMENT OF DEFICIENCIES PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		495267	B. WING			1	0/2019	
	PROVIDER OR SUPPLIER			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 PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 758	MEDICATIONS: (F psychotropic medications as ord with pharmacy, MI dosage reduction least quarterly"  On 10/9/19 at 5:16 was conducted with member) #5 (Resi was asked about to prescribing as needed anti-anxied will write an as needed anti-anxied will write an as needed anti-anxied will write an as needed anti-anxied will write an as needed anti-anxied will write an as needed anti-anxied will write an as needed anti-anxied will write an as needed anti-anxied residents and	Resident #63) uses cations r/t (related to) mood ant disorder, Behavior minister PSYCHOTROPIC dered by physician. Consult D (medical doctor) to consider when clinically appropriate at D p.m., a telephone interview th ASM (administrative staff dent #63's physician). ASM #5 he facility process for aded anti-anxiety medication. Tries to avoid prescribing as the medication but sometimes he edd order for less than 14 the diff the order must be ments a note to explain why. The metimes he must prescribe as the medication for psychiatric dents receiving hospice. ASM the hospice patients are ort measures from hospice. The has explained the protocol for edd anti-anxiety medications to anies but sometimes they do mical record failed to contain a hospice physician regarding azepam solution.  2 p.m., ASM #1 (the SM #2 (the director of nursing) clinical regional vice president) of the above concern.		758				

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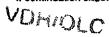
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		495267	B. WING		A STATE OF THE STA	10/10/2019		
	PROVIDER OR SUPPLIER	ING CENTER		614	REET ADDRESS, CITY, STATE, ZIP CODE I HASTINGS LANE ARRENTON, VA 20186			
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F 761 SS=E	Standard of Practic (as needed) Order: medications, excluing the property of t	bychoactive Medication Review be documented, "Type of PRN PRN orders for psychotropic ding antipsychotics. Time Exception: Order may be 4 days if the attending ibing practitioner believes is not the orders. Required hysician or practitioner should nale for the extended time had record and indicate a dion was presented prior to exit. The state of medications called the works by slowing activity in or relaxation." This information the website:		761	F 761 It is the practice of this facility tand store medications according professional standards of practice.  I The Unit Manager disposed of bottles of Ativan found in the Medication room refrigerator.  REC.	ng to ice. both		
l						<u> </u>	<u> </u>	

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

Event ID:R1V111

Facility ID: VA0178

If continuation wheet Page 64 of 76



AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING		ON	(X3) DATE SURVEY COMPLETED			
	495267	B. WING _		±	10/10/	2019
PROVIDER OR SUPPLIER	ING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186				
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supersture control personnel to have a supersonnel to have a super	als, and permit only authorized access to the keys.  facility must provide separately by affixed compartments for ad drugs listed in Schedule II of an other drugs subject to and other drugs subject to an the facility uses single unit ibution systems in which the minimal and a missing dose can l.  NT is not met as evidenced ation, staff interview and facility it was determined that the lo label and store medication assional standards for one of trage rooms, the south unit, a room. The facility staff failed ottle of lorazepam intensol (1) and one open bottle of I per manufacturer's		Licensed s when open that a med expiration administra  The DON education licensed st requirement medication opening, of on medica use and di expired. N will receiv	ned and verify before dication has not reach date before ation.  III  //ADON /SDC will provide the dependent of dating multidate on bottles/vials when checking the expiration before use, and disposal of medication bewly hired Licensed on the ethic education during this education during the expiration before use, and disposal of medication bewly hired Licensed on the ethic education during the ethic education during the expiration of the ethic education during the ethic education during the ethic education during the ethic education during the expiration during the expiration during the ethic education during the ethic education during the expiration during the ethic education during the edu	ovide ne on date not to if it is staff	
On 10/8/19 at 2:06 unit, medication st conducted with LP The following was -One open bottle clabeled open date dateOne open bottle clabeled with an open bottle clabeled with a clabeled wi	is p.m., observation of the south orage-room refrigerator was N (licensed practical nurse) #3. observed: of lorazepam intensol with no or labeled modified expiration of lorazepam intensol that was en date of 6/4/19.					
	PROVIDER OR SUPPLIER SIDE REHAB & NURS  SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE  Continued From patemperature control personnel to have a §483.45(h)(2) The locked, permanent storage of controlle the Comprehensive Control Act of 1976 abuse, except whe package drug distr quantity stored is n be readily detected This REQUIREME by: Based on observat document review, i facility staff failed to according to profest two medication storage to label an open bo and failed to discal lorazepam intenso instructions in the room.  The findings include On 10/8/19 at 2:06 unit, medication st conducted with LP The following was One open bottle of labeled open date date. One open bottle of labeled with an op The manufacturer	PROVIDER OR SUPPLIER  SIDE REHAB & NURSING CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 64 temperature controls, and permit only authorized personnel to have access to the keys.  §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.  This REQUIREMENT is not met as evidenced by:  Based on observation, staff interview and facility document review, it was determined that the facility staff failed to label and store medication according to professional standards for one of two medication storage rooms, the south unit, medication storage room. The facility staff failed to label an open bottle of lorazepam intensol (1) and failed to discard one open bottle of lorazepam intensol per manufacturer's instructions in the south unit, medication storage room.  The findings include:  On 10/8/19 at 2:06 p.m., observation of the south unit, medication storage-room refrigerator was conducted with LPN (licensed practical nurse) #3. The following was observed:  -One open bottle of lorazepam intensol with no labeled open date or labeled modified expiration	PROVIDER OR SUPPLIER  SIDE REHAB & NURSING CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 64 temperature controls, and permit only authorized personnel to have access to the keys.  §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.  This REQUIREMENT is not met as evidenced by:  Based on observation, staff interview and facility document review, it was determined that the facility staff failed to label and store medication according to professional standards for one of two medication storage rooms, the south unit, medication storage room. The facility staff failed to label an open bottle of lorazepam intensol (1) and failed to discard one open bottle of lorazepam intensol for manufacturer's instructions in the south unit, medication storage room.  The findings include:  On 10/8/19 at 2:06 p.m., observation of the south unit, medication storage-room refrigerator was conducted with LPN (licensed practical nurse) #3. The following was observed:  One open bottle of lorazepam intensol with no labeled open date or labeled modified expiration date.  One open bottle of lorazepam intensol with no labeled with an open date of 6/4/19. The manufacturer's boxes containing the bottles	PROVIDER OR SUPPLIER  SIDE REHAB & NURSING CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 64 temperature controls, and permit only authorized personnel to have access to the keys.  \$483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.  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On 10/8/19 at 2:06 p.m., observation of the south unit, medication storage-room refrigerator was conducted with LPN (licensed practical nurse) #3. The following was observed:  One open bottle of lorazepam intensol with no labeled open date or labeled modified expiration date.  One open bottle of lorazepam intensol that was labeled with an open date of 6/4/19. The manufacturer's boxes containing the bottles	SUMMARY STATEMENT OF DEFICIENCIES (SPANSARY TRANSPORTED TO THE APPROPRIATE TO PROVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCIES (SPANSARY STATEMENT OF DEFICIENCIES) (SPANSARY STATEMENT OF DEFICIENCIES) (SPANSARY STATEMENT OF DEFICIENCIES) (SPANSARY STATEMENT OF DEFICIENCIES) (SPANSARY STATEMENT OF DEFICIENCIES) (SPANSARY STATEMENT OF DEFICIENCIES) (SPANSARY STATEMENT OF DEFICIENCIES) (SPANSARY STATEMENT OF DEFICIENCIES) (SPANSARY STATEMENT OF DEFICIENCIES) (SPANSARY STATEMENT OF DEFICIENCY)  Continued From page 64  temperature controls, and permit only authorized personnel to have access to the keys.  §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.  This REQUIREMENT is not met as evidenced by:  Based on observation, staff interview and facility document review, it was determined that the facility staff falled to label and store medication according to professional standards for one of two medication storage rooms, the south unit, medication storage rooms, the south unit, medication storage rooms, the south unit, medication storage rooms, the south unit, medication storage room the remultacturer's instructions in the south unit, medication storage room refrigerator was conducted with LPN (licensed practical nurse) #3.  The following was observed:  On 10/8/19 at 2:06 p.m., observation of the south unit, medication storage-room refrigerator was conducted with LPN (licensed practical nurse) #3.  The following was observed: One open bottle of lorazepam intensol with no labeled open date or labeled modified expiration date. One open bottle of lorazepam intensol that was labeled with an open date of 6/4/19.  The manufacturer's boxes containing the bottles	A SULDING

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
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NAME OF PROVIDER OR SUPPLIER BROOKSIDE REHAB & NURS	ING CENTER		61	TREET ADDRESS, CITY, STATE, ZIP CODE 14 HASTINGS LANE VARRENTON, VA 20186		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
At this time, an inte #3. LPN #3 was as for labeling lorazep "Label them with th my initials so they k When asked why, I know when it was o expires." LPN #3 v intensol has a mod opened. LPN #3 si one. LPN #3 was s for lorazepam inter open bottle of loraz open date or labele should have been I open bottle of loraz open date of 6/4/19  The manufacturer's intensol documente after 90 days."  On 10/9/19 at 6:02 staff member) #1 ( (the director of nur regional vice presid above concern.  The facility/pharma STORAGE IN THE "Expiration Dating: package typesor expiration date sho expiration date to i potencyF. When manufacturer's col	age 65 after being opened. Inview was conducted with LPN sked about the facility process am intensol. LPN #3 stated, he day we open them and put know I'm the one who did it." LPN #3 stated, "That way they opened and how long until it was asked if lorazepam iffied expiration date after being tated she was not aware of shown the manufacturer's box host. LPN #3 confirmed the repam intensol with no labeled ad modified expiration date abeled when opened and the repam intensol labeled with an obshould have been discarded.  Is instructions for lorazepam hed, "Discard opened bottle in p.m., ASM (administrative the administrator), ASM #2 sing) and ASM #3 (the clinical dent) were made aware of the p. Certain medications or ince opened, require an orter than the manufacturer's insure medication purity and the original seal of a intainer or vial is initially broken, at will be dated. The nurse			IV The charge nurses will monitor to storage of medication to ensure multi -dose medications are date when opened and disposed of as indicated. The Unit Managers/Supervisors/DON or ADON/designee will complete random audits of the Medication rooms, Medication of and treatment carts to ensure the medications are dated when operand discarded if out of date. This audit will be conducted week for 8 weeks, then randomly. And discrepancy noted in the audit will be corrected at that time. Results of the audit will be submitted, by the DON, to the Committee for its review and recommendations monthly.  V The facility alleges compliance of these tasks on or before 11/8/20	carts at ned ekly vill	

	OF DEFICIENCIES F CORRECTION				COMPLETED	
		495267	B. WING _		C 10/10/2019	
	PROVIDER OR SUPPLIER	ING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186		
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F 761 F 842 SS=D	medication and ent new date of expiration date administering it. H. administered to a medications will be supply and destroy.  No further informat:  (1) Lorazepam inte This information we https://medlineplus.tml  Resident Records CFR(s): 483.20(f)(5)  §483.20(f)(5) Resid (i) A facility may no resident-identifiable (ii) The facility may resident-identifiable accordance with a agrees not to use cexcept to the extert to do so.  §483.70(i) Medical §483.70(i)(1) In accordance with a agrees not to use of except to the extert to do so.  §483.70(i) Medical §483.70(i)(1) In accordance with a agrees not to use of except to the extert to do so.  §483.70(i) Medical §483.70(i)(1) In accordance with a agrees not to use of except to the extert to do so.	er the date opened and/or the ionG. The nurse will check of each medication before. No expired medication will be esident. I. All expired removed from the active ed in the facility"  ion was presented prior to exit. Insol is used to treat anxiety. It is obtained from the website: Insol is used to treat anxiety. It is obtained from the website: Insol is used to treat anxiety. Insol is used to treat anxiety	F 76	E 042	ate sfer	
	§483.70(i)(2) The f	lacility must keep confidential				

NAME OF PROVIDER OR SUPPLIER  BROOKSIDE REHAB & NURSING CENTER    CALL   DEPCISE   SUMMARY STATEMENT OF DEFICIENCIES   PREFIX   REQULATORY OR LSC IDENTIFYING INFORMATION)	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE A. BUILDING		1		SURVEY PLETED
NAME OF PROVIDER OR SUPPLIER  BROOKSIDE REHAB & NURSING CENTER    SUMMARY STATEMENT OF DEFICIENCIES (REGULATION) VA 20188   SUMMARY STATEMENT OF DEFICIENCIES (REGULATION) OR LOS DENTIFYING INFORMATION)			495967	B. WING				
BROOKSIDE REHAB & NURSING CENTER    CAPID   SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRIEW)   TAG   CONTINUED FOR INCIDENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   TAG   CROSS-REFERENCE TO THE APPROPRIATE DATE OF THE APPROPRIATE DATE OF THE APPROPRIATE DEFICIENCY)    F 842   Continued From page 67 all information contained in the resident's records, regardless of the form or storage method of the records, except when release is— (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.    §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.    §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (iii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law.    §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services				L D. WARE		TOSET ANDDESS CITY STATE 710 CORE	1 10/1	10/2019
DOAJ ID CACH DE REHAB & NURSING CENTER  DOAJ ID CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 842  Continued From page 67 all information contained in the resident's records, regardless of the form or storage method of the records, except when release is (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, or pan donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.  § 483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.  § 483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (iii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law.  § 483.70(i)(5) The medical record must contain-(i) Sufficient information to identify the resident; (iii) A record of the resident's assessments; (iii) The comprehensive plan of care and services	NAME OF I	PROVIDER OR SUPPLIER						ļ
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provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;  OCT 3 0 2019 VDH/OLC	F 842	all information corregardless of the records, except w (i) To the individual representative who (ii) Required by La (iii) For treatment, operations, as perwith 45 CFR 164.4 (iv) For public hean eglect, or domes activities, judicial law enforcement purposes, research medical examiner a serious threat to by and in complial §483.70(i)(3) The record information unauthorized use. §483.70(i)(4) Medion-(i) The period of till (ii) Five years from there is no require (iii) For a minor, 3 legal age under Season endormation (iii) A record of the (iii) The comprehen provided; (iv) The results of and resident reviewed.	ntained in the resident's records, form or storage method of the hen release isla, or their resident ere permitted by applicable law; aw; payment, or health care mitted by and in compliance 506; alth activities, reporting of abuse, and administrative proceedings, burposes, organ donation on the purposes, or to coroners, so funeral directors, and to avert to health or safety as permitted nagainst loss, destruction, or against loss, destruction, or the date of discharge when ement in State law; or a tyears after a resident reaches state law.  I medical record must containment on to identify the resident; a resident's assessments; ensive plan of care and services any preadmission screening ew evaluations and		842	The DON/ADON/designee conducted an audit of resident transfers over the previous 3 m to identify areas of noncomplia upon transfer. Any discrepance cannot be corrected but will be as a teaching tool for licensed staff will utilize a resident transfer checklist to ensure compliance with transfer and documentation guidelines. The Nursing supervisor will sign of its completion at the time of transfer and documentation at the time of transfer and documentation requirements to include use of transfer to hospital checklist. Newly hired Licensed staff will receive this education during orientation.	nce y used taff. lent e f on ansfer. the	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIEF/CLIA IDENTIFICATION NUMBER:	' '	riple construction NG		MPLETED
		495267	B. WING		1 10	C 0/10/2019
	PROVIDER OR SUPPLIER BIDE REHAB & NURS	ING CENTER		STREET ADDRESS, CITY, STATE, 614 HASTINGS LANE WARRENTON, VA 20186		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AI CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE THE APPROPRIATE	(XS) COMPLETION DATE
F 842	professional's prog (vi) Laboratory, rad services reports as This REQUIREMEI by: Based on staff intereview, it was deter failed to maintain a record for one of 45 sample, Resident 45 failed to include a p	se's, and other licensed ress notes; and iology and other diagnostic required under §483.50.  NT is not met as evidenced erview and clinical record rmined that the facility staff complete and accurate clinical residents in the survey \$100 and \$73. The facility staff progress note regarding ansfer to the hospital on 9/5/19 nical record.	F8	The DON/ADON or review the transfer cl next business day, du meeting to ensure co the required docume transfer. Once review will be added to the record. Any discrepa audit will be correcte Results of the audit when the DON monthly committee for its review recommendations.	hecklist, on the uring the IDT ompliance with entation on wed the checklist resident medical ancy noted in the ed at that time. will be submitted by, to the QAPI	
	6/1/18 and most rewith diagnoses incorebral palsy (1) a disease) (2). On the data set), a, a sign with an assessment Resident #100 was communication different cognitively intact for having scored 15 conterview for mental A review of Resident revealed the follow 9/13/19: "Resident [name of hospital], initiation of dialysis (abdomen) soft and	s admitted to the facility on cently readmitted on 9/13/19 luding, but not limited to, and ESRD (end stage renal e most recent MDS (minimum nificant change assessment nt reference date of 9/20/19, s coded as having no ficulties, and as being or making daily decisions, but of 15 on the BIMS (brief al status.  ent #100's clinical record ving progress note, dated a arrived via stretcher from Readmission following (3)Lungs sound clear, abd d bowel sounds active."		The facility alleges of these tasks on or bef	-	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
		495267	B. WING	B. WING			0/2019
,	PROVIDER OR SUPPLIER	ING CENTER		61	TREET ADDRESS, CITY, STATE, ZIP CODE 14 HASTINGS LANE /ARRENTON, VA 20186		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC 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 842	regarding Resident to the hospital.  On 10/9/19 at 4:19 nurse) #2 was inter #100 had been dire 9/5/19 so that dialy asked about the pr regarding a resider LPN #2 stated, "Ye of the patient should not be hospital should note." When asked #1 stated, "The chastory."  On 10/10/19 at 10:	ion in the progress notes #100's transfer and admission p.m., LPN (licensed practical rviewed. She stated Resident ectly admitted to the hospital on sis could be started. When ocess for writing a note not's transfer to the hospital, is, the nurse who is taking care ld write the note."  9 a.m., RN #1, the unit rviewed. When asked if the of a patient who is transferred uld write a note, RN #1 stated, things have to be done. After one, the nurse should write a d why this note is important, RN art should tell the resident's	F	342			
	the director of nurs concerns.	the administrator, and ASM #2, sing), were informed of these					
F 880 SS≔D	Infection Prevention CFR(s): 483.80(a) §483.80 Infection 0 The facility must e infection prevention designed to provide	ention & Control O(a)(1)(2)(4)(e)(f)  It is the practice of this food in a sanitary mann dining room.  It is the practice of this food in a sanitary mann dining room.		food in a sanitary manner in the			
		transmission of communicable					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495267	B. WING			10/1	0/2019
NAME OF PROVIDER OR SUPPLIER					REET ADDRESS, CITY, STATE, ZIP CODE	10/1	0/2019
NAME OF F	PROVIDER OR SUPPLIER				4 HASTINGS LANE		
BROOKS	IDE REHAB & NURS	ING CENTER			ARRENTON, VA 20186		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	Continued From pa	ge 70	F8	380	I		
	diseases and infect	tions.		1	There were no residents identifi	ed in	
					the statement of deficiency. The	ere	
	• • •	n prevention and control			was not a negative outcome as a	1	
	program. The facility must es	stablish an infection prevention (IPCP) that must include, at			of the alleged deficient practice.		
	and control program (IPCP) that must include, at a minimum, the following elements:				II		
	§483.80(a)(1) A svs	stem for preventing, identifying,			Staff serving meals will handle p		
	reporting, investiga	ting, and controlling infections			in a sanitary manner to avoid cr	oss	
		diseases for all residents,			contamination. The main dinin	ıg	
		sitors, and other individuals under a contractual			room will be monitored daily by	7 a	
	arrangement base	d upon the facility assessment			member of management to ensi	ıre	
		ng to §483.70(e) and following			compliance		
	§483.80(a)(2) Writt procedures for the but are not limited (i) A system of surve possible communic infections before the persons in the facil (ii) When and to what communicable disc reported; (iii) Standard and to to be followed to possible.	ten standards, policies, and program, which must include, to: veillance designed to identify cable diseases or ney can spread to other lity; nom possible incidents of ease or infections should be ransmission-based precautions revent spread of infections; isolation should be used for a			The DON/ADON/designee will provide the nursing staff and department heads with education serving meals in a sanitary man without contamination of the part All new nursing hires will received ucation as a part of general orientation.	on on ner late.	
	resident; including but not limited to:  (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the				RECE	VED	
					OCT 3 0	2019	
	least restrictive po- circumstances.	ssible for the resident under the nces under which the facility			VDH/(	OLC	
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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	COM	E SURVEY PLETED
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	PROVIDER OR SUPPLIER SIDE REHAB & NURS	ING CENTER		6	TREET ADDRESS, CITY, STATE, ZIP CODE 14 HASTINGS LANE VARRENTON, VA 20186		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLÉTION DATE
F 880	must prohibit emploidisease or infected contact with resider contact will transmi (vi)The hand hygier by staff involved in §483.80(a)(4) A sysidentified under the corrective actions to §483.80(e) Linens. Personnel must ha transport linens so infection.  §483.80(f) Annual I The facility will confection.  The facility will confect and update the part of the main update the plates from the member) #5, activities the residents' plate.  The findings included the finding included the residents was a served dinner observed transferritable to the residents.	byees with a communicable skin lesions from direct nots or their food, if direct to the disease; and the procedures to be followed direct resident contact.  In the for recording incidents of acility's IPCP and the aken by the facility.  Indle, store, process, and as to prevent the spread of the review.  In the facility of the facility of the facility that is not met as evidenced the facility that the contact surface area of the facility of th		380	IV The administrator or DON/AD will conduct daily random audithe main dining room and resideray passes on the halls to ensurt that resident meals are set up in sanitary manner without cross contamination. The audit will place 5 days per week across all meals, for 1 week, then 5 days pweek for 1 meal for 4 weeks. A discrepancy noted in the audit be addressed at that time with education provided to the staff member. Results of the audit with submitted by the ADON to the QAPI committee for its review recommendations	ts of lent re a a take 3 wer my will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		COMPLETED	
		495267	B. WING		1	10/2019
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)			PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 880	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 72 placed in front of each resident. OSM #6 (Other Staff Member) the Activities Director was one of the staff members. She was observed serving approximately half of the 15 residents in the dining room. For each resident, she was observed arriving at the table with a tray of the resident's meal. She was then observed removing each item from the tray and placing it on the table in front of the resident. When removing the plates from the tray, she was noted to have her thumb on the food, contact surface area on the top side of the plate rim.  On 10/9/19 at 3:05 PM, in an interview with OSM #5, when asked how plates are removed from the tray and served to residents, OSM #5 stated, and demonstrated with her hand, "underneath and set it down in front of them." When asked if plates should be handled with the thumb on the food contact surface on top of the plate, OSM #5 stated, "No." When asked why, OSM #5 stated, "For infection control reasons. You don't want to put your fingers on the plate."  A review of the facility policy, "Preventing Foodborne Illness - Food Handling" documented, "3. All employees who handle, prepare or serve food will be trained in the practices of safe food handling and preventing foodborne illness. Employees will demonstrate knowledge and competency in these practices prior to working with food or serving food to residents."  On 10/10/19 at 1:03 PM, ASM #1 (Administrative Staff Member) the Administrator was made aware of the findings. No further information was provided by the end of the survey.			947		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
495267		495267	B. WING		C 10/10/2019		
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO			
BROOKSIDE REHAB & NURSING CENTER				614 HASTINGS LANE WARRENTON, VA 20186			
(X4) ID PREFIX TAG				PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	ON SHOULD BE COMPLI IE APPROPRIATE DAT		
				F 947		A CONTRACTOR OF THE CONTRACTOR	
F 947	1		F9	<sup>47</sup> It is the practice of this faci	of this facility that		
SS=D	CFR(s): 483.95(g)(	(1)-(4)		required in-service training	g hours are	and the state of t	
	\$483 05/a) Require	ed in-service training for nurse		met and include 12 hours of	met and include 12 hours of training		
	aides.	THE SERVICE HANNING TO THE SE		which includes abuse prevention		100	
	In-service training	must-		training as well as dementia training.		pelili haran san n	
	§483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year.  §483.95(g)(2) Include dementia management training and resident abuse prevention training.  §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff.  §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by:  Based on staff interview, facility document review and employee record review, it was determined that the facility staff failed to evidence that three out of 5 employee records reviewed, (CNA [certified nursing assistant] #5 #6 and #7) received and completed required dementia care in -service training.  The findings include:  On 10/10/19 at approximately 9:00 AM, a review of the training records for 5 CNA's (Certified Nursing Assistants) was conducted. The			The employees affected by deficient practice will comprequired education hours I past non-compliance for the months cannot be corrected. The hours of education will associated and tracked on tracking form for each empthe SDC or DON/ADON.  II  The HR director or Staff decoordinator will complete audit of C N A's to identifice employees not in regulator compliance with the 12 hor required training. Any distinct the audit will be corrected additional hours of educated provided to those employed. Training may be completed didactic education, via sent computer-based trainings.	plete the nowever, ne prior 12 ed. Ill be a personal ployee by  evelopment a 100% y any ry ours of acrepancy in with aion being ees. ed by minars or via	managamena araba a managamena ang ang ang ang ang ang ang ang ang a	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION 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				
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F 947	DE REHAB & NURSING CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		F	PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPR		in in le le le le le le le le le le le le le	
	requested at this ti On 10/10/19 at 10:	rne. :40 AM, OSM #5 provided a					

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

Event ID: R1V111

Facility ID: VA0178

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		COMPLETED		
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F 947	page from the emp which documented staff members mus Orientation, departs training and all facil Hall" meetings. En for all approved cost training."  On 10/10/19 at 1:00 Staff Member) the staff Member) the staff Member at 1:00 the findings. When regarding required ASM #1 stated that page from the emp	loyee handbook, page 44, , "Learning Requirements: All st attend New Employee ment orientation, job specific lity wide in-services and "Town inployees will be compensated impany-specific required  3 PM, ASM #1 (Administrative Administrator, was notified of in asked about a policy staff education and training, it there was no policy, just the sloyee handbook. No further lovided by the end of the	F	947			