STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 2/15/22 through 2/17/22. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000	This Plan of correction is respectfully submitted as evidence of alleged compliance. This submission is not an admission that the deficiencies existed or that we are in agreement with them. It is an affirmation that corrections to the areas cited have been made and the facility is in compliance with participation requirements.	
F 000	INITIAL COMMENTS An unannounced standard Medicare/Medicaid standard survey was conducted 2/15/2022 through 2/17/2022 and Five complaints were investigated during the survey; VA00051024 (unsubstantiated), VA00052196 (unsubstantiated), VA00052357 (unsubstantiated), VA00052836 (unsubstantiated) and VA00053428 (unsubstantiated). Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 130 certified bed facility was 111 at the time of the survey. The survey sample consisted of 33 current resident reviews and 11 closed record reviews.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that	F 550	**F550/12 VAC 5-371-150 (A) Resident Rights/Exercise of Rights** 1.) Affected resident was not identified in 2567, therefore no corrective action could be implemented for that resident. 2.) Nursing staff performed observations and interviews pertaining to mealtime preferences with residents on north wing and recorded results in medical record. Nursing has adjusted seating arrangements in dining room to comply with resident meal serving preferences. Nursing staff has	3/23/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 3/8/22

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 1 promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, it was determined the facility staff failed to maintain a dignified dining experience in one of two dining rooms, the North Wing dining room. The facility staff failed to provide a dignified dining experience on the North Wing, not serving all	F 550	ensured that care plan interventions are appropriate and address resident specific care needs. 3.) The Director of Nursing/designee has educated clinical staff, including RNs, LPNs, CNA's and NAs regarding meal serving times and the order of tray delivery in order to adhere to resident rights and dignity regulations. The education includes, but is not limited to, the importance of serving meals in a dignified manner while honoring residents care-planned preferences and reporting any concerns or refusals to supervisor. 4) The Director of Nursing/designee will perform observation audits on north unit five times weekly for six weeks to ensure that meals are served in a manner which promotes dignity and honors residents' care-planned preferences. Any issues identified will be addressed immediately by Director of Nursing/designee and appropriate actions will be taken.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 2 residents at the same table at the same time. The findings include: Observation was made of the North Wing, the secured dementia unit, on 2/15/2022 at 12:02 p.m. The cart of trays arrived on the unit at 12:02 p.m. The staff started delivering trays to the dining room and resident rooms at the same time. Four residents were sitting at a table by the back wall. The first resident got their tray at 12:11 p.m. The second resident got their tray at 12:18 p.m. The third resident got their tray at 12:26 p.m. The fourth resident got their tray at 12:27 p.m., sixteen minutes after the first resident was served. A second table, where four residents were seated, was observed near the front of the dining room. The first resident at that table got their tray at 12:12 p.m. The second resident got their tray at 12:15 p.m. Two of the four residents had their lunch trays. At 12:17 p.m. one of the residents, without their tray saw a staff member walk by with a tray in their hand when this resident stated, "I'll take that one." At that time, 12:17 p.m. the third resident at the table got their tray. At 12:21 p.m. the same resident who asked for the other tray saw another staff member walk by with a meal tray, the resident stated, "Can we get one like that?" This resident got her tray at 12:22 p.m., ten minutes after the first resident received their food. An interview was conducted with CNA (certified nursing assistant) #3 on 2/16/2022 at 4:09 p.m. When asked the process for delivering trays to the residents at a meal, CNA #3 stated the staff try to serve the residents table by table, as that would be the proper way. CNA #3 stated that if they serve one, then the others may try to get	F 550	The Director of Nursing/designee will identify any trends and/or patterns, and provide education as needed on an ongoing basis. Findings will be discussed with the QAPI committee on at least a quarterly basis.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 3 their food while they wait. The observations above were shared with CNA #3. CNA #3 stated, "For one, up here, [dementia unit], if you don't serve them all at one table at a time, the others tend to grab food off the others plates." When asked if it was a dignity issue not to deliver all of the trays at the same table at the same time, CNA #3 stated, absolutely, and it's just rude not to serve them at the same time. The facility policy, "Dignity" documented in part, "Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life and feelings of self-worth and self-esteem. Dignity is the right of a person to be valued and respected for their own sake, and to be treated ethically. Residents will be treated with dignity and respect at all times...Staff are expected to treat cognitively impaired residents with dignity and sensitivity." ASM (Administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the director of risk management, quality assurance and compliance, were made aware of the above concern on 2/16/2022 at 5:48 p.m. No further information was obtained prior to exit.	F 550		
F 580 SS=E	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring	F 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 4 physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to	F 580	**F580- Notification of Changes** 1.) Residents #45 and #11 were assessed by nursing staff and medical record reviewed. The resident's responsible party and provider have all been notified and updated on all changes in conditions and new orders up to date. The residents' plans of care were reviewed and updated to reflect their resident-specific needs. 2.) The Director of Nursing/designee has audited resident clinical documentation for the past 30 days to ensure providers have been notified of medications not administered to residents. Any variances were addressed and residents and/or resident representatives were notified and the notification was documented in the medical record.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 5 room changes between its different locations under §483.15(c)(9). 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 notify the physician or resident representative of a change in condition or a possible need to alter treatment for two of 44 residents in the survey sample, Residents #45 and #11. The findings include: 1. The facility staff failed to notify Resident #45's physician (or nurse practitioner) when the physician prescribed medications Flomax (1), Metformin (2) and Buspar (3) were not administered on multiple dates in October 2021, November 2021, December 2021 and January 2022, and failed to notify the physician (or nurse practitioner) when the physician prescribed medication Levaquin (4) was not administered on 2/15/22. Resident #45 was admitted to the facility on 3/11/21. Resident #45's diagnoses included but were not limited to diabetes and benign prostatic hyperplasia. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 1/9/22, the resident scored 11 out of 15 on the BIMS (brief interview for mental status), indicating the resident is moderately cognitively impaired for making daily decisions. Review of Resident #45's clinical record revealed a physician's order dated 3/11/21 for Flomax 0.4 mg (milligrams) - two capsules by mouth one time	F 580	3) The Director of Nursing/designee has in-serviced clinical nursing staff, including RN's and LPN's, regarding notification of provider of any medications that were not administered as ordered. The in-service includes, but is not limited to, the importance of notifications of changes in condition, seeking alternative medication options, reviewing stat-box medications for equivalent medications, as well as the importance of documenting notifications in the medial record. 4.) The Director of Nursing/designee will review all progress notes and new orders five times weekly for six weeks to ensure that notifications are being completed and documented appropriately. Any issues identified will be addressed immediately by the Director of Nursing/designee and appropriate actions will be taken. The Director of Nursing/designee will identify any trends and/or patterns and additional education and training will be provided on an ongoing basis. Findings will be discussed with the QAPI committee on at least a quarterly basis.	3/23/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 6 a day for benign prostatic hyperplasia. Review of Resident #45's October 2021 MAR (medication administration record) failed to reveal Flomax was administered to Resident #45 on 10/20/21, 10/21/21, 10/22/21 and 10/24/21. A nurse's note dated 10/20/21 documented there was no medication card containing Flomax and the pharmacy was advised of this on 10/16/21. Nurses' notes dated 10/21/21 and 10/22/21 documented Flomax administration was pending pharmacy delivery. A nurse's note dated 10/24/21 documented Flomax was not available. Review of Resident #45's clinical record revealed a physician's order dated 3/11/21 for Metformin 500 mg- one tablet by mouth two times a day for diabetes. Review of Resident #45's October 2021 and December 2021 MARs failed to reveal Metformin was administered at 9:00 a.m. on 10/20/21, 10/21/21, 10/27/21, 10/30/21 and 12/17/21. Nurses' notes dated 10/20/21 and 10/21/21 documented Metformin administration was pending pharmacy delivery. A nurse's note dated 10/27/21 documented the nurse was unable to administer Metformin to Resident #45 because the refill had not been received from the pharmacy. A nurse's note dated 10/30/21 documented Resident #45 did not have Metformin and the pharmacy stated it was too soon to refill the medication. A nurse's note dated 12/17/21 documented the nurse was unable to administer Metformin and the medication was reordered from the pharmacy. Review of Resident #45's clinical record revealed a physician's order dated 5/14/21 for Buspar 5 mg (milligrams) by mouth three times a day for anxiety. Review of Resident #45's October 2021, November 2021 and January 2022 MARs failed	F 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 7 to reveal Buspar was administered at 9:00 a.m. on 10/25/21, 10/27/21, 10/28/21, 10/30/21, 11/1/21, 11/2/21 and 1/8/22. Further review of Resident #45's October 2021, November 2021 and January 2022 MARs failed to reveal Buspar was administered at 1:00 pm. on 10/25/21, 10/27/21, 10/28/21, 10/30/21, 11/1/21, 11/2/21 and 1/9/22. Nurses' notes dated 10/27/21 documented Resident #45 was out of Buspar and the pharmacy was advised. Nurses' notes dated 10/28/21, 11/1/21 and 11/2/21 documented Buspar was not available. Nurses' notes dated 1/8/22 and 1/9/22 documented the pharmacy was contacted. Review of Resident #45's clinical record revealed a physician's order dated 2/9/22 for Levaquin 750 mg- one tablet by mouth in the evening for seven days for pneumonia. Review of Resident #45's February 2022 medication administration record failed to reveal the resident was administered the prescribed Levaquin on 2/15/22. A nurse's note dated 2/15/22 documented the Levaquin was not available. Review of nurses' notes for all of the above dates that all of the above medications were not administered to Resident #45 failed to reveal the physician (or nurse practitioner) was notified that the medications were not administered. On 2/16/22 at 1:57 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated the physician or nurse practitioner should be notified when a medication is not available for administration but this does not always happen. On 2/16/22 at 5:15 p.m., ASM (administrative	F 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 8 staff member) #1 (the administrator), ASM #2 (the director of nursing) and ASM #3 (the director of risk management, quality assurance and compliance) were made aware of the above concern. The facility pharmacy policy titled, "Unavailable Medications" documented, "Nursing staff shall: 1. Notify the attending physician of the situation and explain the circumstances, expected availability and optional therapy(ies) that are available." No further information was presented prior to exit. References: (1) Flomax is used to treat symptoms of an enlarged prostate. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a698012.html (2) Metformin is used to treat diabetes. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a696005.html (3) Buspar is a psychotropic medication used to treat anxiety. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a688005.html (4) Levaquin is used to treat pneumonia. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a697040.html	F 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 9	F 580		

2. The facility staff failed to notify the nurse practitioner and the responsible party of a medication/supplement that was ordered for Resident #11 was not available from the pharmacy, and was not a stock medication in the facility.

Resident #11 was admitted to the facility on 12/16/2020 with diagnoses of chronic respiratory failure and asthma. On the most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 11/30/2021, the resident scored a 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident is cognitively intact for making daily decisions.

The physician order dated 1/21/2021 documented, "UtyMax Packet (Nutritional Supplements) (used as a dietary management of urinary tract health) (1); Give 1 packet by mouth one time a day for dysuria for 14 days." Start date was documented as 1/22/2022.

The nurse practitioner note dated 1/26/2022 at 4:52 p.m. documented in part, "Asked to see by staff request for f/u on urinary complaints...Dysuria - episode of dysuria 5 days ago per nursing."

Review of the January 2022 MAR (medication administration record) documented the above physician order. On 1/22/2022 through 1/28/2022, and 1/30/2022 through 1/31/2022, a "9" was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 10 documented. The Chart Code for "9" indicated "Other/see progress notes." Review of the February 2022 MAR documented the above physician order. On 2/1/20221, 2/3/2022 and 2/4/2022, a "9" was documented. The nurses' notes for 1/22/2022 at 1:29 p.m.,1/23/2022 at 11:37 a.m., 1/24/2022 at 9:59 a.m., 1/25/2022 at 10:54 a.m., 1/26/2022 at 1:06 p.m., 1/27/2022 at 12:06 p.m., 1/28/2022 at 11:56 a.m., 1/31/2022 at 10:33 a.m., 2/1/2022 at 10:02 a.m., 2/3/2022 at 9:47 a.m., and 2/4/2022 at 1:45 p.m. documented, "pharmacy aware." The nurses' note dated 1/30/2022 at 12:35 p.m. documented, "Not administered - unavailable in stock." The comprehensive care plan, dated 12/17/2020 and revised on 3/21/2021, failed to evidence documentation related to the urinary tract system or dysuria. An interview was conducted with LPN (licensed practical nurse) #6 on 2/16/2022 at 3:52 p.m. The above MARs and nurses' notes were reviewed with LPN #6. When asked the process for when a medication is not available to be given at the scheduled time, LPN #6 stated the nurse first calls the pharmacy to see if it's pending delivery. She stated she would look in the supply of back up medications. If it's not given, the nurse should write a nurses' note as to why it wasn't given. When asked how many missed doses should happen before the pharmacy or a provider is notified, LPN #6 stated the notification should happen with the first dose missed. LPN #6 stated she would call the pharmacy. She stated she	F 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 11 would find out if it's a pharmacy issue or maybe an insurance issue, and then notify the RP (responsible party) and the doctor and the nurse practitioner on call. An interview was conducted with RN (registered nurse) #5 on 2/16/2022 at 4:02 p.m. When asked the process to be followed when a nurse does not administer a medication, RN #5 stated first the nurse needs to go into [name of computer system] to order the medication. Then the nurse practitioner should be notified, and the reason the medication was not given should be charted in the MAR. She stated she would also notify the family as to why it wasn't given. On 2/16/2022 at 5:49 p.m. a request was made to ASM (administrative staff member) #1, the administrator, for the pharmacy manifest of the delivery of the UtyMax for Resident #11. An interview was conducted on 2/17/2022 at 8:36 a.m. with ASM #2, the director of nursing. When asked the process to be followed if a medication is not available for administration at the scheduled time, ASM #2 stated the pharmacy should be called first, then the stat box checked. When asked if the nurse has to notify someone if a medication is not available, ASM #2 stated the doctor or nurse practitioner and the RP (responsible party) must be contacted. ASM #2 presented an email from the pharmacy dated 2/16/2022 at 7:33 p.m. The email documented, "This is an OTC (over the counter), shown as profile only, and is not something that we delivered." Review of the facility stock medication/supplement list failed to evidence	F 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 12 documentation of the UtyMax as a stock medication. An interview was conducted with ASM #4, the nurse practitioner, on 2/17/2022 at 11:47 a.m. When asked why she ordered the UtyMax, ASM #4 stated the resident reported discomfort with urination. ASM #4 stated she had seen her that day and then the next day, the resident stated she felt better. When asked if she was notified that the UtyMax was not available and not given, ASM #4 stated, "I don't believe so." ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, the director of risk management, quality assurance and compliance, were made aware of the above concern on 2/17/2022 at 12:25 p.m. No further information was obtained prior to exit.	F 580		
F 582 SS=D	(1) This information was obtained from the following website: https://www.Medtirtion.com Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and	F 582		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 582	Continued From page 13 (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.	F 582	**F582 – Medicaid/Medicare Coverage/Liability Notice** 1) Resident #357 is no longer a resident at Brookside Rehab and Nursing Center therefore it is not appropriate to provide an ABN currently. Resident #87 is now a long-term care resident and therefore it is not appropriate to provide an ABN at this time. The individual who failed to issue the ABNs is no longer employed by this facility. Brookside Rehab and Nursing Center has identified that all Medicare A residents are at risk from not receiving an ABN. 2.) Administrator/designee audited all skilled discharges since 8/14/21 to ensure that the ABN was issued appropriately. No other concerns were identified. 3.) The Administrator/designee has in-serviced Director of Therapy Department and Social Services Director regarding ABNs and policy and procedure. The in-service includes, but not limited to, the facility to provide ABN "information to the beneficiary so that s/he can decide whether or not to get the care that may not be paid for by Medicare and assume financial responsibility".	3/23/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 582	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determined that the facility staff failed to provide skilled nursing facility advance beneficiary notice of non-coverage (SNFABN) to two of three beneficiary protection notification resident reviews, Resident #87 and Resident #357. The findings include: 1. Resident #87's last covered day of Medicare part A services was 8/14/21. The facility staff failed to provide the advance beneficiary notice to Resident #87 (and/or the resident's representative). Resident #87 was admitted to the facility on 6/22/2021 with diagnoses that included but were not limited to COVID-19, multiple sclerosis and seizures. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 1/25/22, the resident scored 9 out of 15 on the BIMS (brief interview for mental status), indicating the resident is moderately impaired for making daily decisions. The progress notes for Resident #87 documented in part, "6/23/2021 10:04 (10:04 a.m.) MD (medical doctor) progress note...Pt (patient) recently hospitalized after new onset of seizure activity at facility...Pt returns to [Name of facility] for PT/OT/ST (physical therapy, occupational therapy, speech therapy) then LTC (long term care)..." On 2/16/22 at 11:42 a.m., ASM (administrative	F 582	4.) The Administrator/designee will meet with therapy department manager and social services director weekly for 6 weeks to review all previous weeks SNF discharges from therapy services to ensure ABN was issued prior to discharge of services and documentation of such is completed appropriately. Any issues identified will be addressed immediately by the Administrator/designee and appropriate actions will be taken. The Administrator/designee will identify any trends and/or patterns and additional education and training will be provided on an ongoing basis. Findings will be discussed with the QAPI committee on at least a quarterly basis.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 582	Continued From page 15 staff member) #1, the administrator provided the notice of Medicare Non-coverage dated 8/10/21 for Resident #87 and stated that they did not have an advance beneficiary notice to provide for Resident #87. ASM #1 stated that the former social worker did not complete these. ASM #1 stated that the current social worker had started doing this when they started working at the facility. ASM #1 stated that they could not say why they were not sent out and the former social worker no longer worked at the facility. On 2/16/22 at 1:54 p.m., an interview was conducted with OSM (other staff member) #1, the social worker. OSM #1 stated that they had started sending out the advance beneficiary notices around November of 2021. OSM #1 stated that the business office or therapy let the social worker know when a resident was nearing the end of their skilled nursing services. The social worker completed the required notices, reviewed them with the resident and/or family, and also sent them to the responsible party by certified mail. OSM #1 stated that an advance beneficiary notice should have been provided for Resident #87. The facility policy "Medicare Liability Notice" documented in part, "5. The facility will utilize and follow the Medicare approved notices and instructions. a. SNFABN [Skilled Nursing Facility Advanced Beneficiary Notice] i. The SNFABN notice is required when the SNF provider cuts the beneficiary from Medicare Part A services and the beneficiary has remaining days in the benefit period, because the facility believes the beneficiary no longer meets the Medicare criteria and the beneficiary will remain in the certified bed under another payer source after the Part A last	F 582		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 582	Continued From page 16 covered day. ii. The notice must be provided to the beneficiary/beneficiary representative no later than the last covered day..." On 2/16/22 at 5:15 p.m., ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, the director of risk management, quality assurance and compliance were notified of the findings. No further information was presented prior to exit. 2. Resident #357's last covered day of Medicare part A services was 5/21/21. The facility staff failed to provide the advance beneficiary notice to Resident #357 (and/or the resident's representative). Resident #357 was admitted to the facility on 5/7/2021 with diagnoses that included but were not limited to diabetes mellitus with foot ulcer, peripheral vascular disease and methicillin susceptible staphylococcus aureus infection. On the most recent MDS (minimum data set), a five-day assessment with an ARD (assessment reference date) of 5/14/21, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident is cognitively intact for making daily decisions. The physician orders for Resident #357 documented in part, "Admit to skilled level of care. Order Date: 5/8/2021." On 2/16/22 at 11:42 a.m., ASM (administrative staff member) #1, the administrator provided the notice of Medicare Non-coverage dated 5/19/21 for Resident #357 and stated that they did not have an advance beneficiary notice to provide for	F 582		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 582	Continued From page 17 Resident #357. ASM #1 stated that the former social worker did not complete these. ASM #1 stated that the current social worker had started doing this when they started working at the facility. ASM #1 stated that they could not say why they were not sent out and the former social worker no longer worked at the facility. On 2/16/22 at 1:54 p.m., an interview was conducted with OSM (other staff member) #1, the social worker. OSM #1 stated that they had started sending out the advance beneficiary notices around November of 2021. OSM #1 stated that the business office or therapy let them know when a resident was nearing the end of their services. The social worker completed the required notices, reviewed them with the resident and/or family, and also sent them to the responsible party by certified mail. OSM #1 stated that an advance beneficiary notice should have been provided for Resident #357. On 2/16/22 at 5:15 p.m., ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, the director of risk management, quality assurance and compliance were notified of the findings. No further information was presented prior to exit.	F 582		
F 622 SS=E	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the	F 622		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 622	Continued From page 18 resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified	F 622	**F622/12VAC 5-371-140/12VAC 5-371-150/12VAC 5-371-150-Transfer and Discharge Requirements** 1) Residents #60 and #81 and #104 returned from the emergency room or hospital and therefore no corrective action can be taken with the residents at this time. Resident #700 is no longer a resident of this facility and therefore no corrective action can be taken at this time. It is the policy of Brookside Rehab and Nursing Center to ensure that transfer and discharge requirements are met. All residents have the potential to be affected by the alleged deficient practice. 2) Residents that transferred to the emergency room or admitted to the hospital in the last 30 days and remain outside of this facility will be reviewed to ensure that the comprehensive care plan summary and goals were sent with the resident. Any variances will be corrected.	3/23/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 622	Continued From page 19 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 resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.	F 622	3) The Director of Nursing/designee has educated clinical nursing staff, including RN's and LPN's, on transfer and discharge requirements. The education included, but was not limited to, sending comprehensive care plan summary and goals with the resident upon discharge or transfer and documentation ion the medical record that the information was provided to the resident upon transfer or discharge to the hospital. 4) The Director of Nursing/designee will review all emergency room and hospital transfers for six weeks to ensure the comprehensive care plan summary and goals was sent with the resident and documented in the medical record. The Director of Nursing/designee will identify any trends and/or patterns and additional education and training will be provided on an ongoing basis. Findings will be discussed with the QAPI committee on at least a quarterly basis.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 622	Continued From page 20 This REQUIREMENT is not met as evidenced by: 2. The facility staff failed to provide the required documentation to the hospital for two transfers to the hospital for Resident #104. Resident #104 was admitted to the facility on 1/29/2020, with two recent readmissions on 1/25/2022 and 1/31/2022. On the most recent MDS (minimum data set), a Medicare five day assessment, with an ARD (assessment reference date) of 2/3/2022, the resident scored a 3 out of 15 on the BIMS (brief interview for mental status), indicating the resident was severely cognitively impaired for making daily decisions. The nurses' note dated, 1/15/2022 at 9:37 p.m. documented, "Resident decreased LOC (level of consciousness), no PO (by mouth) intake. 179/91 (blood pressure) heart rate 109, resp (respirations) 16, temp (temperature) 97.6. Spoke with wife/RP (responsible party) regarding change in condition and she requested he be sent to hospital. EMS (emergency medical services) transport resident to hospital. Sent with bed hold policy and current records. Report called to [name of hospital]. ADON (assistant director of nursing) notified." The nurses' note dated, 1/28/2022 at 5:11 p.m. documented, "Resident found in room with decreased LOC. 100/53, heart rate 103, resp 20. 99.9 temp, 99% on 5 liters. Unable to take any PO fluids. Condition discussed with wife, at her request 911 called, transferred to [name of hospital] with current records and bed hold policy." An interview was conducted with LPN (licensed	F 622		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 622	Continued From page 21 practical nurse) #1, on 02/16/2022 2:08 p.m. When asked what the nurse sends to the hospital with the resident when a resident is transferred to the hospital, LPN #1 stated they send the medication record, any pertinent labs, DNR (do not resuscitate) if applicable, the E-Interact form, the care plan and the bed hold agreement. There is a checklist on the front of the folder that has the bed agreement and the checklist. LPN #1 further stated they are supposed to pull the checklist off and send to medical records and put in a nurses' note. An interview was conducted with ASM (administrative staff member) #2, the director of nursing, on 2/17/2022 at 7:46 a.m. When asked about the process for sending a resident to the hospital, ASM #2 stated if a resident has a change in condition, the nurse notifies the nurse practitioner or calls the doctor with the information in an SBAR (situation, background, assessment, response) format. The nurse does an E-Interact transfer form. The nurse should write a progress note, summarizing the change in condition and should put in what is being sent with the resident with the bed hold agreement. The other things that should go are the orders, care plan, copies of change in condition and transfer forms, any recent progress notes they need. We send that or a MD (medical doctor) notes, any pertinent labs (laboratory tests). When asked why this was not done with (Resident #104) for both of his transfers to the hospital in January 2022, ASM #2 stated it appears the nurses did not follow the process. ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, the director of risk management, quality assurance and compliance,	F 622		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 622	Continued From page 22 were made aware of the above concern on 2/17/2022 at 12:25 p.m. No further information was obtained prior to exit. 3. The facility staff failed to provide the required documentation to the hospital for a transfer to the hospital for Resident #60. Resident #60 was admitted to the facility on 9/7/2019 with a readmission on 1/11/2022. On the most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 12/16/2021, the resident scored a 14 out of 15 on the BIMS (brief interview for mental status), indicating the resident was not cognitively impaired for making daily decisions. The nurses' note dated 1/6/2022 at 1:30 a.m. documented, "Resident sent out 911 via stretcher in route to [name of hospital] symptoms of hypoxia and possible sepsis. MD (medical doctor)/DON (director of nursing) notified." An interview was conducted with LPN (licensed practical nurse) #1, on 02/16/2022 2:08 p.m. When asked what the nurse sends to the hospital with the resident when a resident is transferred to the hospital, LPN #1 stated they send the medication record, any pertinent labs, DNR (do not resuscitate) if applicable, the E-Interact form, the care plan and the bed hold agreement. There is a checklist on the front of the folder that has the bed agreement and the checklist. LPN #1 further stated they are supposed to pull the checklist off and send to medical records and put in a nurses' note. An interview was conducted with ASM	F 622		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 622	Continued From page 23 (administrative staff member) #2, the director of nursing, on 2/17/2022 at 7:46 a.m. When asked about the process for sending a resident to the hospital, ASM #2 stated if a resident has a change in condition, the nurse notifies the nurse practitioner or calls the doctor with the information in an SBAR (situation, background, assessment, response) format. The nurse does an E-Interact transfer form. The nurse should write a progress note, summarizing the change in condition and should put in what is being sent with the resident with the bed hold agreement. The other things that should go are the orders, care plan, copies of change in condition and transfer forms, any recent progress notes they need. We send that or a MD (medical doctor) notes, any pertinent labs (laboratory tests). When asked why this was not done with (Resident #60) for his transfer to the hospital in January 2022, ASM #2 stated it appears the nurses did not follow the process. ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, the director of risk management, quality assurance and compliance, were made aware of the above concern on 2/17/2022 at 12:25 p.m. No further information was obtained prior to exit. 4. The facility staff failed to evidence required documentation was provided for Resident #81 to the receiving facility for a facility-initiated transfer on 2/13/2022. On the most recent MDS (minimum data set), a 5-day assessment with an ARD (assessment reference date) of 1/22/2022, the resident scored a 15 out of 15 on the BIMS (brief interview for	F 622		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 622	Continued From page 24 mental status), indicating the resident was cognitively intact for making daily decisions. The progress notes for Resident #81 documented in part, "2/13/2022 17:57 (5:57 p.m.) Resident was sent to the hospital as advised by physician due to critical lab results, last vital signs taken 86/46 (blood pressure), HR (heart rate) 89, O2 (oxygen) 92, T (temperature) 96.8, resident had altered mental status, sister contacted twice but couldn't reach her, left voicemail. NP (nurse practitioner) notified." The clinical record failed to evidence documentation of information provided to the hospital on 2/13/2022. On 2/16/2022 at 2:08 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated that they sent the medication record, any pertinent labs, the DNR (do not resuscitate), the E Interact change in condition form, the care plan and the bed hold agreement with any resident going to the hospital. LPN #1 stated that they had a checklist on the front of a folder that had the bed hold agreement inside they used. LPN #1 stated that they did not send Resident #81 out to the hospital on 2/13/2022 but the nurse should have pulled checklist off and sent it to medical records and put in a nurses note documenting everything that was provided to the emergency room. On 2/17/2022 at 7:45 a.m., an interview was conducted with ASM (administrative staff member) #2, the director of nursing. ASM #2 stated that the nurses completed the E Interact change in condition form for residents and contacted the nurse practitioner using the SBAR	F 622		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 622	Continued From page 25 (situation, background, assessment, recommendations) format. ASM #2 stated that if the resident was sent out to the hospital the nurse completed the E Interact transfer form and sent it with the resident to the hospital. ASM #2 stated that the nurses were responsible for writing a progress note documenting the required documents being sent with the resident including the bed hold notice, orders, care plan, recent progress notes, physician notes, pertinent labs and copies of the change in condition and transfer form. ASM #2 stated that they did not have any evidence of the documents sent to the hospital for Resident #81 and it appeared the nurses did not follow through on the process. On 2/17/2022 at approximately 12:15 p.m., ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, the director of risk management, quality assurance and compliance. No further information was provided prior to exit. Based on staff interview, clinical record review, facility document review, and in the course of a complaint investigation, it was determined that the facility staff failed to ensure the physician documented the required note regarding a hospital transfer and/or the facility staff failed to evidence the receiving facility was provided with all the required documentation for a hospital transfer for 4 of 44 residents in the survey sample; Residents #700, #104, #60, and #81. The findings include:	F 622		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 622	Continued From page 26 1. Facility staff failed to ensure the physician documented the required note regarding the circumstances of a hospital transfer on 1/23/21; and failed to evidence that the hospital was provided with the required documentation of a hospital transfer on 1/23/21 for Resident #700. Resident #700 was admitted to the facility on 10/23/20 and discharged on 1/12/22. The resident had the diagnoses of, but not limited to: chronic obstructive pulmonary disease, COVID-19, dysphagia, pancreatic insufficiency, diabetes, alcohol dependence, depression, adjustment disorder, anxiety disorder, hepatitis, high blood pressure, and prostate malignancy. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 11/12/21, the resident scored 15 out of 15 on the BIMS (brief interview for mental status, indicating the resident is not cognitively impaired for making daily decisions. The resident was coded as requiring extensive assistance for bathing; supervision for toileting; and was independent for all other areas of activities of daily living. In the course of a complaint investigation, the complaint documented that the resident was sent to the ER (emergency room) on 1/23/21 at 4:00 AM. The complaint further documented, "Patient was sent with a copy of current orders and face sheet, however a copy of the patient's care plan and E-Interact transfer of care report was not provided to the ER." A review of the clinical record revealed a nurses' note dated 1/23/21 at 4:39 AM which documented, "Per NP (nurse practitioner).	F 622		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 622	Continued From page 27 Resident sent to ER for elevated glucose.out (sic) of building at this time." There were no other notes regarding this hospital transfer. Further review of the clinical record failed to reveal any evidence that an E-Interact transfer form was completed and what, if any, documentation was provided to hospital upon this transfer. In addition, there was no documentation following the hospital transfer from the physician or nurse practitioner regarding the need for the transfer and why the resident could not be treated at the facility. On 2/17/2022 at 7:46 AM, an interview was conducted with ASM (administrative staff member) #2, the Director of Nursing. When asked about the process for sending a resident to the hospital, ASM #2 stated if a resident has a change in condition, the nurse notifies the nurse practitioner or calls the doctor with the information in a SBAR (situation, background, assessment, response) format. The nurse does an E-Interact transfer form. The nurse should write a progress note, summarizing the change in condition and should put in what is being sent to the hospital with the resident, along with the bed hold agreement. The other things that should go are the orders, care plan, copies of change in condition and transfer forms, any recent progress notes they need and any pertinent laboratory tests. On 2/17/22 at 8:22 AM, an interview was conducted with RN (Registered Nurse) #5. She	F 622		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 622	Continued From page 28 stated that she would expect the physician to write a note at some point regarding the resident being sent to the ER. She stated that documentation of transfer requirements would include the E-Interact form, demographic information, acute medicinal condition causing the need for transfer, allergies, medical history, contact information, medication list, current orders, and care plan goals. She stated that nurses should document in a progress note what was sent with the resident when documenting why the resident was sent out. A review of the facility policy, "Facility Initiated Transfer and Discharge" documented: "3. Facility initiated transfers/discharges will be implemented when any one or more of the following conditions are met: a. The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; i. The medical record will contain documentation by the attending physician to include the identification of the resident's specific needs that cannot be met by the facility and of the facility's attempt to meet those needs. ii. The medical record will contain documentation that the needed services are available at the receiving facility or location... 4. The medical record: a. Will clearly identify the basis or reason for transfer or discharge b. Identify Information provided to the receiving provider which at a minimum will include: i. Contact information of the practitioner who was responsible for the care of the resident; ii. Resident representative information, including contact information;	F 622		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 622	Continued From page 29 iii. Advance directive information; iv. Special instructions and/or precautions for ongoing care, as appropriate, which must include, if applicable, but are not limited to treatments and devices (oxygen, implants, IVs, tubes/catheters); v. Precautions such as isolation or contact; vi. Special risks such as risk for falls, elopement, bleeding, or pressure injury and/or aspiration precautions; vii. The resident's comprehensive care plan goals; and viii. All information necessary to meet the resident's needs, which includes, but may not be limited to: (1) Resident status, including baseline and current mental, behavioral, and functional status, reason for transfer, recent vital signs; (2) Diagnoses and allergies; (3) Medications (including when last received); and (4) Most recent relevant labs, other diagnostic tests, and recent immunizations..." On 2/17/22 12:20 PM, ASM #1, #2, and #3 (Administrative Staff Member), the Administrator, Director of Nursing, and the Director of Risk Management, Quality Assurance and Compliance, were notified of the concern. No further information was provided by the end of the survey. COMPLAINT DEFICIENCY	F 622		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must-	F 623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 30 (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written	F 623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 31 notice specified in paragraph (c)(3) of this section must include the following: (I) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information	F 623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 32 becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview and facility document review, it was determined that the facility staff failed to evidence written notification was provided to the responsible party and/or the ombudsman for a facility-initiated transfer for 2 of 44 residents in the survey sample, Resident #81 and Resident #104. The findings include: 1. The facility staff failed to evidence written notification of transfer was provided to Resident #81 and/or their representative for a facility-initiated transfer on 2/13/2022. On the most recent MDS (minimum data set), a 5-day assessment with an ARD (assessment reference date) of 1/22/2022, the resident scored a 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact for making daily decisions. The progress notes for Resident #81 documented in part, "2/13/2022 17:57 (5:57 p.m.) Resident was sent to the hospital as advised by physician	F 623	**F623- Notice Requirements Before Transfer/Discharge** 1. Residents #81 and #104 returned from the emergency room or hospital and therefore no corrective action can be taken with the residents at this time. It is the policy of Brookside Rehab and Nursing Center to ensure that notice requirements before transfer/discharge are met. All residents have the potential to be affected by the alleged deficient practice. 2) Residents that transferred to the emergency room or admitted to the hospital in the last 30 days and remain outside of this facility will be reviewed to ensure that evidence of written notification of transfer was provided to the responsible party and/or the ombudsman. Any variances will be corrected.	3/23/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 33 due to critical lab results, last vital signs taken 86/46 (blood pressure), HR (heart rate) 89, O2 (oxygen) 92, T (temperature) 96.8, resident had altered mental status, sister contacted twice but couldn't reach her, left voicemail. NP (nurse practitioner) notified." The clinical record failed to evidence documentation of written notification being provided to Resident #81 or their representative for the transfer on 2/13/2022. On 2/16/2022 at 2:08 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated that they send the medication record, any pertinent labs, the DNR (do not resuscitate), the E Interact change in condition form, the care plan and the bed hold agreement with any resident going to the hospital. LPN #1 stated that they did not send any written notice of transfer or discharge and thought the social worker did this. On 2/16/2022 at 1:54 p.m., an interview was conducted with OSM (other staff member) #1. OSM #1 stated that they sent a written notice of transfer to the resident's representative within 24 hours of transfer by certified mail. OSM #1 stated that they also reviewed the written notice verbally and put in a note regarding the conversation. OSM #1 stated that they were looking for the written notification of transfer for Resident #81. On 2/17/2022 at 7:50 a.m., OSM #1 stated that they did not have any evidence to provide of written notification of transfer provided to Resident #81 or their representative for the transfer on 2/13/2022.	F 623	3 The Administrator/designee has educated social workers on notice requirements before transfer/discharge. The education included, but was not limited to, notifying the resident or resident representative of transfer/discharge, and documentation in the medical record that the information was provided to the resident upon transfer or discharge. 4. The Administrator/designee will review all transfers/discharges for six weeks to ensure that notification of transfer/discharge was sent to the resident or resident representative and that the notification was documented in the medical record. The Administrator/designee will identify any trends and/or patterns and additional education and training will be provided on an ongoing basis. Findings will be discussed with the QAPI committee on at least a quarterly basis.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 34 The facility policy, "Facility Initiated Transfer and Discharge" documented in part, "...8. Before a facility transfers or discharges a resident, the facility will notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand..." The policy further documented, "... The facility will send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. i. The copy of the notice to the ombudsman will sent at the same time notice is provided to the resident and resident representative. ii. Copies of notices for emergency transfers will be sent to the ombudsman, but they may be sent when practicable, such as in a list of residents on a monthly basis..." On 2/17/2022 at approximately 12:15 p.m., ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, the director of risk management, quality assurance and compliance. No further information was provided prior to exit. 2. The facility staff failed to give the resident and/or responsible party notice of a transfer to the hospital on 1/14/2022 for Resident #104. Resident #104 was admitted to the facility on 1/29/2020, with two recent readmissions on 1/25/2022 and 1/31/2022. On the most recent MDS (minimum data set), a Medicare five day assessment, with an ARD (assessment reference date) of 2/3/2022, the resident scored a 3 out of 15 on the BIMS (brief interview for mental status), indicating the resident was severely cognitively impaired for making daily decisions.	F 623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 35 The nurses' note dated 1/15/2022 at 9:37 p.m. documented, "Resident decreased LOC (level of consciousness), no PO (by mouth) intake. 179/91 (blood pressure) heart rate 109, resp (respirations) 16, temp (temperature) 97.6. Spoke with wife/RP (responsible party) regarding change in condition and she requested he be sent to hospital. EMS (emergency medical services) transport resident to hospital. Sent with bed hold policy and current records. Report called to [name of hospital]. ADON (assistant director of nursing) notified." An interview was conducted with ASM (administrative staff member) #2, the director of nursing, on 2/17/2022 at 7:46 a.m. When asked whose responsibility it is to send out the written notice to the responsible party, ASM #2 stated it is the social worker's responsibility. An interview was conducted with OSM (other staff member) # 1, the social worker, on 2/17/2022. When asked why the notice of transfer was not sent for the transfer on 1/15/2022, OSM #1 stated, "I missed that one." ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, the director of risk management, quality assurance and compliance, were made aware of the above concern on 2/17/2022 at 12:25 p.m. No further information was obtained prior to exit.	F 623		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return-	F 625		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 36 §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview and facility document review, it was determined that the facility staff failed to evidence bed hold notice was provided to the resident and/or the responsible party for a facility-initiated transfer for 2 of 44 residents in the survey sample, Residents #81and #60. The findings include:	F 625		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 37 1. The facility staff failed to evidence bed hold notice was provided to Resident #81 and/or their representative for a facility-initiated transfer on 2/13/2022. On the most recent MDS (minimum data set), a 5-day assessment with an ARD (assessment reference date) of 1/22/2022, the resident scored a 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact for making daily decisions. The progress notes for Resident #81 documented in part, "2/13/2022 17:57 (5:57 p.m.) Resident was sent to the hospital as advised by physician due to critical lab results, last vital signs taken 86/46 (blood pressure), HR (heart rate) 89, O2 (oxygen) 92, T (temperature) 96.8, resident had altered mental status, sister contacted twice but couldn't reach her, left voicemail. NP (nurse practitioner) notified." The clinical record failed to evidence documentation of bed hold notice being provided to the resident or the responsible party for the transfer on 2/13/2022. On 2/16/2022 at 2:08 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated that they sent the medication record, any pertinent labs, the DNR (do not resuscitate), the E-Interact change in condition form, the care plan and the bed hold agreement with any resident going to the hospital. LPN #1 stated that they had a checklist on the front of a folder that had the bed hold agreement inside. LPN #1 stated the nurse should have pulled the checklist off and sent it to medical records. and put in a nurses note documenting everything that	F 625	**F625- Notice of Bed Hold Policy Before/Upon Transfer** 1.) Residents #81 and #60 returned from the emergency room or hospital and therefore no corrective action can be taken with the residents at this time. It is the policy of Brookside Rehab and Nursing Center to ensure that bed hold policy requirements are met. All residents have the potential to be affected by the alleged deficient practice. 2.) Residents that transferred to the emergency room or admitted to the hospital in the last 30 days and remain outside of this facility will be reviewed to ensure that bed hold notice was provided to the resident and/or the responsible party for each facility-initiated transfer. Any variances will be corrected.	3/23/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 38 was provided to the emergency room. On 2/17/2022 at 7:45 a.m., an interview was conducted with ASM (administrative staff member) #2, the director of nursing. ASM #2 stated that the nurses completed the E-Interact change in condition form for residents and contacted the nurse practitioner using the SBAR (situation, background, assessment, recommendations) format. ASM #2 stated that if the resident was sent out to the hospital, the nurse completed the E-Interact transfer form and sent it with the resident to the hospital. ASM #2 stated that the nurses were responsible for writing a progress note documenting the required documents being sent with the resident, including the bed hold notice, orders, care plan, recent progress notes, physician notes, pertinent labs and copies of the change in condition and transfer form. ASM #2 stated that they did not have any evidence of the documents sent to the hospital for Resident #81 and it appeared the nurses did not follow through on the process. The facility policy, "Facility Initiated Transfer and Discharge" failed to evidence guidance on providing notice of bed hold to residents or responsible parties. On 2/17/2022 at approximately 12:15 p.m., ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, the director of risk management, quality assurance and compliance. No further information was provided prior to exit. 2. The facility staff failed to provide a bed hold	F 625	3.) The Director of Nursing/designee has educated clinical nursing staff, including RNs and LPNs on providing the bed hold policy to residents and/or resident representatives upon each facility-initiated transfer. The education included, but was not limited to, providing the bed hold policy to residents and/or resident representatives upon facility-initiated transfer, and documentation in the medical record that the information was provided. 4.) The Director of Nursing/designee will review all facility-initiated transfers for six weeks to ensure that the bed hold policy was provided to the resident or resident representative and that the this was documented in the medical record. The Director of Nursing/designee will identify any trends and/or patterns and additional education and training will be provided on an ongoing basis. Findings will be discussed with the QAPI committee on at least a quarterly basis.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 39 notice to the resident and/or responsible party upon a transfer to the hospital for Resident #60. Resident #60 was admitted to the facility on 9/7/2019, with a readmission on 1/11/2022. On the most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 12/16/2021, the resident scored a 14 out of 15 on the BIMS (brief interview for mental status), indicating the resident was not cognitively impaired for making daily decisions. The nurses' note dated 1/6/2022 at 1:30 a.m. documented, "Resident sent out 911 via stretcher in route to [name of hospital] symptoms of hypoxia and possible sepsis. MD (medical doctor)/DON (director of nursing) notified." An interview was conducted with LPN (licensed practical nurse) #1 on 02/16/2022 at 2:08 p.m. When asked what the nurse sends to the hospital with the resident when a resident is transferred to the hospital. LPN #1 stated they send the medication record, any pertinent labs, DNR (do not resuscitate) if applicable, the E-Interact form, the care plan and the bed hold agreement. She stated there is a checklist on the front of the folder that has the bed agreement and the checklist. LPN #1 further stated they are supposed to pull the checklist off and send it to medical records and put in a nurses' note. An interview was conducted with ASM (administrative staff member) #2, the director of nursing, on 2/17/2022 at 7:46 a.m. When asked about the process for sending a resident to the hospital, ASM #2 stated if a resident has a change in condition, the nurse notifies the nurse practitioner or calls the doctor with the information	F 625		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 40 in a SBAR (situation, background, assessment, response) format. The nurse does an E-Interact transfer form. The nurse should write a progress note, summarizing the change in condition and should put in what is being sent with the resident with the bed hold agreement. The other things that should go are the orders, care plan, copies of change in condition and transfer forms, any recent progress notes they need. We send that or a MD (medical doctor) notes, any pertinent labs (laboratory tests). When asked why this was not done with (Resident #60) for his transfer to the hospital in January 2022, ASM #2 stated it appears the nurses did not follow the process. ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, the director of risk management, quality assurance and compliance, were made aware of the above concern on 2/17/2022 at 12:25 p.m. No further information was obtained prior to exit.	F 625		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 41 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)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review and facility document review, it was determined that the facility staff failed to develop and/or implement the comprehensive care plan for eight of 44 residents in the survey sample, Residents #43, #407, #18, #70, #73, #61, #45 and #307. The findings include:	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 42 1. The facility staff failed to develop a care plan for Resident #43's G-tube (gastrostomy tube) (1) and drainage bag. Resident # 43 was admitted to the facility with a diagnosis that included but not limited to ulcerative colitis. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 01/08/2022, the resident scored 12 out of 15 on the BIMS (brief interview for mental status), indicating the resident is moderately impaired of cognition for making daily decisions. On 02/15/22 at 12:01 p.m., an observation of Resident # 43 was observed lying in bed with G-tube connected to a drainage bag that was hung on side of their bed. On 02/16/22 at 2:0 p.m., an observation of Resident # 43observed lying in bed with G-tube connected to a drainage bag that was hung on side of their bed. The POS (physician's order sheet) dated February 2022 documented in part, "Gastroenterology consult required as soon as possible every day shift for G & J tube site assessment, drainage related to ULCERATIVE COLITIS ... Order Date: 12/06/2021. Start Date: 12/07/2021." Review of Resident # 43's comprehensive care plan dated 11/12/2021 failed to evidence interventions for the care of the G-tube and drainage bag.	F 656	**F656/12 VAC 5-371-250/ 12 VAC 5-371-250 (G)- Develop/Implement Comprehensive Care Plan** 1) Residents #43, #407, #18, #70, #73, #61, #45 and #307 were assessed by nursing staff and their medical records were reviewed. The residents' care plans have been updated to reflect current individualized plans of care. 2.) The Director of Nursing/designee has performed an audit of all current residents' care plans. Care plans have been updated to ensure individualized needs are addressed appropriately and that results are being tracked and addressed appropriately. A process has been developed and implemented to identify resident care needs in the daily interdisciplinary team meeting, and to update the care plans to reflect the needs identified.	3/23/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 43 On 02/17/2022 at approximately 8:10 a.m., an interview was conducted with RN (registered nurse) # 1, MDS coordinator. When asked if Resident # 43's comprehensive care plan dated 11/12/2021 addressed the care and services for Resident # 43's G-tube and drainage bag, RN # 1 reviewed Resident # 43's care plan and stated, "It's not on the care plan, it should be." When asked to describe the purpose of a resident's care plan, RN # 1 stated, "It tells the kind of care you are going to provide, a picture of the resident and how to take care of them." When asked to describe the process for developing a resident's care plan, RN # 1 stated, "We look at what is triggered on the MDS and the baseline care plan, information from the history and physical, the discharge summary from the hospital, physician orders and nursing notes." The facility's policy "Care Planning - Comprehensive Care Plan" documented in part, "A person-centered comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychosocial needs shall be developed for each resident." On 02/17/2022 at approximately 12:15 p.m., ASM (administrative staff member) # 1, administrator, and ASM # 2, director of nursing, were made aware of the findings. No further information was provided prior to exit. References: (1) The G-tube is inserted through this cut into the stomach. The tube is small, flexible, and hollow. The doctor uses stitches to close the stomach around the tube. This information was obtained	F 656	3.) The Director of Nursing/designee has in-serviced nursing leadership and interdisciplinary team members regarding care plan updates. The in-service includes, but no limited to, the importance of care plan reviews and updates with any changes for each resident and care plans being reflective of individualized care needs. 4) The Director of Nursing/designee will conduct an audit of 25% of resident care plans weekly for four weeks to ensure that interventions are appropriate and reflect the individual needs of each resident. The Director of Nursing/designee will also audit the care plans of any new admissions daily for six weeks to ensure that interventions are appropriate and reflect the individual needs of each resident. Any issues identified will be addressed immediately by the Director of Nursing/designee and appropriate actions will be taken to update the resident care plans.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 44 from the website:https://medlineplus.gov/ency/article/002937.htm. 2. The facility staff failed to implement the comprehensive care plan for dialysis communication for Resident #407. Resident #407 was admitted to the facility on 12/24/21. Resident #407's diagnoses included but were not limited to: end stage renal disease (end stage of renal failure-inability of the kidneys to excrete wastes and function in the maintenance of electrolyte balance) (1), congestive heart failure (abnormal congestion caused by circulatory congestion and retention salt and water by the kidneys) (2) and chronic respiratory failure (inability of the heart and lungs to maintain and adequate level of gas exchange) (3). Resident #407's most recent MDS (minimum data set) assessment, a five day assessment, with an assessment reference date of 12/31/21, coded the resident as scoring 11 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident is moderately cognitively impaired for making daily decisions. The resident was coded as requiring total dependence for transfers, locomotion and bathing; extensive assistance for bed mobility, dressing; limited assistance for mobility, and hygiene and supervision for eating. The resident was coded as always incontinent for bowel and for bladder. The resident was coded as receiving dialysis during the look back period. A review of the comprehensive care plan dated 12/26/21 revealed, in part, "Resident needs	F 656	The Director of Nursing/designee will identify any trends and/or patters and provide education and training to staff on an ongoing basis. Findings will be discussed with the QAPI committee on at least a quarterly basis.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 45 Hemodialysis related to renal failure ...Encourage resident to go for the scheduled dialysis appointments. Resident receives dialysis 3X a week (Tues-Thurs-Sat). Provide communication book for resident to dialysis for continuation of care between dialysis and facility per protocol." A review of the physician orders dated 12/27/21, revealed in part, "Hemodialysis, time to be picked up 10 every day shift every Monday, Wednesday and Friday." Order renewed through 2/18/22. A review of Resident #407's dialysis binder containing the "Dialysis Communication Record," with top section to be completed by the facility and the bottom portion to be completed by the dialysis center, revealed records dated 2/12/22 and 2/15/22, and evidenced a missing a total of 23 forms for the dates of: 12/26/21, 12/27/21, 12/29/21, 12/31/21, 1/3/22, 1/5/22, 1/7/22, 1/10/22, 1/12/22, 1/14/22, 1/17/22, 1/19/22, 1/21/22, 1/24/22, 1/26/22, 1/28/22, 1/31/22, 2/2/22, 2/4/22, 2/7/22, 2/9/22, 2/11/22, 2/14/22. On 2/16/22 at 8:45 AM, an interview was conducted with RN (registered nurse) #2. When asked if there was a dialysis book for Resident #407, RN #2 stated, "Yes, here it is." When asked the purpose of the communication forms, RN #2 stated, "They are to ensure we are providing information between the facility and the center regarding the resident; vital signs, any changes, any issues with fistula or device." On 2/17/22 at 11:45 AM, an interview was conducted with RN #2. When asked what the care plan intervention "Provide communication book for resident to dialysis for continuation of care between dialysis and facility per protocol"	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 46 meant, RN #2 stated, "It means that we provide communication for each dialysis appointment for the resident." When asked if the missing dialysis communication forms for Resident #407 indicated the care plan had been implemented, RN #2 stated, "No, we did not fully implement the care plan." On 2/17/22 at 12:17 PM, an interview was conducted with ASM #2, the director of nursing. When asked if there were any additional dialysis communication forms, other than the two provided, for Resident #407, ASM #2 stated, "No, there are no additional forms." When asked if the care plan was implemented, ASM #2 stated, "No, it was not." On 2/16/22 at 5:16 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the director of risk management, quality and compliance, were made aware of the above concern. A review of the facility's "Care Planning-Person Centered" policy, documented in part, "The facility will develop and implement a comprehensive person-centered care plan for each resident, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs as identified throughout the comprehensive Resident Assessment Instrument (RAI) process. The comprehensive care plan will: Incorporate identified problem areas; Incorporate risk factors associated with identified problems; Reflect treatment goals, timetables and objectives in measurable outcomes." No further information was provided prior to exit.	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 47 References: (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 498. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 133. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 502. 3. The facility staff failed to develop a care plan for the use of assistive devices for Resident #18. Resident #18 was admitted to the facility on 9/12/2019. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/14/2021, the resident scored a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident is not cognitively impaired to make daily decisions. The physician order dated 2/11/2022 documented, "Patient to wear finger extension splint on L (left) 4th and 5th fingers during daytime up to 6 hrs (hours) as tolerated and as patient allows for contracture mgmt (management) every day shift." The physician order dated, 12/18/2019 documented, "Pt (patient) to wear compression gloves on B (bilateral) hands when out of bed to chair during daytime for up to 8 hrs as tolerated. Remove when in bed. Perform skin checks q shift and as needed, every day shift."	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 48	F 656		

Review of the comprehensive care plan dated 9/13/2019, and last revised on 3/29/2021, failed to reveal any information related to the splint or compression gloves.

An interview was conducted with RN (registered nurse) #1, the MDS nurse, on 2/16/2022 at 3:30 p.m. When asked the purpose of the care plan, RN #1 stated it's the plan of care for the resident. When asked who develops and/or updates the care plans, RN #1 stated it's a whole team approach. When asked if a resident's order for a splint and compression gloves should be on the care plan, RN #1 stated yes. When asked why it should be on the care plan, RN #1 stated it has to be on the care plan so the whole team knows that the resident needs them. She stated it's something they have to do for the resident.

ASM (Administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the director of risk management, quality assurance and compliance, were made aware of the above concern on 2/16/2022 at 5:48 p.m.

No further information was obtained prior to exit.

4. For Resident #70, the facility staff failed to follow the comprehensive care plan regarding the use of psychoactive medications.

Resident #70 was admitted to the facility on 11/29/21 with the diagnoses of but not limited to Alzheimer's disease, diabetes, high blood pressure, breast cancer, and anxiety disorder. On the most recent MDS (Minimum Data Set), a 5-day assessment with an ARD (Assessment Reference Date) of 1/18/22, the resident scored a 4 out of 15 on the BIMS (brief interview for mental

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 49 status, indicating the resident was severely cognitively impaired for making daily decisions. A review of the clinical record revealed physician's orders as follows: An order dated 11/29/21 for Seroquel (1) 25 mg (milligrams), give 3 tablets (75 mg) at bedtime related to Alzheimer's disease. An order dated 11/29/21 for Depakote (2) 250 mg, give 2 tablets (500 mg) at bedtime related to Alzheimer's disease. An order dated 12/1/21 for psychiatry consult PRN (as needed). A physician's note dated 11/30/21 documented, "...Alzheimer's dementia with behaviors, anxiety - psych follow-up required..." A physician's note dated 12/7/21 documented, "...Alzheimer's dementia with behaviors, anxiety...psych follow-up required..." A physician's note dated 2/7/22 documented, "...On assessment, pt (patient) awake and alert sitting up in dining room, denies acute complaints, staff deny acute issues....Alzheimer's dementia with behaviors, anxiety - psych follow-up required..." There were no notes by the nurses or the physician that the resident had actually displayed any behaviors since admission. There was no documented target behaviors for the use of the Seroquel. There was no documented behavior monitoring for the use of the Seroquel. There was no evidence of any psychiatric consult having occurred as ordered by the physician and documented in physician notes that it was required.	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 50 A review of the comprehensive care plan dated 12/10/21 revealed, in part: "[Resident #70] uses psychotropic medication r/t (related to) Dementia with agitation ...Administer PSYCHOTROPIC medications as ordered by physician. Monitor for side effects and effectiveness Q-SHIFT (every shift) ...Review behaviors/interventions and alternate therapies attempted and their effectiveness as per facility policy." There was no evidence any of these interventions were being followed. On 2/17/22 at 8:22 AM, an interview was conducted with RN #5 (Registered Nurse). She stated that there wasn't any documentation of behaviors. She stated the resident has had some behaviors but was not sure why there had not been any charting on the behaviors. She stated that the care plan was not being followed. A review of the facility policy, "Care Planning - Comprehensive Person-Centered" documented, "A person-centered comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychosocial needs shall be developed for each resident.... 9. The resident will receive the services and/or items included in the plan of care...." On 2/17/22 12:20 PM, ASM #1, #2, and #3 (Administrative Staff Member), the Administrator, Director of Nursing, and the Director of Risk Management, Quality Assurance and Compliance, were notified of the concern. No further information was provided by the end of	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 51 the survey. References: (1) Seroquel is an antipsychotic medication. It is used for the treatment of schizophrenia; episodes of mania or depression in patients with Bipolar disorder; as conjunctive therapy for the treatment of depression (not related to bipolar disorder). Seroquel has a documented warning of increasing risk of death in older adults with dementia. Seroquel has a warning that it is not approved by the Food and Drug Administration (FDA) for the treatment of behavioral problems in older adults with dementia. There was no reference on the below web page regarding the use of Seroquel for the treatment of anxiety. Information obtained from https://medlineplus.gov/druginfo/meds/a698019.html (2) Depakote is used to treat certain types of seizures; is used to treat mania in patients with Bipolar disorder. There was no reference on the below web page regarding the use of Depakote for Alzheimer's disease. Information obtained from https://medlineplus.gov/druginfo/meds/a682412.html 5. For Resident #73, the facility staff failed to follow the comprehensive care plan regarding obtaining monthly weights. Resident #73 was admitted to the facility on 3/19/18 and had the diagnoses of, but not limited to dementia and diabetes. On the most recent MDS (Minimum Data Set), a 5-day assessment	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 52 with an ARD (Assessment Reference Date) of 1/17/22, the resident scored a 3 out of 15 on the BIMS (brief interview for mental status, indicating the resident was severely cognitively impaired for making daily decisions. A review of the clinical record revealed a physician's order dated 2/2/21 that documented, "Monthly weight every day shift every 1 month(s) starting on the 1st for 1 day(s)." The "start date" was documented as 3/1/21. A review of the monthly weights revealed the following: 1/1/21 149.2 pounds 2/2/21 (above order written, no weight obtained until 9/1/21) 9/1/21 160.2 pounds 9/21/21 157.5 pounds 10/12/21 156.2 pounds 11/2/21 157.8 pounds 12/1/21 154.4 pounds 1/1/22 (no weight obtained) 2/4/22 141.2 pounds This reflected a period of 6 consecutive months for which weights should have been obtained and were not, plus no weight was obtained on 1/1/22, for a total of 7 months (3/1/21, 4/1/21, 5/1/21, 6/1/21, 7/1/21, 8/1/21 and 1/1/22) that ordered weights were not obtained. A review of the comprehensive care plan revealed one dated 1/10/22 for "Nutrition/weight: [Resident #73] has nutritional risk related to dementia, HLD (hyperlipidemia), DM2 (diabetes), HTN (high blood pressure). Rsd (resident) has Mechanical Soft diet r/t (related to) dysphagia and	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 53 therapeutic diet for supplements." This care plan included an intervention dated 9/4/19 and revised on 5/20/21 for "Assess weight monthly." On 2/17/22 at 8:22 AM, an interview was conducted with RN #5 (Registered Nurse). She stated that the expectation was the weights would be obtained as ordered and that the care plan was not being followed. On 2/17/22 12:20 PM, ASM #1, #2, and #3 (Administrative Staff Member), the Administrator, Director of Nursing, and the Director of Risk Management, Quality Assurance and Compliance, were notified of the concern. No further information was provided by the end of the survey. 6. For Resident #61, the facility staff failed to follow the comprehensive care plan regarding the use of psychoactive medications. Resident #61 was admitted to the facility on 12/8/21 with the diagnoses of but not limited to Alzheimer's disease, depression, high blood pressure and history of falls. On the most recent MDS (Minimum Data Set), a significant change assessment with an ARD (Assessment Reference Date) of 1/10/22, the resident scored a 3 out of 15 on the BIMS (brief interview for mental status, indicating the resident was severely cognitively impaired for making daily decisions. A review of the clinical record revealed the following physician's orders: An order dated 12/8/21, and discontinued on 1/3/21, for Seroquel (1) 25 mg (milligrams) twice	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 54 daily for anxiety. An order dated 1/3/21, and discontinued on 2/7/22, for Seroquel 25 mg every night at bedtime for anxiety. An order dated 2/8/21 for Seroquel 25 mg every night related to Alzheimer's disease. The resident also had the following orders: An order dated 12/8/21 for Trazadone (2) 50 mg at bedtime for depression. An order dated 1/3/22 for Trazadone 50 mg at bedtime for depression. An order dated 2/8/21 for Trazadone 100 mg at bedtime for depression. A review of the physician's orders revealed an order dated 12/8/21 for psychiatry consult PRN (as needed). There were no targeted behaviors identified for the use of Seroquel. There were no orders for behavior monitoring for the use of Seroquel. There was no monitoring of the effectiveness for either medication. Review of the clinical record revealed one nurse's note, dated 12/13/21, that documented any behaviors. This note documented, "Resident continues to walk up to others and touch their faces, continues when asked to stop by staff and residents. Unable to verbally re-direct. Hitting staff with open hand." Further review revealed a physician's note dated 12/15/21, that documented, "Alzheimer's Dementia with behaviors - writer notified of patient behaviors physical aggression towards staff and difficulty being redirected - psych consulted for further evaluation."	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 55 There was no evidence that the psych consult ever occurred. There was no other behaviors documented, or evidence of behavior monitoring, from the date of admission. A review of the comprehensive care plan dated 12/17/21 revealed, in part: "[Resident #61] uses antidepressant medication ...r/t (related to) Depression ...Monitor/document side effects and effectiveness Q-SHIFT. (every shift)." There was no evidence this monitoring was occurring. Further review of the comprehensive care plan dated 12/17/21 revealed, in part: "[Resident #61] uses psychotropic medications r/t Dementia with Behavior symptoms ...Administer PSYCHOTROPIC medications as ordered by physician. Monitor for side effects and effectiveness Q-SHIFT ....Review behaviors/interventions and alternate therapies attempted and their effectiveness as per facility policy ...Psych consult as ordered ...Record occurrence of target behavior symptoms; aggression towards staff/others, document per facility protocol." There was no evidence any of these interventions were being done. On 2/17/22 at 8:22 AM, an interview was conducted with RN #5 (Registered Nurse). She stated the resident was not really having any behaviors and there was no documentation of monitoring behaviors, and that the psych consult should have been obtained when the physician documented as much on 12/15/21. She stated that the care plan was not being followed.	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 56 On 2/17/22 12:20 PM, ASM #1, #2, and #3 (Administrative Staff Member), the Administrator, Director of Nursing, and the Director of Risk Management, Quality Assurance and Compliance, were notified of the concern. No further information was provided by the end of the survey. References: (1) Seroquel is an antipsychotic medication. It is used for the treatment of schizophrenia; episodes of mania or depression in patients with Bipolar disorder; as conjunctive therapy for the treatment of depression (not related to bipolar disorder). Seroquel has a documented warning of increasing risk of death in older adults with dementia. Seroquel has a warning that it is not approved by the Food and Drug Administration (FDA) for the treatment of behavioral problems in older adults with dementia. There was no reference on the below web page regarding the use of Seroquel for the treatment of anxiety. Information obtained from https://medlineplus.gov/druginfo/meds/a698019.html (2) Trazadone is an antidepressant. Information obtained from https://medlineplus.gov/druginfo/meds/a681038.html Surveyor: Woolf, Samantha 7. The facility staff failed to implement Resident #45's comprehensive care plan for the administration of the physician prescribed medications Flomax (1), Metformin (2) and Buspar (3) on multiple dates in October 2021,	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 57 November 2021, December 2021 and January 2022. Resident #45 was admitted to the facility on 3/11/21. Resident #45's diagnoses included but were not limited to diabetes and benign prostatic hyperplasia. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 1/9/22, the resident scored 11 out of 15 on the BIMS (brief interview for mental status), indicating the resident is moderately cognitively impaired for making daily decisions. Resident #45's comprehensive care plan dated 3/13/21 documented, "[Resident #45] has care needs r/t (related to): DM2 (diabetes), BPH (benign prostatic hyperplasia)...Administer medications as ordered...[Resident #45] uses psychotropic medications for Behavior management...Administer PSYCHOTROPIC medications as ordered by physician..." Review of Resident #45's clinical record revealed a physician's order dated 3/11/21 for Flomax 0.4 mg (milligrams) - two capsules by mouth one time a day for benign prostatic hyperplasia. Review of Resident #45's October 2021 MAR (medication administration record) failed to reveal Flomax was administered to Resident #45 on 10/20/21, 10/21/21, 10/22/21 and 10/24/21. A nurse's note dated 10/20/21 documented there was no medication card containing Flomax and the pharmacy was advised of this on 10/16/21. Nurses' notes dated 10/21/21 and 10/22/21 documented Flomax administration was pending pharmacy delivery. A nurse's note dated 10/24/21 documented Flomax was not available.	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 58 Review of Resident #45's clinical record revealed a physician's order dated 3/11/21 for Metformin 500 mg- one tablet by mouth two times a day for diabetes. Review of Resident #45's October 2021 and December 2021 MARs failed to reveal Metformin was administered at 9:00 a.m. on 10/20/21, 10/21/21, 10/27/21, 10/30/21 and 12/17/21. Nurses' notes dated 10/20/21 and 10/21/21 documented Metformin administration was pending pharmacy delivery. A nurse's note dated 10/27/21 documented the nurse was unable to administer Metformin to Resident #45 because the refill had not been received from the pharmacy. A nurse's note dated 10/30/21 documented Resident #45 did not have Metformin and the pharmacy stated it was too soon to refill the medication. A nurse's note dated 12/17/21 documented the nurse was unable to administer Metformin and the medication was reordered from the pharmacy. Review of Resident #45's clinical record revealed a physician's order dated 5/14/21 for Buspar 5 mg (milligrams) by mouth three times a day for anxiety. Review of Resident #45's October 2021, November 2021 and January 2022 MARs (medication administration records) failed to reveal Buspar was administered at 9:00 a.m. on 10/25/21, 10/27/21, 10/28/21, 10/30/21, 11/1/21, 11/2/21 and 1/8/22. Further review of Resident #45's October 2021, November 2021 and January 2022 MARs failed to reveal Buspar was administered at 1:00 pm. on 10/25/21, 10/27/21, 10/28/21, 10/30/21, 11/1/21, 11/2/21 and 1/9/22. Nurses' notes dated 10/27/21 documented Resident #45 was out of Buspar and the pharmacy was advised. Nurses' notes dated 10/28/21, 11/1/21 and 11/2/21 documented Buspar was not available. Nurses' notes dated	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 59 1/8/22 and 1/9/22 documented the pharmacy was contacted. On 2/16/22 at 1:57 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated the purpose of the care plan is to include any plan of care for that resident or anything staff needs to know for that resident. LPN #1 stated staff can review a resident's care plan in the computer system to ensure the care plan is being implemented. In regards to medication administration, LPN #1 stated she reorders medications when the supply is down to one week. LPN #1 stated that if a prescribed medication is not available for administration then the nurse should obtain the medication from the emergency supply box (if available) or call the pharmacy to have the medication sent STAT (immediately) from the pharmacy or from a local back-up pharmacy. On 2/16/22 at 5:15 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing) and ASM #3 (the director of risk management, quality assurance and compliance) were made aware of the above concern. No further information was presented prior to exit. References: (1) Flomax is used to treat symptoms of an enlarged prostate. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a698012.html (2) Metformin is used to treat diabetes. This	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 60 information was obtained from the website: https://medlineplus.gov/druginfo/meds/a696005.html (3) Buspar is a psychotropic medication used to treat anxiety. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a688005.html 8. The facility staff failed to implement Resident #307's comprehensive care plan for oxygen administration. Resident #307 was admitted to the facility on 8/12/2020. Resident #307's diagnoses included but were not limited to chronic obstructive pulmonary disease and acute respiratory failure. On the most recent MDS (minimum data set), a five day Medicare assessment with an ARD (assessment reference date) of 1/26/22, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident is not cognitively impaired for making daily decisions. Review of Resident #307's clinical record revealed a physician's order dated 11/11/21 that documented, "Apply supplemental O2 (oxygen) via nasal cannula at 2L (liters) PRN (as needed) to maintain SpO2 (oxygen level) > (greater than) 92%" and another physician's order dated 1/13/22 that documented, "Oxygen at 4 liters per minute via NC (nasal cannula)..." Resident #307's comprehensive care plan dated 1/21/22 documented, "[Resident #307] has oxygen therapy R/T (related to) ineffective gas exchange, Respiratory illness (Pneumonia, COVID). OXYGEN SETTINGS: O2 via nasal cannula as	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 61 ordered..." On 2/15/22 at 11:57 a.m., Resident #307 was observed lying in bed and receiving oxygen via a nasal cannula (tubing in the nose). The oxygen concentrator was set at a rate between three liters and three and a half liters as evidenced by the ball in the concentrator flowmeter positioned between the three liter line and the three and a half liter line. On 2/16/22 at 1:57 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated the purpose of the care plan is to include any plan of care for that resident or anything staff needs to know for that resident. LPN #1 stated staff can review a resident's care plan in the computer system to ensure the care plan is being implemented. In regards to oxygen administration, LPN #1 stated the middle of the ball in the oxygen concentrator flowmeter should run through the two liter line for a physician's order of two liters because oxygen would not be administered at two liters if the ball was above or below the two liter line. LPN #1 stated this also applies to a physician's order for four liters. On 2/16/22 at 5:15 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing) and ASM #3 (the director of risk management, quality assurance and compliance) were made aware of the above concern. No further information was presented prior to exit.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 62 §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, it was determined that the facility staff failed to review and/or revise the comprehensive care plan for 2 of 44 residents in the survey sample, Residents #61 and #45. The findings include: 1. For Resident #61, the facility staff failed to review and revise the comprehensive care plan	F 657	**F657/12 VAC 5-371-210/12VAC 5-371-250- Care Plan Timing and Revision** 1.) Residents #43, #407, #18, #70, #73, #61, #45 and #307 were assessed by nursing staff and their medical records were reviewed. The residents' care plans have been updated to reflect a current individualized plan of care. 2.) The Director of Nursing/designee has performed an audit of all current residents' care plans. Care plans have been updated to ensure individualized needs are addressed appropriately and that results are being tracked and addressed appropriately. A process has been developed and implemented to identify resident care needs in the daily interdisciplinary team meeting, and to update the care plans to reflect the needs identified. .) The Director of Nursing/designee has in-serviced nursing leadership and interdisciplinary team members regarding care plan updates. The in-service includes, but no limited to, the importance of care plan reviews	3/23/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 63 after a fall with injury on 1/2/22. Resident #61 was admitted to the facility on 12/8/21 and had the diagnoses of but not limited to Alzheimer's disease, depression, high blood pressure and history of falls. On the most recent MDS (Minimum Data Set), a significant change assessment with an ARD (Assessment Reference Date) of 1/10/22, the resident scored a 3 out of 15 on the BIMS (brief interview for mental status, indicating the resident was severely cognitively impaired for making daily decisions. A review of the clinical record revealed a nurse's note dated 1/2/22 that documented, "This morning at approximately 07:20 am (7:20 AM) this nurse was called to room [number] by certified nursing assistant, once at location, nurse noted resident laying on floor on her back. Nurse assessed resident for pain and injury, resident was noted with skin tear to bilateral hands, and resident complained of right hip pain, unable to bear weight, physician was notified and 911 was called, [name of resident representative] and DON (Director of Nursing) of facility were notified." A review of the comprehensive care plan dated 12/8/21 revealed: "Risk for falls related to dementia ...Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed ...Anticipate and meet the resident's needs." There were no new interventions after the fall on 1/2/22 and no evidence the care plan had been reviewed for potential new interventions after the fall on 1/2/22.	F 657	and updates with any changes for each resident and care plans being reflective of individualized care needs. 4.) The Director of Nursing/designee will conduct an audit of 25% of resident care plans weekly for four weeks to ensure that interventions are appropriate and reflect the individual needs of each resident. The Director of Nursing/designee will also audit the care plans of any new admissions daily for six weeks to ensure that interventions are appropriate and reflect the individual needs of each resident. Any issues identified will be addressed immediately by the Director of Nursing/designee and appropriate actions will be taken to update the resident care plans. The Director of Nursing/designee will identify any trends and/or patters and provide education and training to staff on an ongoing basis. Findings will be discussed with the QAPI committee on at least a quarterly basis.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 64 On 2/17/22 at 8:22 AM, an interview was conducted with RN #5 (Registered Nurse). She stated that the facility "Looked at the care plan last night (2/16/22) and made changes. I'm not sure if it was looked at before. Any nurse can review and revise a care plan. It should have been done at the time of the incident." A review of the facility policy, "Care Planning - Comprehensive Person-Centered" documented, "The Care Planning/Interdisciplinary Team is responsible for the review and updating of care plans: a. When requested by the resident / resident representative; b. When there has been a significant change in the resident's condition; c.When the desired outcome is not met; d. When goals, needs, and preferences change." On 2/17/22 12:20 PM, ASM #1, #2, and #3 (Administrative Staff Member), the Administrator, Director of Nursing, and the Director of Risk Management, Quality Assurance and Compliance, were notified of the concern. No further information was provided by the end of the survey. 2. The facility staff failed to review and revise Resident #45's comprehensive care plan when the resident was diagnosed with pneumonia on 2/9/22. Resident #45 was admitted to the facility on 3/11/21. Resident #45's diagnoses included but were not limited to diabetes and benign prostatic hyperplasia. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 1/9/22, the resident scored 11 out of 15 on the BIMS (brief interview for mental status), indicating the	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 65 resident is moderately cognitively impaired for making daily decisions. Review of Resident #45's clinical record revealed a note signed by the nurse practitioner on 2/9/22 that documented, "Writer reviewed abnormal chest xray, [name of physician] consulted, +PNA (pneumonia). Medications ordered...start Levaquin (1) 750mg (milligrams) daily x (times) 7 days..." A physician's order dated 2/9/22 documented an order for Levaquin 750 mg- one tablet by mouth in the evening for seven days for pneumonia. Resident #45's comprehensive care plan dated 3/13/21 failed to document information regarding the 2/9/22 pneumonia. On 2/19/22 at 3:29 p.m., an interview was conducted with RN (registered nurse) #1. RN #1 stated the purpose of the care plan is that it's the plan of care for the residents and what staff is doing for the residents. RN #1 stated a resident's care plan should be reviewed and revised to include a new diagnosis of pneumonia because pneumonia is an infection and a change in the patient so it has to be in the plan of care. On 2/16/22 at 5:15 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing) and ASM #3 (the director of risk management, quality assurance and compliance) were made aware of the above concern. No further information was presented prior to exit. Reference:	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 66 (1) Levaquin is used to treat pneumonia. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a697040.html	F 657	**F684/12VAC 5-371-22-/12VAC 5-371-250- Quality of Care**	3/23/22
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review and facility document review, it was determined that the facility staff failed to maintain the resident's highest level of well-being for five of 44 residents in the survey sample, Residents # 43, # 91, #11, # 45 and # 73. The findings include: 1. Facility staff failed to obtain a physician's order for the care and treatment of Resident # 43's G-tube (gastrostomy tube) (1) and drainage bag. Resident # 43 was admitted to the facility with a diagnosis that included but not limited to ulcerative colitis. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment	F 684	1) Residents #43, #91, #11, #45 and #73 have been assessed by nursing staff and providers have been notified of findings. No adverse effects were noted to the residents from the failure to provide care per medical provider's orders. It is the policy of Brookside Rehab and Nursing Center to ensure that treatment and care are provided per medical provider orders. All residents have the potential to be affected by this alleged deficient practice. 2. The physician orders were reviewed for residents to ensure that medical care provided is being provided as ordered. Observation audits of resident rooms have been performed to ensure that care is being provided per provider orders. MARs have been reviewed to ensure that medications are being administered per provider orders. Resident weights have been reviewed to ensure that they are obtained per provider orders.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 67 reference date) of 01/08/2022, the resident scored 12 out of 15 on the BIMS (brief interview for mental status), indicating the resident is moderately impaired of cognition for making daily decisions. On 02/15/22 at 12:01 p.m., an observation of Resident # 43 was observed lying in bed with G-tube connected to a drainage bag that was hung on side of their bed. On 02/16/22 at 2:0 p.m., an observation of Resident # 43observed lying in bed with G-tube connected to a drainage bag that was hung on side of their bed. The POS (physician's order sheet) dated February 2022 documented in part, "Gastroenterology consult required as soon as possible every day shift for G & J tube site assessment, drainage related to ULCERATIVE COLITIS ... Order Date: 12/06/2021. Start Date: 12/07/2021." Review of Resident # 43's comprehensive care plan dated 11/12/2021 failed to evidence interventions for the care of the G-tube and drainage bag. On 02/16/2022 at approximately 3:45 p.m. an interview was conducted with LPN (licensed practical nurse) # 1. When asked about Resident # 43's G-tube, LPN # 1 stated that Resident # 43 had the G-tube for drainage of stomach content. When asked about the physician's orders for the care and treatment of the G-tube and drainage bag, LPN # 1 reviewed the physician's orders for Resident # 43 and stated, "There are no orders for treatment, nothing specific to the G-tube and	F 684	3. Licensed staff were re-educated on providing care per provider orders. The training included but was not limited to: "The 5 Rights" of medication administration, as well as timely documentation of all medications and treatments administered, ensuring medical care given is given as ordered, and obtaining weights per provider orders. 4. The Director of Nursing/Designee will audit physician orders and compare the orders to the care being given to residents to ensure that the care is given in accordance with provider orders. The audit will be performed on 20% of residents weekly for 4 weeks and then monthly for 3 months to ensure that substantial compliance is achieved. The Director of Nursing/Designee will identify any patterns or trends and report to the Quality Assurance and Performance Improvement Committee at least quarterly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 68 drainage bag, there's nothing for me to sign off on." When asked about providing care for Resident # 43's G-tube and drainage bag LPN # 1 stated, "I empty the bag on my shift and provide site care for the G-tube by cleaning it with a four-by-four gauze pad." On 02/17/2022 at approximately 7:20 a.m. an interview was conducted with ASM (administrative staff member) # 2, director of nursing. When asked about a physician's order for the care and treatment of the G-tube and drainage bag for Resident # 43, ASM # 2 stated, "We have one now." ASM # 2 stated that they obtained a physician order on 02/16/2022 for the care and treatment of Resident # 43's G-tube and drainage bag. When asked to describe the procedure for obtaining a physician's order for the care and treatment of Resident # 43's G-tube and drainage bag, ASM # 2 stated. "They (nursing) should have called the NP (nurse practitioner) or MD (medical doctor) to get clarification." When asked why it was important to obtain clarification for the care and treatment of Resident # 43's G-tube and drainage bag ASM # 2 stated, "Nursing should be monitoring the output, don't want the bag to be to full, make sure there is no blockage of the tubing and any change in the drainage." The facility's policy "Medication Orders" documented in part, "7. Treatment Orders - When recording treatment orders, specify the treatment frequency, and duration of the treatment. Orders should also identify products [i.e., dressing type, ointments, creams, cleansers, etc.] that are to be used in carrying out the treatment." On 02/17/2022 at approximately 12:15 p.m., ASM	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 69 # 1, administrator, ASM # 2, director of nursing, were made aware of the findings. No further information was provided prior to exit. References: (1) The G-tube is inserted through this cut into the stomach. The tube is small, flexible, and hollow. The doctor uses stitches to close the stomach around the tube. This information was obtained from the website:https://medlineplus.gov/ency/article/002937.htm. 2. The facility staff failed to provide the care and services for a physician-ordered fluid restriction for Resident #91 from 1/16/22 through 2/16/22. Resident #91 was admitted to the facility on 11/10/21. Resident #91's diagnoses included but were not limited to: hyponatremia (low concentration of sodium in the blood often caused by excessive water intake) (1), hypo-osmolality (low concentration of substances in plasma) (2) and alcohol cirrhosis of the liver (fibrous tissues and nodules replace normal tissue in the liver) (3). Resident #91's most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 1/4/22, coded the resident as scoring 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired for making daily decisions. Section G coded the resident as independent with bed mobility, transfers, walking, locomotion, dressing, eating, personal hygiene and bathing. Section H coded the resident as always continent for bowel and bladder.	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 70 A review of Resident #91's comprehensive care plan dated 11/26/21 revealed in part, "FOCUS-Resident has potential for fluid overload or fluid volume deficit r/t (related to) Cirrhosis of Liver, Internal bleeding as evidence by tarry stools ...Ensure that all the resident's snacks and beverages offered at activities comply with diet and fluid restrictions. Monitor vital signs as ordered, Notify MD of significant abnormalities. Monitor/document/report as needed any signs or symptoms of fluid overload." A review of the physician orders dated 11/26/21, revealed in part, "Fluid restriction 1.5 liter. Record shift intake. Every night record for 24 hour intake." A review of the physician progress note dated 1/18/22 at 5:19 PM, revealed in part, "Seen and examined. Per physician recommendations from liver specialist, fluid restriction at 1.5 liters, monitor edema and adjust as needed." A review of the nutrition/dietary notes dated 11/22/21, 12/21/21, 1/4/22 and 1/11/22 did not evidence any documentation of a fluid restriction. A review of the 11/22/21 and 12/22/21 mini nutritional evaluation did not reveal any documentation of a fluid restriction. An interview was conducted with the resident on 2/16/22 at 12:30 PM. When asked if her fluids were restricted, Resident #91 stated, "No, they are not. Not that I know of." An interview was conducted on 2/16/22 at 12:30 PM with LPN (licensed practical nurse) #1. When	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 71	F 684		

asked the purpose of a fluid restriction, LPN #1 stated, "The purpose is to monitor their intake of fluid, so they do not excessively drink water, or gain weight or have physical problems with fluid overload."

On 2/16/22 at 5:16 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the director of risk management, quality and compliance, were made aware of the above concern.

On 2/17/22 at 12:17 PM, an interview was conducted with ASM #2, the director of nursing. When asked if there were any TARs (treatment administration record) for Resident #91's fluid restriction, ASM #2 stated, "No, there are no fluid restriction monitoring for that resident."

The facility's "Fluid and Nutrition Management" policy, documented in part, "Orders for fluid and nutrition management will be obtained from the physician in collaboration with the registered dietitian. The registered dietitian of the nursing facility will collaborate with the registered dietitian from the dialysis team. If the resident is on fluid restriction, the medical record will clearly document the amount of fluid restriction per day. The medical record will document the amount of fluid consumed by the resident each shift."

No further information was provided prior to exit.

References:
(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 284.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 72 Chapman, page 419. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 121. 3. The facility staff failed to administer a physician ordered medication/supplement for Resident #11. Resident #11 was admitted to the facility on 12/16/2020 with a diagnosis of chronic respiratory failure and asthma. On the most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 11/30/2021, the resident scored a 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident is not cognitively impaired for making daily decisions. The nurse practitioner note dated 1/26/2022 at 4:52 p.m. documented in part, "Asked to see by staff request for f/u on urinary complaints...Dysuria - episode of dysuria 5 days ago per nursing." The physician order dated 1/21/2021 documented, "UtyMax Packet (Nutritional Supplements) (used as a dietary management of urinary tract health) (1); Give 1 packet by mouth one time a day for dysuria for 14 days." The start date was documented as 1/22/2022. Review of the January 2022 MAR (medication administration record) documented the above physician order. On 1/22/2022 through 1/28/2022, and 1/30/2022 through 1/31/2022, a "9" was documented. The Chart Code for "9" indicated "Other/see progress notes." Review of the February 2022 MAR documented	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 73 the above physician order. On 2/1/20221, 2/3/2022 and 2/4/2022, a "9" was documented. The nurses' notes for 1/22/2022 at 1:29 p.m.,1/23/2022 at 11:37 a.m., 1/24/2022 at 9:59 a.m., 1/25/2022 at 10:54 a.m., 1/26/2022 at 1:06 p.m., 1/27/2022 at 12:06 p.m., 1/28/2022 at 11:56 a.m., 1/31/2022 at 10:33 a.m., 2/1/2022 at 10:02 a.m., 2/3/2022 at 9:47 a.m., and 2/4/2022 at 1:45 p.m. documented, "pharmacy aware." The nurses' note dated 1/30/2022 at 12:35 p.m. documented, "Not administered - unavailable in stock." The comprehensive care plan dated, 12/17/2020 and revised on 3/21/2021 failed to evidence information related to the urinary tract system or dysuria. An interview was conducted with LPN (licensed practical nurse) #6 on 2/16/2022 at 3:52 p.m. The above MARs and nurses' notes were reviewed with LPN #6. When asked the process for when a medication is not available to be given at the scheduled time, LPN #6 stated the nurse first calls the pharmacy to see if it's pending delivery. She stated she would look in the back up medications. If it's not given, the nurse should write a nurses' note as to why it wasn't given. When asked how many doses can not be given before the physician, nurse practitioner, or pharmacy is notified, #6 stated it should be with the first dose missed. LPN #6 stated she would call the pharmacy. She stated she would find out if it's a pharmacy issue or maybe an insurance issue, and then notify the RP (responsible party) and the doctor and the nurse practitioner on call.	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 74	F 684		

An interview was conducted with RN (registered nurse) #5 on 2/16/2022 at 4:02 p.m. When asked the process if a nurse does not administer a medication, RN #5 stated first the nurse needs to go into [name of computer system] to order the medication. Then the nurse should notify the nurse practitioner as well, and chart in the MAR that medication was not given, and why. She stated she would also notify the family as to why is wasn't given.

On 2/16/2022 at 5:49 p.m. a request was made to the ASM #1, the administrator, for the pharmacy manifest of the delivery of the UtyMax for Resident #11.

An interview was conducted on 2/17/2022 at 8:36 a.m. with ASM (administrative staff member) #2, the director of nursing. When asked the process to be followed if a medication is not available for administration at the scheduled time, ASM #2 stated first the pharmacy is called, then the stat box is checked. When asked if the nurse has to notify someone if a medication is not available, ASM #2 stated the staff member has to call the doctor or nurse practitioner and the RP. ASM #2 presented an email from the pharmacy dated 2/16/2022 at 7:33 p.m. The email documented, "This is an OTC (over the counter), shown as profile only, and is not something that we delivered."

Review of the facility list of stock medications and supplements failed to evidence documentation of the UtyMax as a stock medication.

An interview was conducted with ASM #4, the nurse practitioner on 2/17/2022 at 11:47 a.m. When asked why she ordered the UtyMax, ASM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 75 #4 stated the resident reported discomfort with urination. ASM #4 stated she had seen her that day and then the next day, the resident stated she felt better. When asked if she was notified that the UtyMax was not available and not given, ASM #4 stated, "I don't believe so." The facility policy, "Unavailable Medications" documented in part, "Medications used by resident in the nursing facility may be unavailable for dispensing from the pharmacy on occasion...Procedures: The pharmacy staff shall 1. Call or notify nursing staff that the ordered product(s) is/are unavailable. 2. Notify nursing when it is anticipated that the drug(s) will become available. 3. Suggest alternative, comparable drug(s) and dosage of drug(s) and that is/are available, which is covered by resident's insurance. Nursing staff shall: 1. Notify the attending physician of the situation and explain the circumstances, expected availability and optional therapy(ies) that are available. 2. If the facility nurse is unable to obtain a response from the attending physician, the nurse should notify the nursing supervisor and contact the Facility Medical Director for orders and/or direction. 3. Obtain a new order and cancel/discontinue the order for the non-available medication. 4. Transmitted the replacement order to the pharmacy." ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, the director of risk management, quality assurance and compliance, were made aware of the above concern on 2/17/2022 at 12:25 p.m. No further information was obtained prior to exit.	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 76 (1) This information was obtained from the following website: https://www.Medtirtion.com 4. a. The facility staff failed to administer the physician prescribed medication Levaquin (1) to Resident #45 on 2/15/22. This medication was available in the facility emergency medication supply. Resident #45 was admitted to the facility on 3/11/21. Resident #45's diagnoses included but were not limited to diabetes and benign prostatic hyperplasia. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 1/9/22, the resident scored 11 out of 15 on the BIMS (brief interview for mental status), indicating the resident is moderately cognitively impaired for making daily decisions. Review of Resident #45's clinical record revealed a note signed by the nurse practitioner on 2/9/22 that documented, "Writer reviewed abnormal chest xray, [name of physician] consulted, +PNA (pneumonia). Medications ordered...start Levaquin 750mg (milligrams) daily x (times) 7 days..." A physician's order dated 2/9/22 documented an order for Levaquin 750 mg- one tablet by mouth in the evening for seven days for pneumonia. Review of Resident #45's February 2022 medication administration record failed to reveal the resident was administered the prescribed Levaquin on 2/15/22. A nurse's note dated 2/15/22 documented the Levaquin was not available. Review of the facility emergency medication supply box list revealed 250 mg tablets and 500 mg tablets of Levaquin were available in the box. Resident #45's	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 77 comprehensive care plan dated 3/13/21 failed to document information regarding pneumonia. On 2/16/22 at 1:57 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated that if a prescribed medication is not available for administration then the nurse should obtain the medication from the emergency supply box or call the pharmacy. On 2/16/22 at 5:15 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing) and ASM #3 (the director of risk management, quality assurance and compliance) were made aware of the above concern. On 2/17/22 at 7:20 a.m., an interview was conducted with LPN #2 (the nurse responsible for administering Levaquin to Resident #45 on 2/15/22). LPN #2 stated the medication was not in the medication cart so she did not administer it. The facility pharmacy policy titled, "Medication Administration General Guidelines" documented, "Medications are administered in accordance with written orders of the prescriber." No further information was presented prior to exit. Reference: (1) Levaquin is used to treat pneumonia. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a697040.html 4. b. The facility staff failed to administer the physician prescribed medications Flomax (1) and	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 78 Metformin (2) to Resident #45 on multiple dates in October 2021 and December 2021. These medications were available in the facility emergency supply box. Review of Resident #45's clinical record revealed a physician's order dated 3/11/21 for Flomax 0.4 mg (milligrams) - two capsules by mouth one time a day for benign prostatic hyperplasia. Review of Resident #45's October 2021 MAR (medication administration record) failed to reveal Flomax was administered to Resident #45 on 10/20/21, 10/21/21, 10/22/21 and 10/24/21. A nurse's note dated 10/20/21 documented there was no medication card containing Flomax and the pharmacy was advised of this on 10/16/21. Nurses' notes dated 10/21/21 and 10/22/21 documented Flomax administration was pending pharmacy delivery. A nurse's note dated 10/24/21 documented Flomax was not available. Review of the facility emergency medication supply box list revealed 0.4 mg capsules of Flomax were available in the box. Review of Resident #45's clinical record revealed a physician's order dated 3/11/21 for Metformin 500 mg- one tablet by mouth two times a day for diabetes. Review of Resident #45's October 2021 and December 2021 MARs failed to reveal Metformin was administered at 9:00 a.m. on 10/20/21, 10/21/21, 10/27/21, 10/30/21 and 12/17/21. Nurses' notes dated 10/20/21 and 10/21/21 documented Metformin administration was pending pharmacy delivery. A nurse's note dated 10/27/21 documented the nurse was unable to administer Metformin to Resident #45 because the refill had not been received from the pharmacy. A nurse's note dated 10/30/21 documented Resident #45 did not have	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 79	F 684		

Metformin and the pharmacy stated it was too soon to refill the medication. A nurse's note dated 12/17/21 documented the nurse was unable to administer Metformin and the medication was reordered from the pharmacy. Review of the facility emergency medication supply box list revealed 500 mg tablets of Metformin were available in the box.

Resident #45's comprehensive care plan dated 3/13/21 documented, "[Resident #45] has care needs r/t (related to): DM2 (diabetes), BPH (benign prostatic hyperplasia)...Administer medications as ordered..."

On 2/16/22 at 1:57 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated she reorders medications when the supply is down to one week. LPN #1 stated that if a prescribed medication is not available for administration then the nurse should obtain the medication from the emergency supply box or call the pharmacy.

On 2/16/22 at 5:15 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing) and ASM #3 (the director of risk management, quality assurance and compliance) were made aware of the above concern.

No further information was presented prior to exit.

References:

(1) Flomax is used to treat symptoms of an enlarged prostate. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a698012.h

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 80 tml (2) Metformin is used to treat diabetes. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a696005.html 5. The facility staff failed to obtain monthly weights as ordered by the physician for Resident #73. Resident #73 was admitted to the facility on 3/19/18 and had the diagnoses of, but not limited to dementia and diabetes. On the most recent MDS (Minimum Data Set), a 5-day assessment with an ARD (Assessment Reference Date) of 1/17/22, the resident scored a 3 out of 15 on the BIMS (brief interview for mental status, indicating the resident was severely cognitively impaired for making daily decisions. A review of the clinical record revealed a physician's order dated 2/2/21 that documented, "Monthly weight every day shift every 1 month(s) starting on the 1st for 1 day(s)." The "start date" was documented as 3/1/21. A review of the monthly weights revealed the following:	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 81 1/1/21 149.2 pounds 2/2/21 (above order written, no weight obtained until 9/1/21) 9/1/21 160.2 pounds 9/21/21 157.5 pounds 10/12/21 156.2 pounds 11/2/21 157.8 pounds 12/1/21 154.4 pounds 1/1/22 (no weight obtained) 2/4/22 141.2 pounds This reflected a period of 6 consecutive months for which weights should have been obtained and were not, plus no weight was obtained on 1/1/22, for a total of 7 months (3/1/21, 4/1/21, 5/1/21, 6/1/21, 7/1/21, 8/1/21 and 1/1/22) that ordered weights were not obtained. A review of the comprehensive care plan revealed one dated 1/10/22 for "Nutrition/weight: [Resident #73] has nutritional risk related to dementia, HLD (hyperlipidemia), DM2 (diabetes), HTN (high blood pressure). Rsd (resident) has Mechanical Soft diet r/t (related to) dysphagia and therapeutic diet for supplements." This care plan included an intervention dated 9/4/19 and revised on 5/20/21 for "Assess weight monthly." On 2/17/22 at 8:22 AM, an interview was conducted with RN #5 (Registered Nurse). She stated that the expectation was the weights would be obtained as ordered, and that there was a big gap between weights obtained. She stated that without the weights, the resident cannot be monitored for potential weight loss. On 2/17/22 12:20 PM, ASM #1, #2, and #3 (Administrative Staff Member), the Administrator, Director of Nursing, and the Director of Risk	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 82 Management, Quality Assurance and Compliance, were notified of the concern. No further information was provided by the end of the survey.	F 684	**F695/12 VAC 5-371-220 (B)- Respiratory/Tracheostomy Care and Suctioning** 1.) Oxygen orders for residents #11 and #307 have been reviewed and clarified and the residents are receiving the correct amount of oxygen per the provider orders and the oxygen tubing is correctly dated and stored in a sanitary manner. The residents' plans of care were reviewed and updated to include resident-specific needs. 2.) An observation audit of resident oxygen administration amounts was performed on all residents receiving oxygen and the amounts were compared to the provider's orders. The observation included ensuring that oxygen tubing was properly dated and stored in a sanitary manner. Any discrepancies wer immediately corrected, and orders were verified or clarified with the provider.	3/23/22
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review and clinical record review, it was determined the facility staff failed to provide respiratory care and services in accordance with professional standards of practice for two of 44 residents in the survey sample, Residents # 11 and # 307. The findings include: 1. The facility staff failed to obtain a physician order for the use of oxygen, and failed to store the oxygen cannula and tubing in a sanitary manner for Resident #11. Resident #11 was admitted to the facility on 12/16/2020 with a diagnosis of chronic respiratory failure and asthma. On the most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 83 11/30/2021, the resident scored a 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident is not cognitively impaired for making daily decisions. Section O did not code the resident as having used oxygen. Observation was made of Resident #11 on 2/15/2022 at 11:45 a.m. The resident was sitting on the side of her bed; the oxygen concentrator was next to her bed. The oxygen tubing with cannula was sitting on top of the oxygen concentrator. The tubing was dated 2/15/2022. When asked if she used her oxygen, Resident #11 stated she used it at night. A second observation was made of Resident #11 on 2/16/2022 at 8:25 a.m. The resident way lying in her bed, she stated she had just finished her breakfast and was taking a rest. The oxygen tubing with the cannula was coiled up and sitting on top of the concentrator. The tubing was dated 2/15/2022. Review of the clinical record failed to evidence a physician order for the use of oxygen for Resident #11. The comprehensive care plan dated, 12/25/2020 and revised on 9/13/2021, documented in part, "Focus: [Resident #11] is at risk for shortness of breath r/t (related to) Hypoxia, Chronic Asthma, history of smoking ...Administer oxygen via nasal cannula as ordered; the resident applies own oxygen." An interview was conducted with LPN (licensed practical nurse) #4, on 2/16/2022 at 2:00 p.m. LPN #4 was asked to come to Resident #11's room. When shown the oxygen tubing coiled on top of the oxygen concentrator, LPN #4 was	F 695	3.) The Director of Nursing/designe has in-serviced licensed nurses (RNs and LPNs) regarding oxyge amounts administered to residents. The in-service include but is not limited to, the importance of administering oxygen per provider's orders an clarifying oxygen orders if there any variance between what is ordered and what is stated elsewhere in the medical record, as well as sanitary storage of oxygen tubing. 4.) The Director of Nursing/designee will perform an audit to compare all oxygen orders to amounts administered weekly for six weeks to ensure that oxygen is being administered as per provider orders. The Director of Nursing/designee will perform observation audits of all residents receiving oxygen weekly for six weeks to ensure that tubing is dated and stored in a sanitary manner. Any issues identified will be addressed immediately by	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 84 asked where the oxygen equipment should be stored when not in use. LPN #4 stated it should be stored in a plastic bag. LPN #4 looked for a plastic bag and could not find one. She stated she would have to get a bag. LPN #4 was asked to review Resident #11's physician orders. When asked if there was an order for the oxygen, LPN #4 stated she did not see an order for oxygen. When asked if there should be an order, LPN #4 stated, "Yes." The facility policy, "Oxygen Administration", documented in part, "Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration..." The policy did not address the storage of oxygen equipment when not in use. According to Fundamentals of Nursing, Fifth Edition, Lippincott Williams & Wilkins, 2007, page 851, "Because oxygen is a drug, its use requires a prescription. Policies and standing orders often permit the nurse to administer oxygen in emergency situations if the physician is not immediately available to write an order. Although oxygen is generally safe when used properly, certain precautions must be observed. As with all drugs, the potential exists for causing harm with misuse." ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the director of risk management, quality assurance and compliance, were made aware of the above concern on 2/16/2022 at 5:48 p.m. No further information was obtained prior to exit.	F 695	Director of Nursing/designee and appropriate actions will be taken. The Director of Nursing/designee will identify any trends and/or patterns and additional education and training will be provided to staff on an ongoing basis. Findings will be discussed with the QAPI committee on at least a quarterly basis.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 85 2. The facility staff failed to clarify two different physician's orders for Resident #307's oxygen administration, and failed to administer oxygen to the resident per either order. Resident #307 was admitted to the facility on 8/12/2020. Resident #307's diagnoses included but were not limited to chronic obstructive pulmonary disease and acute respiratory failure. On the most recent MDS (minimum data set), a five day Medicare assessment with an ARD (assessment reference date) of 1/26/22, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident is not cognitively impaired for making daily decisions. Review of Resident #307's clinical record revealed a physician's order dated 11/11/21 that documented, "Apply supplemental O2 (oxygen) via nasal cannula at 2L (liters) PRN (as needed) to maintain SpO2 (oxygen level) > (greater than) 92%" and another physician's order dated 1/13/22 that documented, "Oxygen at 4 liters per minute via NC (nasal cannula)..." Resident #307's comprehensive care plan dated 1/21/22 documented, "[Resident #307] has oxygen therapy R/T (related to) ineffective gas exchange, Respiratory illness (Pneumonia, COVID). OXYGEN SETTINGS: O2 via nasal cannula as ordered..." On 2/15/22 at 11:57 a.m., Resident #307 was observed lying in bed and receiving oxygen via a nasal cannula (tubing in the nose). The oxygen concentrator was set at a rate between three liters and three and a half liters, as evidenced by the ball in the concentrator flowmeter positioned	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 86 between the three liter line and the three and a half liter line. On 2/16/22 at 1:57 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated if a resident has two different physician's orders for oxygen, then the orders should be clarified with the nurse practitioner or the person who entered the orders into the computer system. LPN #1 stated Resident #307 had been transferred to the hospital and she thought the resident was supposed to receive two liters before the hospitalization and four liters after her return. In regards to oxygen administration, LPN #1 stated the middle of the ball in the oxygen concentrator flowmeter should run through the two liter line for a physician's order of two liters because oxygen would not be administered at two liters if the ball was above or below the two liter line. LPN #1 stated this also applies to a physician's order for four liters. On 2/16/22 at 5:15 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing) and ASM #3 (the director of risk management, quality assurance and compliance) were made aware of the above concern. The facility policy titled, Oxygen Administration" documented, "1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration...Turn on the oxygen at the number of liters / minute as ordered by the physician/practitioner." The oxygen concentrator manufacturer's instructions documented, "5. Adjust the flow to	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 87 the prescribed setting by turning the knob on the top of the flow meter until the ball is centered on the line marking the specific flow rate." No further information was presented prior to exit.	F 695		
F 697 SS=E	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, it was determined that the facility staff failed to implement a complete pain management program by documenting the location of the resident's pain and implementing non-pharmacological interventions prior to the administration of a prn (as needed) pain medications for two of 44 residents in the survey sample, Residents # 35 and # 77. The findings include: 1. The facility staff failed to document the location of the Resident #35's pain, and to implement non-pharmacological interventions prior to the administration of oxycodone (1). Resident # 35 was admitted to the facility with a diagnosis that included contractures. On the most recent MDS (minimum data set), a	F 697	**F697/12 VAC 5-371-220 (B)- Pain Management** 1.) Residents #35 and #77 have been assessed by nursing staff and provider to ensure pain management regimen is effective. The residents' PRN pain medication orders have been updated to include pain location and non-pharmacological interventions. Plan of care was reviewed and updated for individualized care needs. 2.) The Director of Nursing/designee has performed an audit of all current PRN pain medication orders to ensure that pain location and non-pharmacological interventions are included in the orders. Plans of care have been reviewed and updated for individualized care needs.	3/23/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 88 quarterly assessment with an ARD (assessment reference date) of 01/04/2022, the resident scored 5 (five) out of 15 on the BIMS (brief interview for mental status), indicating the resident is severely impaired of cognition for making daily decisions. The resident was coded as frequently experiencing pain at a level of three out of 10 during the look back period. The physician's order sheet (POS) for Resident # 35 dated February 2022 documented in part: "Oxycodone HCl (hydrogen chloride) Tablet 5 (five) MG (milligrams). Give 1 (one) tablet by mouth every 6 (six) hours as needed for pain. Order Date: 12/03/2021. Start Date: 12/03/2021." The comprehensive care plan for Resident # 35 with a revision date of 10/29/2021 documented in part, "[Resident # 35] is at risk for pain related to sacral wound, right heel wound, contracture to extremities. Revision on: 10/29/2021." The eMAR (electronic medication administration record) for Resident # 35 dated January 2022 documented the physician's order as stated above. Further review of the eMAR revealed Resident # 35 received 5 mgs of oxycodone the following dates and times, with no evidence of non-pharmacological interventions being attempted: 01/02/2022 at 9:02 p.m.; 01/03/2022 at 6:00 a.m.; 01/11/2022 at 9:06 a.m.; 01/19/2022 at 11:43 a.m.; and on 01/31/2022 at 10:39 p.m. The eMAR for Resident # 35 dated February 2022 documented the physician's order as stated above. Further review of the eMAR revealed Resident # 35 received 5 mgs of oxycodone the following dates and times, with no evidence of non-pharmacological interventions being	F 697	3.) The Director of Nursing/designee has in-serviced licensed nurses (RNs and LPNs) regarding assessing resident pain location and attempting non-pharmacological interventions prior to administering PRN pain medications. The education included, but was not limited to, correct transcription and entry of PRN pain medication orders into the EHR. 4.) The Director of Nursing/designee will audit the MAR five times weekly for 6 weeks to review accuracy of PRN pain medication orders and ensure that the orders include requirements to document pain location and to attempt non-pharmacological interventions prior to administration of PRN pain medication. Any issues identified will be addressed immediately by Director of Nursing/designee and appropriate actions will be taken. The Director of Nursing/designee will identify any trends and/or patterns, and additional education and training will be provided to employees on an	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 89 attempted: 02/04/2022 at 6:55 p.m.; 02/12/2022 at 11:40 p.m.; 01/11/2022 at 9:06 a.m.; 01/16/2022 at 12:00 a.m.; and at 9:17 p.m. Review of the facility's nursing progress notes for Resident # 35 dated 01/01/2022 through 02/16/2022 failed to evidence documentation of the location of Resident # 35's pain and non-pharmacological interventions attempted for the dates Resident # 35 received 5 mgs of oxycodone referenced above. On 02/16/2022 at approximately 1:30 p.m., an interview was conducted with LPN (licensed practical nurse) # 1 regarding the procedure for administering prn (as needed) pain medication and documentation of non-pharmacological interventions. LPN # 1 stated, "Assess the resident's pain, where the pain is and using a scale one to ten, with ten being the worse pain. Attempt interventions, repositioning, to alleviate their pain, if it doesn't work check the order for prn pain medication and administer it. Recheck the resident within an hour to check for effectiveness." When asked how often the non-pharmacological interventions should be attempted LPN # 1 stated, "Every time." When asked about documenting location of the resident's pain and attempts of non-pharmacological interventions LPN # 1 stated, "It's documented in the nurse's notes." After reviewing the physician's orders, eMARs dated January 2022 and February 2022, the nurse's progress notes dated 01/01/2022 through 02/16/2022 for Resident # 35, LPN # 1 was asked if there was documentation of the location Resident # 35's pain and that non-pharmacological interventions were attempted prior to Resident # 35 receiving the	F 697	ongoing basis. Findings will be discussed with the QAPI committee on at least a quarterly basis.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 90 physician ordered pain medication of oxycodone. LPN # 1 stated no. The facility's policy "Pain Management" documented in part, "Various strategies and modalities may be utilized to assist the resident in achieving optimal comfort. Such strategies and modalities may include, but are not limited to: a. Non-pharmacological interventions may be appropriate alone or in conjunction with medications." On 02/16/2022 at approximately 5:00 p.m., ASM (administrative staff member) # 1, administrator, ASM # 2, director of nursing and ASM # 3, director of risk management, quality assurance and compliance, were made aware of the findings. No further information was provided prior to exit. Reference: (1) Oxycodone is used to relieve moderate to severe pain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682132.html. 2. The facility staff failed to document the location of the Resident #77's pain and implement non-pharmacological interventions prior to the administration of acetaminophen (1). Resident # 77 was admitted to the facility with a diagnosis that including low back pain. On the most recent MDS (minimum data set), a 5-Day assessment with an ARD (assessment reference date) of 01/18/2022, the resident	F 697		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 91 scored 13 out of 15 on the BIMS (brief interview for mental status), indicating the resident is cognitively intact for making daily decisions. Resident #77 was coded as frequently experiencing pain at a level of 5 out of 10 during the look back period. The physician's order sheet for Resident # 77 dated February 2022 documented in part: "Acetaminophen Tablet 500 MG (milligrams). Give 2 (two) tablet by mouth every 12 hours as needed for Pain. Oder Date: 11/18/2021. Start Date: 11/18/2021." The comprehensive care plan for Resident # 77 with a revision date of 11/18/2021 documented in part, "[Resident # 77] has the potential for pain. Revision on: 11/18/2021." The eMAR (electronic medication administration record) for Resident # 77 dated January 2022 documented the physician's order as stated above. Further review of the eMAR revealed Resident # 77 received 500 mgs of acetaminophen the following dates and times, with no evidence of non-pharmacological interventions being attempted: 01/02/2022 at 12:52 p.m.; 01/05/2022 at 11:12 a.m.; 01/08/2022 at 12:21 p.m.; 01/10/2022 at 6:08 a.m.; 01/19/2022 at 11:45 a.m.; and on 01/30/2022 at 12:42 p.m. The eMAR for Resident # 77 dated February 2022 documented the physician's order as stated above. Further review of the eMAR revealed Resident # 77 received 500 mgs of acetaminophen the following dates and times, with no evidence of non-pharmacological interventions being attempted: 02/07/2022 at 5:54	F 697		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 92 a.m. Review of the facility's nursing progress notes for Resident # 77 dated 01/01/2022 through 02/07/2022 failed evidence documentation of the location of Resident # 77's pain and non-pharmacological interventions attempted for the dates Resident # 77 received 500 mgs of acetaminophen referenced above. On 02/16/2022 at approximately 1:30 p.m., an interview was conducted with LPN (licensed practical nurse) # 1 regarding the procedure for administering prn (as needed) pain medication and documentation of non-pharmacological interventions. LPN # 1 stated, "Assess the resident's pain, where the pain is and using a scale one to ten, with ten being the worse pain. Attempt interventions, repositioning, to alleviate their pain, if it doesn't work check the order for prn pain medication and administer it. Recheck the resident within an hour to check for effectiveness." When asked how often the non-pharmacological interventions should be attempted LPN # 1 stated, "Every time." When asked about documenting location of the resident's pain and attempts of non-pharmacological interventions LPN # 1 stated, "It's documented in the nurse's notes." After reviewing the physician's orders, eMARs dated January 2022 and February 2022, the nurse's progress notes dated 01/01/2022 through 02/07/2022 for Resident # 77, LPN # 1 was asked if there was documentation of the location Resident # 77's pain and that non-pharmacological interventions were attempted prior to Resident # 77 receiving the physician ordered pain medication of acetaminophen. LPN # 1 stated no.	F 697		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 93 On 02/16/2022 at approximately 5:00 p.m., ASM (administrative staff member) # 1, administrator, ASM # 2, director of nursing and ASM # 3, director of risk management, quality assurance and compliance, were made aware of the findings. No further information was provided prior to exit. References: (1) Used to relieve mild to moderate pain from headaches, muscle aches, menstrual periods, colds and sore throats, toothaches, backaches, and reactions to vaccinations (shots), and to reduce fever. Acetaminophen may also be used to relieve the pain of osteoarthritis (arthritis caused by the breakdown of the lining of the joints). This information was obtained from the website: https: https://medlineplus.gov/druginfo/meds/a681004.html.	F 697		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview, resident interview, facility document review and clinical record review, it was determined the facility staff failed to provide communication to the dialysis facility for one of 44 residents, Resident #407.	F 698		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698	Continued From page 94 For Resident #407, the facility failed to provide communication to the dialysis facility for 23 to 25 visits. The findings include: Resident #407 was admitted to the facility on 12/24/21. Resident #407's diagnoses included but were not limited to: end stage renal disease (end stage of renal failure-inability of the kidneys to excrete wastes and function in the maintenance of electrolyte balance) (1), congestive heart failure (abnormal congestion caused by circulatory congestion and retention salt and water by the kidneys) (2) and chronic respiratory failure (inability of the heart and lungs to maintain and adequate level of gas exchange) (3). Resident #407's most recent MDS (minimum data set) assessment, a five day assessment, with an assessment reference date of 12/31/21, coded the resident as scoring 11 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident is moderately cognitively impaired for making daily decisions. The resident was coded as requiring total dependence for transfers, locomotion and bathing; extensive assistance for bed mobility, dressing; limited assistance for mobility, and hygiene and supervision for eating. The resident was coded as always incontinent for bowel and for bladder. The resident was coded as receiving dialysis during the look back period. A review of the comprehensive care plan dated 12/26/21 revealed, in part, "Resident needs Hemodialysis related to renal failure ...Encourage	F 698	**F698/12 VAC5-371-220- Dialysis** 1.) Dialysis assessments and communication with the dialysis center has been established for resident #407. The resident's plan of care was reviewed and updated to reflect their resident-specific needs. 2.) The Director of Nursing/designee has identified all current residents receiving hemodialysis and has established resident assessments and communication with the dialysis center. Nursing staff has ensured that care plan interventions are appropriate and address resident specific care needs. 3) The Director of Nursing/designee has educated licensed clinical staff regarding dialysis assessment and communication with dialysis centers. The education includes, but is not limited to, the importance of assessing residents pre-dialysis and post-dialysis, and the importance of sending and	3/23/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698	Continued From page 95 resident to go for the scheduled dialysis appointments. Resident receives dialysis 3X a week (Tues-Thurs-Sat). Provide communication book for resident to dialysis for continuation of care between dialysis and facility per protocol." A review of the physician orders dated 12/27/21, revealed in part, "Hemodialysis, time to be picked up 10 every day shift every Monday, Wednesday and Friday." Order renewed through 2/18/22. A review of Resident #407's dialysis binder containing the "Dialysis Communication Record," with top section to be completed by the facility and the bottom portion to be completed by the dialysis center, revealed records dated 2/12/22 and 2/15/22, and evidenced a missing a total of 23 forms for the dates of: 12/26/21, 12/27/21, 12/29/21, 12/31/21, 1/3/22, 1/5/22, 1/7/22, 1/10/22, 1/12/22, 1/14/22, 1/17/22, 1/19/22, 1/21/22, 1/24/22, 1/26/22, 1/28/22, 1/31/22, 2/2/22, 2/4/22, 2/7/22, 2/9/22, 2/11/22, 2/14/22. On 2/16/22 at 8:25 AM, an interview was conducted with Resident #407. When asked if he had a dialysis binder, Resident #407 stated, "I have not seen one. The nurses may have it." On 2/16/22 at 8:45 AM, an interview was conducted with RN (registered nurse) #2. When asked if there was a dialysis book for Resident #407, RN #2 stated, "Yes, here it is." When asked the purpose of the communication forms, RN #2 stated, "They are to ensure we are providing information between the facility and the center regarding the resident; vital signs, any changes, any issues with fistula or device." On 2/16/22 at 4:00 PM, a request was made to	F 698	receiving resident information to and from the dialysis center. 4.) The Director of Nursing/designee will review residents receiving hemodialysis weekly for six weeks to ensure that proper assessments were performed, and that communication has been sent to and received from dialysis centers. Any issues identified will be addressed immediately by Director of Nursing/designee and appropriate actions will be taken. The Director of Nursing/designee will identify any trends and/or patterns, and provide education as needed on an ongoing basis. Findings will be discussed with the QAPI committee on at least a quarterly basis.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698	Continued From page 96 provide the dialysis communication forms for Resident #407. On 2/16/22 at 5:16 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the director of risk management, quality and compliance, were made aware of the above concern. On 2/17/22 at 7:45 AM, two dialysis communication forms, dated 2/12/22 and 2/15/22 were provided for Resident #407. On 2/17/22 at 12:17 PM, an interview was conducted with ASM #2, the director of nursing. When asked if there were any additional dialysis communication forms, other than the two provided, for Resident #407, ASM #2 stated, "No, there are no additional forms." A review of the facility's "End-Stage Renal Disease, Care of a Resident", documented in part, "Agreements between this facility and the contracted ESRD facility will include all aspects of how the resident's care will be managed including but not limited to ...the communication process between the nursing facility and the dialysis center that will reflect ongoing communication, coordination, and collaboration." No further information was provided prior to exit. References: (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 498. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 133.	F 698		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698	Continued From page 97 (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 502.	F 698		
F 730 SS=D	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, it was determined that the facility staff failed to conduct annual performance reviews for 2 of 3 CNAs (certified nursing assistants) whose records were reviewed, CNAs #4 and #6. The findings include: The facility staff failed to conduct a performance review for CNA #4, hired on 3/7/2017 and reviewed for performance evaluation completed between 3/1/2020-3/31/2021; and CNA #6, hired on 11/8/1993 and reviewed for performance evaluation completed between 11/1/2020-11/30/2021. On 2/16/22 at approximately 8:00 a.m., a list of CNAs who were employed at the facility for more than one year was provided by ASM (administrative staff member) #1, the administrator. On 2/16/22 at approximately 12:15 p.m., ASM #2,	F 730	**F730/12VAC 5-371-210 A.5/12VAC3-371-260 E- Nurse Aide Performance Review** 1. The facility has completed annual performance reviews for CNA #4 and CNA #6. In-service education was given to CNA #4 and CNA #6 based on the outcome of the reviews. 2. An audit of 12-month performance reviews have been completed for all CNAs currently employed by the facility. Any variances found have been corrected and all currently employed CNAs have had a 12-month performance review completed. Nursing management and Human Resources staff were re-educated on the importance of conducting	3/23/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 730	Continued From page 98 the director of nursing, was asked to provide the annual performance reviews for the CNAs selected from the facility list. Review of the annual performance reviews failed to reveal a completed review after 11/11/2020 for CNA #4 (hired 3/7/2017) and CNA #6 (hired on 11/8/1993). On 2/16/22 at 5:10 p.m., an interview was conducted with OSM (other staff member) #7, the human resource manager. OSM #7 stated that they had been there for four months and had been working to get the employee evaluations caught up. OSM #7 stated that they had sent out self- evaluations to the staff, but did not have an evaluation for CNA #4 or CNA #6 completed after 11/11/2020. OSM #7 stated that evaluations were completed annually, and these two CNAs should have had one completed in 2021. On 2/17/22 at 7:30 a.m., an interview was conducted with ASM #2, the director of nursing. ASM #2 stated that they received a list of nursing evaluations that were due from the human resources department, and gave them out to the department heads to complete them. ASM #2 stated that the unit managers completed the evaluations for the CNAs with input from the floor nursing staff, and that they were completed annually. ASM #2 was notified of CNA #4's and CNA #6's last evaluation date of 11/11/2020 and stated that they would look to see if they had an evaluation completed in 2021. The facility policy "Evaluation Process" documented in part, "...It is the policy of our facility to review the work performance of employees with a formal written evaluation	F 730	annual CNA performance reviews and providing in-service education based on the outcome of the reviews. The education included, but was not limited to, procedure for conducting the annual performance review, performance benchmarks, and identifying areas of CNA performance requiring in-service education. 4. The Director of Nursing/Designee will perform an audit of annual CNA performance reviews weekly for 6 weeks and then monthly for 3 months to ensure that the reviews are completed and in-service education is provided based on the outcome of the reviews. The Director of Nursing/designee will identify any trends and/or patterns and additional education and training will be provided on an ongoing basis. Findings will be discussed with the QAPI committee on at least a quarterly basis.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 730	Continued From page 99 annually..." The facility policy "Nurse Aide In-Service Training Program" documented in part, "...2. The facility completes a performance review of nurse aides at least annually. 3. In-service training is based on the outcome of the annual performance reviews, addressing weaknesses identified in the reviews and as mandated by federal or state regulation..." On 2/17/22 at 12:15 p.m., ASM #1, the administrator, ASM #2, director of nursing and ASM #3, the director of risk management, quality assurance and compliance were made aware of the findings. No further information was provided prior to exit.	F 730		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 100 pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide pharmacy services for one of 44 residents in the survey sample, Resident #45. The facility staff failed to acquire Resident #45's medication Buspar (1) for administration on multiple dates in October 2021, November 2021 and January 2022. The findings include: Resident #45 was admitted to the facility on 3/11/21. Resident #45's diagnoses included but were not limited to diabetes and benign prostatic hyperplasia. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 1/9/22, the resident scored 11 out of 15 on the BIMS (brief interview for mental status), indicating the resident is moderately cognitively impaired for making daily decisions.	F 755	**F755/12VAC 5-371-220-Pharmacy Services/Procedures/Pharmacist /Records** 1) Resident #45 has been assessed by nursing staff and provider with no negative outcomes noted. The resident, resident representative, and provider were notified of missing doses. Plan of care was reviewed and updated for individualized care needs. 2) The Director of Nursing/designee has performed an audit of all medications administered by nursing staff since 3/1/2022. Any resident who has missed an administration of a medication has been assessed by nursing staff and the provider and resident representative have been notified. Plans of care have been reviewed and updated for individualized care needs. 3.) The Director of Nursing/designee has in-serviced licensed nurses (RNs and LPNs) regarding process for when a medication is not available. The in-service includes, but is not limited to, notification to provider for new orders, accessing the STAT box, using a	3/23/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 101 Review of Resident #45's clinical record revealed a physician's order dated 5/14/21 for Buspar 5 mg (milligrams) by mouth three times a day for anxiety. Review of Resident #45's October 2021, November 2021 and January 2022 MARs (medication administration records) failed to reveal Buspar was administered at 9:00 a.m. on 10/25/21, 10/27/21, 10/28/21, 10/30/21, 11/1/21, 11/2/21 and 1/8/22. Further review of Resident #45's October 2021, November 2021 and January 2022 MARs failed to reveal Buspar was administered at 1:00 pm. on 10/25/21, 10/27/21, 10/28/21, 10/30/21, 11/1/21, 11/2/21 and 1/9/22. Nurses' notes dated 10/27/21 documented Resident #45 was out of Buspar and the pharmacy was advised. Nurses' notes dated 10/28/21, 11/1/21 and 11/2/21 documented Buspar was not available. Nurses' notes dated 1/8/22 and 1/9/22 documented the pharmacy was contacted. Review of the facility emergency medication supply box list revealed Buspar was not in the supply. Resident #45's comprehensive care plan dated 3/13/21 documented, "[Resident #45] uses psychotropic medications for Behavior management...Administer PSYCHOTROPIC medications as ordered by physician..." On 2/16/22 at 1:57 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated she reorders medications when the supply is down to one week. LPN #1 stated that if a prescribed medication is not available for administration, then the nurse should obtain the medication from the emergency supply box (if available) or call the pharmacy to have the medication sent STAT (immediately) from the	F 755	back-up pharmacy if medications are unavailable from the primary pharmacy, and reporting any concerns to the nursing supervisor. 4.) The Director of Nursing/designee will audit the MAR five times weekly for 6 weeks to review medication availability, accurate documentation, and provider notification. Any issues identified will be addressed immediately by Director of Nursing/designee and appropriate actions will be taken. The Director of Nursing/designee will identify any trends and/or patterns, and additional education and training will be provided to employees on ar ongoing basis. Findings will be discussed with the QAPI committee on at least a quarterly basis.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 102 pharmacy or from a local back-up pharmacy. LPN #1 stated there had been times when she had difficulty obtaining medications from the contracted pharmacy, and the facility had obtained services from a different pharmacy. On 2/16/22 at 5:15 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing) and ASM #3 (the director of risk management, quality assurance and compliance) were made aware of the above concern. The facility pharmacy policy titled, "Medication Administration General Guidelines" documented, "Medications are administered in accordance with written orders of the prescriber." No further information was presented prior to exit. Reference: (1) Buspar is a psychotropic medication used to treat anxiety. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a688005.html	F 755		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or	F 757		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 103 §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview and facility document review, it was determined that the facility staff failed to ensure that 1 of 44 residents in the survey sample was free of unnecessary medications, Resident #359. On 7/27/2021, the facility staff administered Narcan nasal spray to Resident #359, rather than the physician-ordered and scheduled saline nasal spray. The findings include: Resident #359 was admitted to the facility with diagnoses that included but were not limited to chronic pain and low back pain. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 10/12/2021, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact for making daily decisions. Section J coded Resident #359 as having pain almost constantly.	F 757	**F757/12VAC 5-371-220 A,B- Drug Regimen is Free from Unnecessary Drugs** 1.) Resident #359 is no longer a resident at the facility. It is the policy of Brookside Nursing and Rehab to ensure that residents' drug regimens are free from unnecessary drugs. All residents have the potential to be affected by this alleged deficient practice. 2.) The Director of Nursing/designee has performed an audit of all medications administered by nursing staff since 3/1/2022. Any resident who has missed an administration of a medication has been assessed by nursing staff and the provider and resident representative have been notified. Plans of care have been reviewed and updated for individualized care needs.	3/23/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 104 On 2/16/2022 at 2:45 p.m., an interview was conducted with OSM (other staff member) #13, the ombudsman. OSM #13 that they had received an anonymous report that Resident #359 had received Narcan by mistake from the nursing staff, and she had verified that this had happened at the facility. The physician orders for Resident #359 documented in part, - "Naloxone HCL liquid 4 MG (milligram)/ 0.1 ML (milliliter) 1 spray in both nostrils every 2 minutes as needed for respiratory depression/sedation. Repeat as needed for respiratory depression/sedation. Repeat q2 (every two) mins (minutes) until pt (patient) responsive or EMS (emergency medical services) arrives *Palliative care order*, Order Date: 2/10/2021." - "Saline Nasal Spray Solution 0.65% (Saline) 2 spray in both nostrils one time a day for congestion. Order Date: 2/10/2021." The progress notes for Resident #359 documented in part, - "7/27/2021 12:31 (12:31 p.m.) Note Text: Resident request transfer to the ED (emergency department); reports N/V (nausea, vomitting [sic]) and chills post administration of Narcan. The resident was sent via 911." - "7/27/2021 18:43 (6:43 p.m.) Note Text: Resident returned from hospital via ambulance report received resident is in no acute distress." - "7/28/2021 12:24 (12:24 p.m.) MD (medical doctor) progress note ...Seen and examined today as requested above. Staff endorse yesterday pt (patient) given Narcan but was not lethargic/sedated. Following administration pt reported N/V, heart palpitations, anxiety, and severe back pain. Staff endorse pt sent to ER	F 757	3.) The Director of Nursing/designee has in-serviced licensed nurses (RNs and LPNs) regarding avoiding the use of unnecessary drugs. The in-service includes, but is not limited to, notification to provider of any unnecessary drugs administered, "The 5 Rights of Medication Administration", and reporting any concerns to nursing management. 4.) The Director of Nursing/designee will audit the MAR five times weekly for 6 weeks to review medication administration, accurate documentation, and provider notification of any unnecessary drugs administered. Any issues identified will be addressed immediately by Director of Nursing/designee and appropriate actions will be taken. The Director of Nursing/designee will identify any trends and/or patterns, and additional education and training will be provided to employees on an ongoing basis. Findings will be discussed with the QAPI committee on at least a quarterly basis.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 105 (emergency room) and pt returned shortly after with orders for Percocet 5/325 mg prn (as needed) and Zofran. Pt denies any N/V or heart palpations. He endorses he still feels some anxiety regarding the situation..." The transfer form for Resident #359 dated 7/27/2021 documented in part, "...Resident reports chills and vommiting [sic] post primary nurse inadvertently administering Narcan and request transfer to the ED..." The facility medication error report for Resident #359 dated 7/27/2021 documented in part, "...Nurse was pulling nasal spray for resident and accidentally pull [sic] Narcan 0.4mg nasal spray and given to resident. Resident c/o SOB (shortness of breath), chills and request to go to ER. No injuries observed at time of incident..." The ED visit note from [Name of Hospital] for Resident #359 dated 7/27/21 documented in part, "...The patient states that he was given his usual dose of oxycodone this morning. About 40 minutes after he was given the oxycodone, his agency nurse came in the room and squirted medicine up is [sic] nose is [sic] which ended up being his p.r.n. (as needed) Narcan order even though he did not demonstrate any signs of sedation. Patient states he felt like "he was going to die" for 30-45 minutes. He had intense, severe back pain, palpitations, anxiety. EMS (emergency medical services) was called. He was given IV (intravenous) Toradol and brought to the emergency department for evaluation. On my initial evaluation, his withdrawal symptoms have resolved. He states he is feeling back to normal..." The progress note/re-examination documented, "Chronic pain patient who was	F 757		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 106 accidentally given at prn dose of Narcan which caused florid opiate withdrawal which caused him great distress and discomfort for 30-45 minutes. After 45 minutes, the Narcan dispersed enough so that the residual oxycodone could once again occupy the pain receptors. He reports he feels back to normal but shortly after initial evaluation, he complained of increasing pain in his back and requested a dose of oxycodone. He was given this, he exhibits no symptoms of withdrawal and is stable for discharge back to LTC (long term care) facility..." On 2/17/2022 at 11:08 a.m., an interview was conducted with RN (registered nurse) #3, the assistant director of nursing. RN #3 stated that the floor nurse had informed them that they had given the Narcan spray instead of the saline nasal spray to Resident #359 on 7/27/2021. RN #3 stated that they had gone in to assess the resident who stated that he did not feel right and complained of nausea and vomiting. RN #3 stated that they contacted the nurse practitioner, checked the vital signs and did a full assessment. RN #3 stated that the nurse practitioner did not feel that Resident #359 needed to go to the hospital but the resident requested to be sent out so they sent him at his request. RN #3 stated that after the incident they completed one on one education with the nurse on six rights of medications. RN #3 stated that the nurse was an agency nurse but still worked the evening shift at the facility. RN #3 stated that they no longer assigned that nurse to Resident #359 when he returned to the facility, at his request. RN #3 stated that the nurse practitioner who treated Resident #359 no longer worked at the facility On 2/17/2022 at 11:33 a.m., an interview was	F 757		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 107 conducted with LPN (licensed practical nurse) #6. LPN #6 stated that they were doing the medication pass on 7/27/2021 for Resident #359 when they accidentally gave Narcan instead of the saline nasal spray. LPN #6 stated that after they realized it was not the right medication, they called the charge nurse right away. LPN #6 stated that the charge nurse came over and they checked the resident and contacted the nurse practitioner. LPN #6 stated that Resident #359 requested to go to the emergency room so they sent him and he came back that evening. LPN #6 stated that after this incident a senior nurse had educated her about the medication and medication administration as well as supervised them during medication pass. LPN #6 stated that they were also being extra cautious when giving medications and always checking to make sure they had the right patient, the right dose of medication, the right route of administration, the right medication, the right time of administration and the right documentation. On 2/17/2022 at 11:46 a.m., an interview was conducted with ASM (administrative staff member) #4, nurse practitioner. ASM #4 stated that Narcan was administered for a suspected overdose or overdose of opioids. ASM #4 stated that inadvertent administration of Narcan would mainly cause tachycardia and was a safe medication. ASM #4 stated that Narcan would cause nervous symptoms but nothing significant and there would be very little harm done by administering Narcan by mistake. The facility policy, "Medication Administration General Guidelines" documented in part, "...Five Rights- Right resident right drug, right dose, right route and right time, are applied for each	F 757		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 108 medication being administered. A triple check of these 5 rights is recommended at three steps in process of preparation of a medication for administration: (1) when the medication is selected, (2) when the dose is removed from the container, and finally (3) just after the dose is prepared and the medication is put away..." The facility policy "Adverse Consequences and Medication Errors" documented in part, "...5. Examples of medications errors include: a. omission - a drug is ordered but not administered; b. unauthorized drug - a drug is administered without a physician's order; c. wrong dose ..." On 2/17/2022 at 12:15 p.m., ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, the director of risk management, quality assurance and compliance were made aware of the findings. No further information was provided prior to exit.	F 757		
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that---	F 758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 109 §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to ensure residents were free of unnecessary psychoactive	F 758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 110 medications for 2 of 44 residents in the survey sample, Residents #70 and #61. The findings include: 1. For Resident #70, the facility failed to evidence documented appropriate diagnosis, target behaviors, behavior monitoring, monitoring of medication effectiveness, psychiatric evaluations as ordered/recommended, and care plan implementation as related to the use of psychoactive medications. Resident #70 was admitted to the facility on 11/29/21 with the diagnoses of but not limited to Alzheimer's disease, diabetes, high blood pressure, breast cancer, and anxiety disorder. On the most recent MDS (Minimum Data Set), a 5-day assessment with an ARD (Assessment Reference Date) of 1/18/22, the resident scored a 4 out of 15 on the BIMS (brief interview for mental status, indicating the resident was severely cognitively impaired for making daily decisions. A review of the clinical record revealed physician's orders as follows: An order dated 11/29/21 for Seroquel (1) 25 mg (milligrams), give 3 tablets (75 mg) at bedtime related to Alzheimer's disease. An order dated 11/29/21 for Depakote (2) 250 mg, give 2 tablets (500 mg) at bedtime related to Alzheimer's disease. An order dated 12/1/21 for psychiatry consult PRN (as needed). A physician's note dated 11/30/21 documented, "...Alzheimer's dementia with behaviors, anxiety - psych follow-up required..."	F 758	**F758/12VAC 5-371-140/12VAC 5-371-220/12VAC 5-371-240/12VAC 5-371-250/12VAC 5-371-300- Free from Unnecessary Psychotropic Meds/PRN Use** 1.) Residents #61 and #70 have been assessed by nursing staff and provider to ensure current PRN psychotropic medication regimen is appropriate and that psychiatric evaluations are ordered as recommended by the provider. The residents' PRN psychotropic medication orders have been updated to include appropriate diagnosis, target behaviors, behavior monitoring, and monitoring of medication effectiveness. The residents' care plans have been updated as related to the use of psychoactive medications. 2.) The Director of Nursing/designee has performed an audit of all residents receiving PRN psychotropic medications to ensure current PRN psychotropic medication regimen is appropriate and that psychiatric evaluations are ordered as recommended by the provider. Any variances have been corrected. Plans of care have	3/23/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 111 A physician's note dated 12/7/21 documented, "...Alzheimer's dementia with behaviors, anxiety...psych follow-up required..." A physician's note dated 2/7/22 documented, "...On assessment, pt (patient) awake and alert sitting up in dining room, denies acute complaints, staff deny acute issues....Alzheimer's dementia with behaviors, anxiety - psych follow-up required..." There were no notes by the nurses or the physician that the resident had actually displayed any behaviors since admission. There was no documented target behaviors for the use of the Seroquel. There was no documented behavior monitoring for the use of the Seroquel. There was no evidence of any psychiatric consult having occurred as ordered by the physician and documented in physician notes that it was required. A review of the comprehensive care plan dated 12/10/21 revealed, in part: "[Resident #70] uses psychotropic medication r/t (related to) Dementia with agitation ...Administer PSYCHOTROPIC medications as ordered by physician. Monitor for side effects and effectiveness Q-SHIFT (every shift) ...Review behaviors/interventions and alternate therapies attempted and their effectiveness as per facility policy." There was no evidence any of these interventions were being followed. On 2/17/22 at 8:22 AM, an interview was conducted with RN #5 (Registered Nurse). She stated that there was no documentation of any behaviors or monitoring. She stated that the	F 758	been reviewed and updated for individualized care needs. All current PRN psychotropic medication orders have been updated to include appropriate diagnosis, target behaviors, behavior monitoring, and monitoring of medication effectiveness. The residents' care plans have been updated as related to the use of psychoactive medications. 3.) The Director of Nursing/designee has in-serviced licensed nurses (RNs and LPNs) regarding use of unnecessary psychotropic medications. The education included, but was not limited to, review of PRN psychotropic medication regimen, communication with providers, advocating for psychiatric evaluations, and proper order entry in the EHR to ensure appropriate documentation for all PRN psychotropic medication orders to include appropriate diagnosis, target behaviors, behavior monitoring, and monitoring of medication effectiveness.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 112 resident has had some behaviors of crying, yelling, getting upset. She stated that she was not sure why there had not had any charting. When asked about the use of Seroquel, she stated "I don't know that her behaviors warrants needing to be on Seroquel. I have never seen her having any behaviors towards any staff or others." She stated that there should be consistent charting evidencing behaviors or lack thereof. She stated that "It makes it difficult for the doctor to assess if there are no notes documenting behaviors or lack of behaviors." She stated that there was not adequate charting done to "warrant these medications." She stated that she was aware that dementia with behaviors was not an acceptable diagnosis, alone, for the use of Seroquel. On 2/17/21 at 11:22 AM an interview was conducted with ASM #4 (Administrative Staff Member) the Nurse Practitioner. She stated that for Resident #70, "Seroquel is appropriate because Alzheimer's has led to behaviors and agitation in the past. Her behaviors are anxiety episodes, crying, upset." Regarding following up to make sure consults are being done, she stated, "I continue the orders recommended by the hospital. I trust their expertise and recommendation, and medications are adjusted by the psychiatric Nurse Practitioner." When notified that the resident had not had any evaluations by the psychiatric nurse practitioner since admission, and asked how she follows up to make sure they are being done, she stated, "For residents I am actively concerned about, I am in constant communication with the psychiatric Nurse Practitioner. I don't believe for this resident there have been any significant issues that made me feel an immediate	F 758	4.) The Director of Nursing/designee will audit all current PRN psychotropic medication orders five times weekly for 6 weeks to review necessity of medications, accurate documentation, and communication with the provider regarding PRN psychotropic medication regimen and necessity for psychiatric evaluations. Any issues identified will be addressed immediately by Director of Nursing/designee and appropriate actions will be taken. The Director of Nursing/designee will identify any trends and/or patterns, and additional education and training will be provided to employees on an ongoing basis. Findings will be discussed with the QAPI committee on at least a quarterly basis.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 113 evaluation was required. The Pharmacy makes recommendations for psychoactive medications, and I review those. I feel comfortable decreasing the medication related to drowsiness, otherwise the psychiatric Nurse Practitioner monitors them." When asked about the appropriateness of the medications, with lack of behavior monitoring and lack of a psychiatric evaluation, she stated, "I believe the medication and dosage upon admission was appropriate. We could have been more specific regarding diagnosis and agitation. We do link dementia to behaviors. I base my evaluation on verbal communication from staff regarding behaviors and effectiveness. It would be helpful to see more documentation." A review of the facility policy "Behavioral Assessment, Intervention and Monitoring" documented: "Non-pharmacological approaches will be utilized to the extent possible to avoid or reduce the use of antipsychotic or psychoactive medications to manage behavioral symptoms ... When medications are prescribed for behavioral symptoms, documentation may include: a. Rationale for use; b. Potential underlying causes of the behavior; c. Other approaches and interventions tried prior to the use of antipsychotic or psychoactive medications; d. Potential risks and benefits of medications as discussed with the resident and/or family; e. Specific target behaviors and expected outcomes; f. Dosage; g. Duration; h. Monitoring for efficacy and adverse consequences; and i. Plans (if applicable) for gradual dose reduction.	F 758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 114 ....4. If antipsychotic or psychoactive medications are used to treat behavioral symptoms, the IDT will monitor their indication and implement a gradual dose reduction, or document why this cannot or should not be done (for example, recurrence of psychotic symptoms after several previous attempts to taper medications). a. The IDT will monitor for side effects and complications related to psychoactive medications; for example, lethargy, abnormal involuntary movements, anorexia, or recurrent falling. b. If such symptoms are identified, and some medication is still needed, the IDT will recommend adjustment of the current regimen to try to minimize side effects while maintaining therapeutic effectiveness..." A review of the facility policy, "Use of Psychotropic Medication" documented, "Residents are not given psychotropic drugs unless the medication is necessary to treat a specific condition, as diagnosed and documented in the clinical record, and the medication is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication(s)... 4. The indications for use of any psychotropic drug will be documented in the medical record ...7. Residents who use psychotropic drugs shall also receive non-pharmacological interventions to facilitate reduction or discontinuation of the psychotropic drugs...." On 2/17/22 12:20 PM, ASM #1, #2, and #3 (Administrative Staff Member), the Administrator, Director of Nursing, and the Director of Risk Management, Quality Assurance and Compliance, were notified of the concern. No	F 758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 115 further information was provided by the end of the survey. References: 1. Seroquel is an antipsychotic medication. It is used for the treatment of schizophrenia; episodes of mania or depression in patients with Bipolar disorder; as conjunctive therapy for the treatment of depression (not related to bipolar disorder). Seroquel has a documented warning of increasing risk of death in older adults with dementia. Seroquel has a warning that it is not approved by the Food and Drug Administration (FDA) for the treatment of behavioral problems in older adults with dementia. Information obtained from https://medlineplus.gov/druginfo/meds/a698019.html 2. Depakote is used to treat certain types of seizures; is used to treat mania in patients with Bipolar disorder. There was no reference on the below web page regarding the use of Depakote for Alzheimer's disease. Information obtained from https://medlineplus.gov/druginfo/meds/a682412.html 2. For Resident #61, the facility staff failed to evidence documented appropriate diagnosis, target behaviors, behavior monitoring, monitoring of medication effectiveness, psychiatric evaluations as ordered/recommended, and care plan implementation as related to the use of psychoactive medications.	F 758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 116 Resident #61 was admitted to the facility on 12/8/21 with the diagnoses of but not limited to Alzheimer's disease, depression, high blood pressure and history of falls. On the most recent MDS (Minimum Data Set), a significant change assessment with an ARD (Assessment Reference Date) of 1/10/22, the resident scored a 3 out of 15 on the BIMS (brief interview for mental status, indicating the resident was severely cognitively impaired for making daily decisions. A review of the clinical record revealed the following physician's orders: An order dated 12/8/21, and discontinued on 1/3/21, for Seroquel (1) 25 mg (milligrams) twice daily for anxiety. An order dated 1/3/21, and discontinued on 2/7/22, for Seroquel 25 mg every night at bedtime for anxiety. An order dated 2/8/21 for Seroquel 25 mg every night related to Alzheimer's disease. The resident also had the following orders: An order dated 12/8/21 for Trazadone (2) 50 mg at bedtime for depression. An order dated 1/3/22 for Trazadone 50 mg at bedtime for depression. An order dated 2/8/21 for Trazadone 100 mg at bedtime for depression. A review of the physician's orders revealed an order dated 12/8/21 for psychiatry consult PRN (as needed). There were no targeted behaviors identified for the use of Seroquel. There were no orders for behavior monitoring for the use of Seroquel. There was no monitoring of the effectiveness for either medication.	F 758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 117 Review of the clinical record revealed one nurse's note, dated 12/13/21, that documented any behaviors. This note documented, "Resident continues to walk up to others and touch their faces, continues when asked to stop by staff and residents. Unable to verbally re-direct. Hitting staff with open hand." Further review revealed a physician's note dated 12/15/21, that documented, "Alzheimer's Dementia with behaviors - writer notified of patient behaviors physical aggression towards staff and difficulty being redirected - psych consulted for further evaluation." There was no evidence that the psych consult ever occurred. There was no other behaviors documented, or evidence of behavior monitoring, from the date of admission. A review of the comprehensive care plan dated 12/17/21 revealed, in part: "[Resident #61] uses antidepressant medication ...r/t (related to) Depression ...Monitor/document side effects and effectiveness Q-SHIFT. (every shift)." There was no evidence this monitoring was occurring. Further review of the comprehensive care plan dated 12/17/21 revealed, in part: "[Resident #61] uses psychotropic medications r/t Dementia with Behavior symptoms ...Administer PSYCHOTROPIC medications as ordered by physician. Monitor for side effects and effectiveness Q-SHIFT ....Review behaviors/interventions and alternate therapies attempted and their effectiveness as per facility	F 758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 118 policy ...Psych consult as ordered ...Record occurrence of target behavior symptoms; aggression towards staff/others, document per facility protocol." There was no evidence any of these interventions were being done. On 2/17/22 at 8:22 AM, an interview was conducted with RN #5 (Registered Nurse). She stated that there was no documentation of any behaviors or monitoring. She stated that the resident hasn't had any behaviors. She stated that she was not sure why there had not had any charting. When asked about the use of Seroquel, she stated "I don't know that her behaviors warrants needing to be on Seroquel. I have never seen her having any behaviors towards any staff or others." She stated that there should be consistent charting evidencing behaviors or lack thereof. She stated that "It makes it difficult for the doctor to assess if there are no notes documenting behaviors or lack of behaviors." She stated that there was not adequate charting done to "warrant these medications." She stated that she was aware that dementia with behaviors was not an acceptable diagnosis alone, for the use of Seroquel. She stated that the psych consult should have been obtained when the nurse practitioner documented as much on 12/15/21. On 2/17/21 at 11:22 AM an interview was conducted with ASM #4 (Administrative Staff Member) the Nurse Practitioner. She stated that for Resident #70, "Seroquel is appropriate because Alzheimer's led to behaviors and agitation in the past. Her behaviors are she gets agitated in bed, anxiety, restless, and this is when she tries to get up and falls." Regarding following up that consults are being done, she stated, "I	F 758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 119 continue the orders recommended by the hospital. I trust their expertise and recommendation, and medications are adjusted by the psychiatric Nurse Practitioner." When notified that the resident had not had any evaluations by the psychiatric nurse practitioner since admission, and asked how she follows up that the evaluations are being done, she stated, "For residents I am actively concerned about, I am in constant communication with the psychiatric Nurse Practitioner. I don't believe for this resident there have been any significant issues that made me feel an immediate evaluation was required. The Pharmacy makes recommendations for psychoactive medications, and I review those. I feel comfortable decreasing the medication related to drowsiness, otherwise the psychiatric Nurse Practitioner monitors them." When asked about the appropriateness of the medications, with lack of behavior monitoring and lack of a psychiatric evaluation, she stated, "I believe the medication and dosage upon admission was appropriate. We could have been more specific regarding diagnosis and agitation. We do link dementia to behaviors. I base my evaluation on verbal communication from staff regarding behaviors and effectiveness. It would be helpful to see more documentation." On 2/17/22 12:20 PM, ASM #1, #2, and #3 (Administrative Staff Member), the Administrator, Director of Nursing, and the Director of Risk Management, Quality Assurance and Compliance, were notified of the concern. No further information was provided by the end of the survey. References: 1. Seroquel is an antipsychotic medication. It is	F 758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 120 used for the treatment of schizophrenia; episodes of mania or depression in patients with Bipolar disorder; as conjunctive therapy for the treatment of depression (not related to bipolar disorder). Seroquel has a documented warning of increasing risk of death in older adults with dementia. Seroquel has a warning that it is not approved by the Food and Drug Administration (FDA) for the treatment of behavioral problems in older adults with dementia. There was no reference on the below web page regarding the use of Seroquel for the treatment of anxiety. Information obtained from https://medlineplus.gov/druginfo/meds/a698019.html 2. Trazadone is an antidepressant. Information obtained from https://medlineplus.gov/druginfo/meds/a681038.html	F 758		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. 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 ensure a resident was free of a significant medication error for one of 44 residents in the survey sample, Resident #45. On 2/9/22, the nurse practitioner prescribed Resident #45 the medication Levaquin (1) for seven days for a diagnosis of pneumonia. The facility staff failed to administer Levaquin to	F 760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 121 Resident #45 on 2/15/22. The findings include: Resident #45 was admitted to the facility on 3/11/21. Resident #45's diagnoses included but were not limited to diabetes and benign prostatic hyperplasia. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 1/9/22, the resident scored 11 out of 15 on the BIMS (brief interview for mental status), indicating the resident is moderately cognitively impaired for making daily decisions. Review of Resident #45's clinical record revealed a note signed by the nurse practitioner on 2/9/22 that documented, "Writer reviewed abnormal chest xray, [name of physician] consulted, +PNA (pneumonia). Medications ordered...start Levaquin 750mg (milligrams) daily x (times) 7 days..." A physician's order dated 2/9/22 documented an order for Levaquin 750 mg- one tablet by mouth in the evening for seven days for pneumonia. Review of Resident #45's February 2022 medication administration record failed to reveal the resident was administered the prescribed Levaquin on 2/15/22. A nurse's note dated 2/15/22 documented the Levaquin was not available. Review of the facility emergency medication supply box list revealed 250 mg tablets and 500 mg tablets of Levaquin were available in the box. Resident #45's comprehensive care plan dated 3/13/21 failed to document information regarding pneumonia. On 2/16/22 at 1:11 p.m., an interview was	F 760	**F760/12 VAC 5-371-220- Residents are Free of Significant Med Errors** 1.) Resident #45 has been assessed by nursing staff and provider with no negative outcomes noted. The resident, responsible party and provider were notified of missing doses. Plan of care was reviewed and updated for individualized care needs. 2.) The Director of Nursing/designee has performed an audit of all medications administered by nursing staff since 3/1/2022. Any resident who has missed an administration of a medication has been assessed by nursing staff and the provider and resident representative have been notified. Plans of care have been reviewed and updated for individualized care needs.	3/23/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 122 conducted with ASM (administrative staff member) #4 (the nurse practitioner). ASM #4 stated about a week ago, Resident #45 presented with a couple episodes of hypoxia (an insufficient amount of oxygen) so a chest x-ray was obtained, the physician was consulted, and Levaquin was prescribed for pneumonia. ASM #4 stated it was very important for Resident #45 to receive each dose of Levaquin because of the concern regarding his respiratory status. ASM #4 stated she was not aware Resident #45 did not receive Levaquin on 2/15/22. ASM #4 further stated she evaluated the resident on 2/15/22 and another chest x-ray was completed because Resident #45 had not completely improved. ASM #4 stated she thought Resident #45's respiratory difficulties may be residual effects from COVID-19 and she was prescribing another antibiotic. On 2/16/22 at 1:57 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated that if a prescribed medication is not available for administration then the nurse should obtain the medication from the emergency supply box or call the pharmacy. On 2/16/22 at 5:15 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing) and ASM #3 (the director of risk management, quality assurance and compliance) were made aware of the above concern. On 2/17/22 at 7:20 a.m., an interview was conducted with LPN #2 (the nurse responsible for administering Levaquin to Resident #45 on 2/15/22). LPN #2 stated the medication was not in the medication cart so she did not administer it.	F 760	3.) The Director of Nursing/designee has in-serviced licensed nurses (RNs and LPNs) regarding process for when a medication is not available. The in-service includes, but is not limited to, notification to provider for new orders, accessing the STAT box, using a back-up pharmacy if medications are unavailable from the primary pharmacy, and reporting any concerns to the nursing supervisor. 4.) The Director of Nursing/designee will audit the MAR five times weekly for 6 weeks to review medication availability, accurate documentation, and provider notification. Any issues identified will be addressed immediately by Director of Nursing/designee and appropriate actions will be taken. The Director of Nursing/designee will identify any trends and/or patterns, and additional education and training will be provided to employees on an ongoing basis. Findings will be discussed with the QAPI committee on at least a quarterly basis.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 123 The facility pharmacy policy titled, "Medication Administration General Guidelines" documented, "Medications are administered in accordance with written orders of the prescriber." No further information was presented prior to exit. Reference: (1) Levaquin is used to treat pneumonia. "Take levofloxacin exactly as directed. Do not take more or less of it or take it more often than prescribed by your doctor." This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a697040.html	F 760		
F 804 SS=F	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview and clinical record review, it was determined that the facility staff failed to provide food at a palatable temperature during lunch service on 02/16/2022, with the potential to affect 55 of 55 residents on the North unit receiving a meal tray. The vegetables, potatoes, and mechanical soft vegetables served at lunch and	F 804		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 804	Continued From page 124 tested for palatability were below a palatable temperature. The findings include: Review of the resident council minutes from 11/30/2021 revealed in part, "...Residents state their food is not hot when they receive their meals." Review of the resident council minutes from 12/01/2021 revealed in part, " ...Resident states his meals are not hot when he receives them in his room each shift ...Resident states ...food is not hot all meals ...Resident states his breakfast is cold when received each morning ..." On the most recent MDS (minimum data set) for Resident # 23, a quarterly assessment with an ARD (assessment reference date) of 12/14/2021, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident is cognitively intact for making daily decisions. On 02/15/2022 at 2:06 p.m., an interview was conducted with Resident #23. The resident stated the facility food could be warmer. On 02/16/2022 at 10:40 a.m., the holding temperatures of lunch were obtained from the service line in the kitchen and were (in degrees Fahrenheit): Pork - 160 Vegetables - 190 Potatoes - 164 Mechanical soft vegetables- 172 After the holding temperatures were obtained, plates were prepared, covered with a lid, placed in food carts and taken to units. On 02/16/2022 at 12:11 p.m., a test tray was plated and sent to the North unit in the food cart with resident trays.	F 804	**F804** 1.) All residents have the potential to be affected. 2.) The Dietary Manager will review the serving process and audit the tray temps to identify if temperatures continue to be out of range. 3.) Regional Dietary Manager will reeducate the Dietary department about the range of acceptable temps and best practices to ensures that the food is served to the residents at a palatable temperature. 4.) The Regional Dietary Manager or designee will complete a tray temperature audit weekly x4 and the monthly x two to ensure will conduct an audit food is served to the residents at a palatable temperature. Findings will be discussed with the QAPI committee on at least a quarterly basis.	3/23/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 804	Continued From page 125 On 02/16/2022 at 12:25 p.m. (when the final meal was served on the North unit), the temperatures of the food on the test tray were obtained by OSM # 12, the dietary manager. The temperatures were: Vegetables - 115 Potatoes - 112 Mechanical soft vegetables- 110 The food on the test tray was sampled by two surveyors who determined the vegetables and potatoes were not warm enough to be palatable. OSM # 12 confirmed this and stated these food items could be warmer. The facility policy, "Food Quality and Palatability" documented in part, "It is the center policy that, food is prepared by methods that conserve nutritive value, flavor and appearance. Food is palatable, attractive and served at a safe and appetizing temperature." On 02/16/2022 at approximately 5:00 p.m., ASM (administrative staff member) # 1, administrator, ASM # 2, director of nursing and ASM # 3, director of risk management, quality assurance and compliance, were made aware of the findings. No further information was presented prior to exit.	F 804		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal,	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 126 state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review it was determined facility staff failed to store and prepare food in a sanitary manner. The findings include; On 02/15/2022 at approximately 10:40 a.m., an observation of the facility's kitchen was conducted with OSM (other staff member) # 12, dietary manager with the following concerns: 1. The facility staff failed to ensure a food processor, ready for use, was cleaned and free from standing water. Observation of the food processor located in the facility's kitchen on a food preparation table was conducted with OSM # 12. When asked if the food processor was cleaned and ready for use, OSM # 12 stated, "Yes." Observation of the inside of the food processor lid revealed it was wet, with standing water inside the bowl, and with a wet	F 812	**F812** 1.) No specific residents were identified but identified items were cleaned and items were dates after being identified. 2.) The Dietary Manager or designee will audit the items on the food prep tables to ensure they are properly cleaned and free of standing water. In addition, the Dietary Manager or designee will audit the fridges to ensure items are date properly 3.) Regional Dietary Manager will reeducate the Dietary department regarding proper cleaning techniques are followed and will reeducate the Dietary department on ensuring opened items are properly dates in the fridge.	3/23/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 127 blade. After observing the food processor bowl OSM # 12 stated that the inside of the lid and blade were wet and that the bowl contained approximately one to two tablespoons of standing water. OSM # 12 immediately removed the food processor lid, blade and bowl and sent it to the dish washer to be cleaned. 2. The facility staff failed to date two bowls containing eight ounces of prepared salad that were available for use in the facility's daily preparation reach-in refrigerator. On 02/15/2022 at approximately 10:40 a.m., an observation of the inside of the daily preparation reach-in refrigerator facility's kitchen revealed two bowls of salad covered with plastic wrap, with no evidence of a date available to be served. When asked when the salads were prepared OSM # 12 stated, "They were made yesterday, they should have been dated and taken out today." OSM # 12 immediately removed the salads from the refrigerator and discarded them. The facility's policy "Food Storage: Cold" documented in part, "5. The Dining Services Director / Cook(s) insures that all food items are stored properly in covered containers, labeled and dated and arranged in a manner to prevent cross contamination." 3. The facility staff failed to implement the use of hair nets during food preparation. During the observation of the facility's kitchen on 02/16/2022 at 11:58 a.m., OSM # 21, dietary aide, was observed entering the kitchen, walking toward the food service line, and leaning over the	F 812	4.) The Regional Dietary Manager or designee will complete an audit weekly x4 and the monthly x two to ensure that the items on the food prep tables are properly cleaned and free of standing water. In addition, the Regional Dietary Manager or designee will complete an audit weekly x4 and the monthly x two to ensure the fridge is free of open items that are not dates Findings will be discussed with the QAPI committee on at least a quarterly basis.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 128 tray preparation line while food was being placed on plates and lunch trays being assembled. Further observation revealed OSM # 21 was not wearing a hair net. On 02/16/2022 at approximately 1:30 p.m., an interview was conducted with OSM # 12 regarding the use of hair nets. OSM # 12 stated that everyone in the kitchen or who enters the kitchen should be wearing a hair net to keep hair out of the food. On 02/17/2022 at 2:00 p.m., an interview was conducted with OSM # 21 regarding the use of hair nets. When OSM # 21 was asked if they were wearing a hair net when they entered the kitchen earlier that day when lunch trays were being prepared OSM # 21 stated, "No." When asked to describe the procedure for the use of a hair net OSM # 21 stated that it should be put on before entering the kitchen. The facility's policy "Authorized Kitchen Personnel" documented in part, "2. All authorized personnel must wear appropriate head covering while in the kitchen or production area." On 02/16/2022 at approximately 5:00 p.m., ASM (administrative staff member) # 1, administrator, ASM # 2, director of nursing and ASM # 3, director of risk management, quality assurance and compliance, were made aware of the findings. No further information was provided prior to exit.	F 812		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 129 §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential 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.	F 842	**F842/12VAC 5-371-140/12VAC 5-371-360- Resident Records - Identifiable Information** 1. Resident #53 was assessed and interviewed by nursing staff and interviewed by social services. The resident and provider were notified of bathing patterns and schedule. The resident's plan of care was reviewed and updated to reflect their resident-specific needs. 2. Nursing staff performed assessments and interviews with residents and recorded results in medical record. Nursing has notified residents, responsible parties and provider of bathing patterns and schedule for residents. Nursing staff has ensured that care plan interventions are appropriate and address resident specific care needs.	3/23/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 130 §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 (ii) 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 provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: 2. The facility staff failed to document showers for Resident #53. The findings include: Resident #53 was admitted to the facility on 3/6/20. Resident #53's diagnoses included but were not limited to: scoliosis (abnormal lateral or sideward curve to the spine) (1), pancreatitis (inflammation of the pancreas usually caused by alcohol or gallstones) (2) and obsessive compulsive disorder (uncontrollable need to	F 842	3. The Director of Nursing/designee has educated clinical staff, including RNs, LPNs, CNA's and NAs regarding shower schedule, bathing preferences, and documentation. The education includes, but is not limited to, the importance of documentation of showers and regular bathing. 4. The Director of Nursing/designee will review ADL documentation and nurses notes five times weekly for six weeks to ensure that showers are being provided to residents as scheduled, and documentation is complete. Any issues identified will be addressed immediately by Director of Nursing/designee and appropriate actions will be taken. The Director of Nursing/designee will identify any trends and/or patterns, and provide education as needed on an ongoing basis. Findings will be discussed with the QAPI committee on at least a quarterly basis.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 131 repeat certain acts or rituals) (3). Resident #53's most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 11/15/21, coded the resident as scoring 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident is not cognitively impaired for making daily decisions. Section G coded the resident as requiring limited assistance for bathing. A review of Resident #53's comprehensive care plan dated 3/9/20, revealed in part, "Resident has an ADL (activity of daily living) self-care performance deficit related to activity intolerance ...Resident prefers to shower 1X/week (once a week) only on a regular basis." During the investigation of the FRI (facility reported incident) dated 1/10/22, an interview was conducted on 2/15/22 at 3:22 PM with Resident #53. When asked if she had any other concerns, Resident #53 stated, "I only want a shower every week. I have not consistently been getting them, but is getting better the last 3-4 weeks. I have a few nursing aides that I like to work with and they have been showering me." The resident was observed wearing clean clothes, with hair combed and no odors. A review of the TAR (treatment administration record), for December 2021, January 2022 and February 2022, revealed that during the twelve weeks from December 1, 2021 through February 16, 2022, there was only one instance of shower documentation. On 12/14/21, the resident was documented to have refused a shower.	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 132 An interview was conducted on 2/16/22 at 4:00 PM with CNA (certified nursing assistant) #1, the staffing coordinator. When asked if she provided showers to Resident #53, CNA #1 stated, "Yes, the Resident likes me to bathe her. She is very particular and only wants certain staff to bathe her weekly. That is her preference for a weekly bath." When shown the ADL sheets for December 2021, January and February 2022 and asked what the blank holes in documentation mean, CNA #1 stated, "If it wasn't charted it just wasn't documented, I know I did her showers, because we work well together. They were done, just not documented." On 2/16/22 at 5:16 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the director of risk management, quality and compliance, were made aware of the above concern. No further information was provided prior to exit. References: (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 519. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 430. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 409. 3. The facility staff failed to maintain an accurate clinical record, for Resident #11. A nurse signed off a medication as being given when it was never delivered from the pharmacy, and was not	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 133 available in the stock medications. Resident #11 was admitted to the facility on 12/16/2020 with a diagnosis of chronic respiratory failure and asthma. On the most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 11/30/2021, the resident scored a 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident is not cognitively impaired for making daily decisions. The physician order dated, 1/21/2021 documented, "UtyMax Packet (Nutritional Supplements) (used as a dietary management of urinary tract health) (1); Give 1 packet by mouth one time a day for dysuria for 14 days." Start date was documented as 1/22/2022. Review of the January 2022 MAR (medication administration record) documented the above physician order. On 1/22/2022 through 1/28/2022 and 1/30/2022 through 1/31/2022, a "9" was documented. The Chart Code for "9" indicated "Other/see progress notes." Review of the February 2022 MAR documented the above physician order. On 2/1/20221, 2/3/2022 and 2/4/2022, a "9" was documented. The nurses' notes for 1/22/2022 at 1:29 p.m.,1/23/2022 at 11:37 a.m., 1/24/2022 at 9:59 a.m., 1/25/2022 at 10:54 a.m., 1/26/2022 at 1:06 p.m., 1/27/2022 at 12:06 p.m., 1/28/2022 at 11:56 a.m., 1/31/2022 at 10:33 a.m., 2/1/2022 at 10:02 a.m., 2/3/2022 at 9:47 a.m., and 2/4/2022 at 1:45 p.m., documented, "pharmacy aware." The nurses' note dated 1/30/2022 at 12:35 p.m.	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 134 documented, "Not administered - unavailable in stock." The comprehensive care plan dated, 12/17/2020 and revised on 3/21/2021 failed to evidence documentation related to the urinary tract system or dysuria. On 2/16/2022 at 5:49 p.m., a request was made to ASM #1, the administrator, for the pharmacy manifest of the delivery of the UtyMax for Resident #11. An interview was conducted on 2/17/2022 at 8:36 a.m. with ASM (administrative staff member) #2, the director of nursing. When asked the process if a medication is not available for administration at the scheduled time, ASM #2 stated first we call the pharmacy, then check the stat box. When asked if the nurse has to notify someone if a medication is not available, ASM #2 stated, yes, they have to call the doctor or nurse practitioner and the RP (responsible party). ASM #2 presented an email from the pharmacy dated 2/16/2022 at 7:33 p.m. The email documented, "This is an OTC (over the counter), shown as profile only, and is not something that we delivered." When asked how the nurse on 1/29/2022 and 2/2/2022 was able to document that it was administered, ASM #2 stated, "It most likely was not given since it wasn't in the facility." When asked if that is an accurate record, ASM #2 stated, "No." When asked if the nurse was available for interview, ASM #2 stated it was an agency nurse, who no longer comes to the facility. Review of the facility stat box failed to evidence documentation of the UtyMax as a stock	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 135 medication. ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, the director of risk management, quality assurance and compliance, were made aware of the above concern on 2/17/2022 at 12:25 p.m. No further information was obtained prior to exit. Based on staff interview, clinical record review, facility document review, and in the course of a complaint investigation, it was determined that the facility staff failed to ensure a complete and accurate clinical record for 3 of 44 residents in the survey sample, Residents #700, #53 and #11. The findings include: 1. Facility staff failed to ensure a complete and accurate clinical record for Resident #700 regarding follow up for a critical laboratory test result. Resident #700 was admitted to the facility on 10/23/20 and discharged on 1/12/22. The resident had the diagnoses of but not limited to chronic obstructive pulmonary disease, COVID-19, dysphagia, pancreatic insufficiency, diabetes, alcohol dependence, depression, adjustment disorder, anxiety disorder, hepatitis, high blood pressure, and prostate malignancy. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 11/12/21, the resident scored 15 out of 15 on the BIMS (brief interview for mental status, indicating the resident is not	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 136 cognitively impaired for making daily decisions. During a review of a complaint investigation, the following was noted: " A review of the clinical record revealed a BMP (Basic Metabolic Panel) (1) result dated as follows: Collected 1/22/21 at 8:30 PM. Received 1/22/21 at 9:16 PM. The lab result documented a glucose level of 1107 and documented "Results called to [facility nurse RN #6 (Registered Nurse)] by [lab staff member] at 9:57 PM." There was no documentation by the facility staff regarding this reported lab value and what care was initiated. " Further review of the clinical record revealed an order dated 10/23/20 for "Accucheck before meals and at bedtime...Notify physician for BG (blood glucose) <70 (less than 70) or >400 (greater than 400)." A review of the January 2021 MAR (Medication Administration Record) revealed that on the evening of 1/22/21 at 10:00 PM a glucose level of 418 was recorded. There was no documentation by the facility staff regarding what care was initiated related to this elevated glucose. " A review of the emergency room record revealed the EMS (Emergency Medical Services) report dated 1/23/21. This report documented that EMS was at the facility at 4:13 AM, and "Primary Impression - Endocrine - Hyperglycemia - Diabetic." In addition, the report documented, "The patient was a 68 year old....with a Chief Complaint of High blood sugar For 1 Hours....Nurse reported that the pt (patient) had	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 137 BGL (blood glucose level) readings in the 1000s on one of their meters and another meter read "Hi." None of the above from the EMS record regarding the assessing and monitoring provided by the facility was documented in the facility's clinical record. " A review of the clinical record revealed a nurse's note dated 1/23/21 at 4:39 AM documented, "Per NP (nurse practitioner). Resident sent to ER for elevated glucose.out (sic) of building at this time." The above note evidenced that the nurse practitioner was notified at some point, and implied that some type of assessing and monitoring had occurred, but none of those details were documented in the clinical record. On 2/17/22 at 8:22 AM, an interview was conducted with RN #5 (Registered Nurse). She stated that the clinical record was not complete and accurate regarding the scenario with the elevated glucose and what assessing and monitoring was conducted. She stated that all monitoring and treatment should have been documented. A review of the facility policy, "Charting and Documentation" documented: "All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition, will be documented in the resident's medical record. The medical record will facilitate communication between the	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 138 interdisciplinary team regarding the resident's condition and response to care.... 2. The following information is to be documented in the resident medical record: a. Objective observations; b. Medications administered; c. Treatments or services performed; d. Changes in the resident's condition; e. Events, incidents, or accidents involving the resident; and f. Progress toward or changes in the care plan goals and objectives." On 2/17/22 12:20 PM, ASM #1, #2, and #3 (Administrative Staff Member), the Administrator, Director of Nursing, and the Director of Risk Management, Quality Assurance and Compliance, were notified of the concern. No further information was provided by the end of the survey. COMPLAINT DEFICIENCY	F 842		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 139 a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 140 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, it was determined that the facility staff failed to follow infection control practices for 1 of 44 residents in the survey sample, Resident #207. Resident #207 was observed being assisted into the main dining room on the North unit for the lunch meal with other residents on 2/15/22 at 12:25 PM. Resident #207 was a newly admitted, unvaccinated resident who was on quarantine isolation for COVID-19 monitoring and observation. The main dining room on the North unit was filled with COVID-19 negative residents who were not on quarantine isolation. Resident #207's presence in this dining room placed other residents in the dining room at risk for contracting COVID-19. The findings include: Resident #207 was admitted to the facility on 2/10/22 with the diagnoses of but not limited to chronic obstructive pulmonary disease,	F 880	**F880 DPOC/ Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)** 1.) Resident #207 returned to his room. 2.) An infection prevention and intervention plan consistent with the requirements of 42 CFR 483.80 has been implemented for all facility residents. 3.) The Director of Nursing/designee has educated all direct care staff regarding quarantining of new residents. 4.) The Director of Nursing/designee will conduct daily rounds weekly for 4 weeks and then monthly for two months to ensure staff is appropriately ensuring the quarantining of newly admitted residents as determined by the residents' vaccination status. The Director of Nursing/designee will identify any trends and/or patterns, and additional education and training will be provided to employees on an ongoing basis. Findings will be discussed with the QAPI committee on at least a quarterly basis.	3/23/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 141 Wernicke's encephalopathy, dysphagia, high blood pressure, and alcohol abuse. An MDS had not yet been completed at the time of the survey. The admission nursing assessment dated 2/10/22 documented the resident as being alert and oriented to person only. Resident #207 was a newly admitted resident, who had not been vaccinated for COVID-19, who was placed on a "warm" unit for temporary isolation for observation purposes as a new admission, to prevent the spread of a potential COVID-19 infection. The isolation unit was set up via a temporary plastic, zippered wall that divided the resident's room at the end of the hallway from the rest of the unit, and from residents who were not on isolation. A review of the clinical record revealed a COVID-19 test dated 2/10/22 (date of admission) that resulted in a negative result. No additional tests since admission were identified. On 2/15/22 at 12:25 PM, Resident # 207, wearing a mask, unzipped the access in the temporary wall, and came through it carrying a large Styrofoam cup. He ambulated to the nurses' station and stood around the nurses' station for a couple of minutes. Then went to where the tray and beverage carts for the lunch meal were stationed in the hallway and helped himself to pour tea in his cup from the community tea dispenser. Then he went back down hall to the temporary wall and went back on the other side of it. After less than 1 minute, he returned from behind the temporary wall without his tea, and went down the hall to the dining room (across from the nurses' station) where residents not on isolation were eating lunch. He was assisted by a	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 142 staff member to sit in a chair less than 6 feet from a table where 3 other residents who were not on isolation were eating. The unidentified staff member provided his tray on an over bed table. Resident #207 removed his mask when he began to eat lunch. At 12:45 PM he got up and walked out of the dining room and went back down the hall to the temporary wall, and entered the isolation unit to his room. On 2/15/22 at approximately 3:40 PM, an interview was conducted with RN #5 (Registered Nurse). She stated that the residents in the isolation (warm) unit are supposed to eat their meals in their rooms, on the isolation unit. She stated that they were not supposed to leave the isolation area. She stated that when they attempt to leave the isolation area, they are reminded to return to the isolation area. On 2/17/22 8:22 AM a follow up interview was conducted with RN #5. She stated that Resident #207 should not have been encouraged to eat in the dining room while on isolation. She stated that attempts were made to identify the staff member but they could not be identified. She stated that there had also been nursing students in the facility as well and that it could have been one of them. On 2/17/22 7:29 AM, an interview was conducted with RN #3 (Registered Nurse) the Infection Preventionist. When notified of the above observation, she stated, "The resident should not be having meals in the dining room with other residents. He is a new admission and had not been vaccinated and should be back behind the (isolation) curtain."	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 143 On 2/16/22 at 5:45 PM a policy regarding dining procedures for residents who were on COVID isolation was requested. None was provided. On 2/17/22 12:20 PM, ASM #1, #2, and #3 (Administrative Staff Member), the Administrator, Director of Nursing, and the Director of Risk Management, Quality Assurance and Compliance, were notified of the concern. No further information was provided by the end of the survey. References: According to the Centers for Disease Control, "Empiric use of Transmission-Based Precautions (quarantine) is recommended for residents who are newly admitted to the facility and for residents who have had close contact with someone with SARS-CoV-2 infection if they are not up to date with all recommended COVID-19 vaccine doses....In general, quarantine is not needed for asymptomatic residents who are up to date with all COVID-19 vaccine doses or who have recovered from SARS-CoV-2 infection in the prior 90 days; potential exceptions are described in the guidance. However, some of these residents should still be tested as described in the testing section of the guidance....In general, all residents who are not up to date with all recommended COVID-19 vaccine doses and are new admissions and readmissions should be placed in quarantine, even if they have a negative test upon admission, and should be tested as described in the testing section above; COVID-19 vaccination should also be offered." This information obtained from https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html#anchor_1631031505598	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 947 F 947 SS=D	Continued From page 144 Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §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 and employee record review it was determined that the facility staff failed to ensure that 1 of 3 CNA (certified nursing assistant) records reviewed received the required annual training. The facility failed to provide evidence that CNA #5 received the required annual abuse training. The findings include: On 2/16/22 at approximately 4:00 p.m., a review of the facility's CNA annual training was conducted. Review of three CNA training transcripts revealed one of three CNAs selected	F 947 F 947	**F947/VAC 5-371-260 (G) – Required In-Service Training for Nurse Aides** 1. The facility has completed annual abuse training for CNA #5. 2. An audit of annual abuse training has been completed for all CNAs currently employed by the facility. Any variances found have been corrected and all currently employed CNAs have had annual abuse training. 3. Nursing management and Human Resources staff were re-educated on the importance of conducting annual CNA abuse training. The education included, but was not limited to, procedure for conducting the annual abuse training and identifying areas of CNA performance requiring additional in-service education.	3/23/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 947	Continued From page 145 for review did not complete annual abuse training for 2021. Review of CNA #5's training transcript documented a hire date of 6/29/09. The transcript documented "Preventing, Recognizing, and Reporting Resident Abuse" completed on 1/8/2010, 10/11/2012 and 3/15/2015. On 2/17/22 at 5:10 p.m., OSM (other staff member) #7, human resource manager, stated that they did not have any evidence of abuse training for CNA #5 except for a signature acknowledging receipt of the facility abuse policy and mandated reporter status dated 7/1/2021. On 2/17/22 at 7:30 a.m., an interview was conducted with ASM (administrative staff member) #2, the director of nursing. ASM #2 stated that CNA #5 still worked at the facility as needed. ASM #2 stated that they had computerized training that automatically assigned staff training based on their role, and they were able to add additional training as needed. ASM #2 stated that the training was monitored by an educator previously but the role was transitioning and the new system was being monitored by human resources. ASM #2 was made aware of the lack of evidence of abuse training for 2021, and stated that they would look to see if there was any. The facility policy "Compliance with Reporting Allegations of Abuse/Neglect/Exploitation" documented in part, "...Training: New employees will be educated by the department manager, or designee, on issues related to abuse prohibition practices and abuse reporting requirements during initial orientation. Annual education and	F 947	4. The Director of Nursing/Designee will perform an audit of annual CNA abuse training weekly for 6 weeks and then monthly for 3 months to ensure that the reviews are completed, and in-service education is provided. The Director of Nursing/designee will identify any trends and/or patterns and additional education and training will be provided on an ongoing basis. Findings will be discussed with the QAPI committee on at least a quarterly basis.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	C 02/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 947	Continued From page 146 training will be provided to all existing employees..." The facility policy "Abuse" documented in part, "...Training: At a minimum, education on abuse, neglect, and exploitation will be provided to facility staff upon hire and annually..." The facility policy "Nurse Aide In-Service Training Program" documented in part, "4. Annual in-services: a. ensure the continuing competence of nurse aides; b. are no less than 12 hours per employment year, and as required by state regulation; c. address areas of weakness as determined by nurse aide performance reviews; d. address the special needs of the residents, as determined by the facility assessment; e. include training that addresses the care of residents with cognitive impairment; and f. include training in dementia management, infection control, and abuse prevention..." On 2/17/22 at 12:15 p.m., ASM #1, the administrator, ASM #2, director of nursing and ASM #3, the director of risk management, quality assurance and compliance were made aware of the findings. No further information was provided prior to exit.	F 947		