PRINTED: 09/18/2023 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
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		495267	B. WING _		09	/01/2023	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
BROOKSI	DE REHAB & NURSING	CENTER		614 HASTINGS LANE			
BROOKS	DE REHAD & NOROING	CENTER		WARRENTON, VA 20186			
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		LD BE	(X5) COMPLETION DATE	
E 000	Initial Comments		E	000			
F 000 F 554 SS=D	survey was conducte The facility was in sul CFR Part 483.73, Re Care Facilities. No e complaints were inversible INITIAL COMMENTS  An unannounced Me survey was conducte 9/1/2023. Significant compliance with 42 CT Term Care requireme (VA00057852- substate VA00059561- substate VA00059398- substate VA00059399- substate VA00059399- substate VA00059399- substate VA00059399- substate VA0005	edicare/Medicaid standard d 8/29/2023 through corrections are required for CFR Part 483 Federal Long ents. Five complaints antiated with deficiency, intiated with deficiency, intiated with deficiency, intiated with deficiency and intiated with no deficiency) ring the survey. The Life eport will follow.  60 certified bed facility was a survey. The survey sample intresident reviews and nine in the survey in the survey sample intresident reviews and nine in the survey. The survey sample intresident reviews and nine in the survey in the survey sample intresident reviews and nine in the survey in the survey sample in the survey i	F (	1. Resident #72 was assessed self-administration of Fluticas nasal spray completed 8/30/2  2. All residents of the facility the potential to be affected by alleged deficient practice. An current residents self-administration	one 023. ave the audit of		
	by: Based on observatio record review and fac determined that the fa	is not met as evidenced in, staff interview, clinical cility document review, it was acility staff failed to assess		medication has been perform ensure assessment related to self-administration of medica complete.			
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE	

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient 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.

Facility ID: VA0178

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	ROVIDER OR SUPPLIER  DE REHAB & NURSING	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186		0 1/2020	
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F 554	The findings include: For Resident #72 (Riassess for self-admir During the medication task, R72 was observed fluticasone nasal spin and self administered by LPN (licensed practice) On the most recent fluticasone nasal spin and self administered by LPN (licensed practice) On the most recent fluticasone nasal spin and self administered by LPN (licensed practice) On the most recent fluticasone nation of 15 on the Bin mental status), indication of 15 on the Bin mental status), indication status (licensed) On 8/30/2023 at 8:05 made of LPN #7 prepredications to R72. medications to R72. medications and enteredications and ent	the survey sample for medication, Resident #72.  The facility staff failed to distration of medication. In administration observation wed to have a bottle of the medication when asked citical nurse) #7.  The facility staff failed to distration of medication when asked citical nurse) #7.  The facility staff failed to distration observation when asked citical nurse) #7.  The facility staff failed to distration observation when asked citical nurse) #7.  The facility staff failed to distration observed in the medication when asked citical nurse) #7.  The facility staff failed to distration observed in the staff permission to distration of medication when asked citical nurse in the staff permission to	F 55	3. DON/designee will ed nursing staff regarding p self-administration of me assessment for residents self-administer medication.  4. DON/designee will pe for any new self-administer medications weekly x4 w results will be reviewed a by the Interdisciplinary T the Quality Assurance procorrective action plans p as indicated based on rewith determinations relatmonitoring.  5. Date of Compliance 1	reforming edication is that cons.  rform an audit stration of veeks. These and discussed feam through rocess and but into place eview, along ted to ongoing		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 554	"Fluticasone Propior MCG (microgram)/A (Nasal)) 1 spray in e for sneezing. The orguidance to leave at self-administration.  Review of R72's clin an assessment for smedications.  The comprehensive evidence self administration assessment for smedications.  The comprehensive evidence self administration assessorder for self-administration assessorder for the Fluticastof nursing provided a administration assessorder for self-administration assessorder for the Fluticastof nursing provided a administration assessoration and stated the night before. Asset self-administration assessoration and stated the night before.	s for R72 documented in part, nate Nasal Suspension 50 CT (Fluticasone Propionate ach nostril one time a day for order failed to evidence the bedside for desired failed to evidence elf-administration of stration of the Fluticasone.  So p.m., a request was made we staff member) #1, the dence of a medication self esment and a physician's estration and leave at bedside sone nasal spray.  So a.m., ASM #2, the director a medication self esment dated 8/30/2023 at a lithat it had been completed elf #2 stated that R72 should eted prior to 8/30/2023 if the	F 554		
	Medication and Trea documented in part, right to self-administ the interdisciplinary to clinically appropriate	Self-Administration of tments" dated 10/1/2021 "Policy: Residents have the er medications / treatments if team has determined that it is and safe for the resident to nistered medications and/or			

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F 554	secure place, which is residents. If safe stora resident's room, the number permitted to self-admicentral medication can Nursing will transfer to the resident when the On 8/31/2023 at 4:31 staff member) #1, the director of nursing annurse consultant were concern.  No further information (1) fluticasone nasal seluticasone comes as nonprescription) liquication in the prescription fluticasone reat nonallergic rhinite each nostril one or two prescription fluticasone treat nasal polyps, it is nostril two times a day your prescription or plask your doctor or phyou do not understand directed. Do not use more often than direct prescribed by your doctor of the well obtained from the well of the prescribed of the prescribed by your doctor of the well obtained from the well of the prescribed by your doctor of the well obtained from the well of the prescribed by your doctor of the well obtained from the well of the prescribed by your doctor of the prescribed from the well obtained from the well of the prescribed by your doctor of the prescribed by your doctor of the prescribed from the well of the prescribed by your doctor of the prescribed from the well obtained from the well of the prescribed by your doctor of t	Il be stored in a safe and a not accessible by other age is not possible in the nedications of residents inister will be stored on a rt or in the medication room. The unopened medication to resident requests them"  p.m., ASM (administrative administrator, ASM #2, the did ASM #3, the regional emade aware of the above as was presented prior to exit.  Expray as a (prescription and did to spray in the nose. When asone nasal spray is used to other allergy symptoms, it is continuously in the nose of the above are not all to spray is used to other allergy symptoms, it is continuously in the nose of the above are nasal spray is used to it is, it is usually sprayed in the nasal spray is used to it is usually sprayed in each as a day. When the nasal spray is used to be usually sprayed in each are nasal spray is used to be usually sprayed in each are nasal spray is used to be usually sprayed in each are nasal spray is used to be usually sprayed in each are nasal spray is used to be usually sprayed in each are nasal spray is used to be usually sprayed in each are nasal spray is used to be usually sprayed in each are nasal spray is used to be usually sprayed in each are nasal spray is used to be usually sprayed in each are nasal spray is used to be usually sprayed in each are nasal spray is used to be usually sprayed in each are not of the package label or not o	F	554			

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F 558 F 558 SS=E	Reasonable Accomm CFR(s): 483.10(e)(3)  §483.10(e)(3) The rig services in the facility accommodation of repreferences except wendanger the health of other residents.  This REQUIREMENT by:  Based on resident in clinical record review determined that the faccommodate needs the survey sample, R  The findings include:  The facility staff failed #28 (R28) with their be R28 was admitted to diagnoses that includ severe morbid obesit [BMI] 70 or greater, and On the most recent M quarterly assessment reference date) of 6/2 14 out of 15 on the B mental status) assess were cognitively intacts section G coded R28 assistance of two or rand totally dependent It documented R28 in stabilize without staff	ht to reside and receive with reasonable sident needs and then to do so would or safety of the resident or is not met as evidenced terview, staff interview, and facility document, it was acility staff failed to for one of 45 residents in esident #28.  It to accommodate Resident bathing preference.  It the facility on 2/4/2022 with ed but were not limited to by (1) and body mass index dult (2).  IDS (minimum data set), a with an ARD (assessment as/2023, the resident scored lMS (brief interview for sment, indicating that they are for making daily decisions. It is as requiring extensive more persons for transfers to on one person for bathing.		5558	<ol> <li>1.Resident #28 received an initial shower on 9/7/2023.</li> <li>2. All residents of the facility have potential to be affected by the all deficient practice. An audit of cur residents was performed to ensure shower was completed for the curveek.</li> <li>3. DON/designee will educate nustaff regarding providing shower/bathing in accordance wiresident preferences.</li> <li>4. DON/designee will perform an of daily shower completion 5x we weeks. These results will be reviant discussed by the Interdiscipl Team through the Quality Assurator process and corrective action plainto place as indicated based on review, along with determinations related to ongoing monitoring.</li> <li>5. Date of Compliance 10/16/202</li> </ol>	e the eged rent are a aurrent arsing ith audit eek x4 ewed inary ance ans put	

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F 558	from a seated to star and off the toilet and transfers. The asses having any impairme extremities, and usin  On 8/29/2023 at 12:3 conducted with R28. resided at the facility wanted to get a show nurses aides and the they were trying to get that they could use a had never gotten one only received bed bat facility and there were (certified nursing assess bath due to their size were working to get to made them mad and shower or been offer size. R28 stated that without a shower and transfer to another far reasons.  Review of the ADL de 6/1/2023 to the present documentation only opartial bed baths.  On 8/31/2023 at 10:5 conducted with LPN LPN #7 stated that so and the CNA's document to the computer. LPN #7 stated that so and the CNA's document to the computer. LPN #7 stated that so and the CNA's document to the computer. LPN #7 stated that so and the CNA's document to the computer. LPN #7 stated that so and the CNA's document to the computer. LPN #7 stated that so and the CNA's document to the computer. LPN #7 stated that so and the CNA's document to the computer. LPN #7 stated that so and the CNA's document to the computer. LPN #7 stated that so and the CNA's document to the computer. LPN #7 stated that so and the CNA's document to the computer. LPN #7 stated that so and the cNA's document to the computer to	assistance when moving adding position, moving on for surface to surface asment documented R28 not ants in the upper or lower g a walker and a wheelchair.  33 p.m., an interview was R28 stated that they had for over a year and really wer. R28 stated that the arapy kept telling them that they had the them a bedside commode is a shower chair but they had the since they were at the e only certain CNA's istants) who would do their as othey had to wait until they had never been to the ed a shower because of their they had never because of their they had that was one of the ed a shower looking to actility and that was one of the coumentation for R28 from the ed and they were looking to actility and that was one of the evidenced bed baths or the evidenced bed baths or the week were twice a week they were twice a week the surface of the surface of the evidenced bed baths or the surface of the evidenced bed baths or the surface of the evidenced bed baths or the surface of the surface of the evidenced bed baths or the surface of the su	F 5	58		

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F 558	Continued From page they knew their routin stated that R28 only in they knew.  On 8/31/2023 at 11:0 conducted with CNA was totally dependental always got bed baths not fit on the shower stated that they were a shower chair so the it had not come in yellone of two obese resishower chair and the the chair for them to ustated that the head of to get the chair. She bed baths from her alweek when they were the other CNA's were size but she did not in had been here over a wanted showers since but they were unable.  On 8/31/2023 at 2:04 conducted with OSM	the and preferences. LPN #7 received bed baths as far as  1 a.m., an interview was #5. CNA #5 stated that R28 t on staff for bathing and . She stated that R28 would requipment they had. She supposed to be getting R28 recy could go to the shower but the stated that R28 was redents who needed the facility was working to buy ruse for the residents. She refer the residents. She received find one other aide twice a received find one other aide twice find one other aid		558		AIE	
	been working with ad bedside commode the shower chair. He sta one chair that was too back and were working the correct size. He se receiving physical the and then occupational resident up for ADL to facility should have ex	ted that they had received on arrow and they had sent it ong on getting another one stated that R28 was currently erapy services for ambulation all therapy planned to pick the aining. He stated that the					

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F 558	a shower. He stated attempted to accomm have a shower prior to the hospitalization of the director of nursing prior to the hospitalizated that determine equipment usually we patient specific. She R28 was the director of nursing prior to specific. She R28 was the first bar and the administrator	that the facility should have nodate R28's request to to this point.  5 p.m., OSM #7 provided to bedside commode was arrived on 8/15/2023. He was too narrow and was order was submitted on wed by administration on ked if R28 had been a shower prior to this, OSM y had not starting working on and they were not sure if the made that allowed the evated or not.  5 p.m., an interview was #10, the admissions director dmitted in February of 2022. In bariatric residents were ed the medical records with the ground to determine the status ation, the current hospital ment needs. OSM #10 and that they had the proper lity to care for the resident ower chairs and lifts. She istrator had the final decision She stated that resident the through therapy and was stated that she thought that itatric resident they admitted to at that time said that they	F	558			
	to admit the resident. equipment usually we patient specific. She R28 was the first bar and the administrator had just gotten a hoy 600 pounds so they of	She stated that resident ent through therapy and was stated that she thought that iatric resident they admitted					

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F 558	long term. She state facility to have the eq provide a shower if the they were able to show they are they were they stated that the face equipment for bariatry shower if the resident stated that they were came in at and what equipment held.  On 8/31/2023 at 3:52 conducted with ASM OSM #7, the director that R28 was almost wheelchair was too work they concerned by the staff gave physical therapy was commode so they concerned by the started working with the bed in February of 20 the bedside commod stated that R28 had the 2023. At this time, a #1 and OSM #7 for election to February was made for completed prior to February to February was made for completed prior to February to February was made for completed prior to February to February was made for completed prior to February to February was made for completed prior to February to February to February was made for completed prior to February to February to February the provided prior to February they was made for completed pr	they have since been there d that she would expect the uipment to care for R28 and hat was their preference and ower.  p.m., an interview was (administrative staff rim director of nursing. ASM	F 5	58		

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F 558	Needs" dated 9/1/202 facility's environment directed toward assis maintaining and/or ac functioning, dignity, a resident's individual rincluding the need for modifications to the pube evaluated upon ac ongoing basis 3. In individual needs and may be made to the pincluding the resident as well as the common providing a variety of with and without arms and firmness of furnitiareas so that resident strength and mobility standing position"  The facility policy "Ass Equipment" dated 10 " 1. Certain devices with resident mobility are provided for resident mobility are provided for resident mobility are not limited to a. specialized eating b. safety devices for toilet risers, bedside to mobility devices (we canes)"	policy "Accommodation of 23 documented in part, "The and staff behaviors are sting the resident in chieving safe independent and wellbeing 2. The needs and preferences, and physical environment, shall dimission and reviewed on an order to accommodate preferences, adaptations physical environment, it's bedroom and bathroom, on areas in the facility g. types (for example, chairs is), sizes (height and depth), ture in rooms and common its with varying degrees of can independently arise to a sesistive Devices and (1/2021 documented in part, is and equipment that assist is, safety and independence tents. These may include (1): utensils and equipment; the bathroom (grab bars, commodes, etc.); and theelchairs, walkers, and	F	558			
	nursing and ASM #3,	2, the interim director of the regional nurse e aware of the concern.					

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F 561 SS=E	References: (1) Obesity means we healthy for a given he chronic disease. It can problems, including of some cancers. This from the website: https://medlineplus.gu (2) Your BMI estimate weigh based on your classes of obesity: Class 1: BMI of 30 to Class 2: BMI of 35 to Class 3: BMI of 40 or considered "severe of This information was https://medlineplus.gu Self-Determination CFR(s): 483.10(f)(1)-\$483.10(f) Self-determination CFR(s): 483.10(f)(1)-\$483.10(f) Self-determination through support of remot limited to the right (1) through (11) of this \$483.10(f)(1) The responsible support of the sectivities, schedules waking times), health	eighing more than what is eight. Obesity is a serious, in lead to other health liabetes, heart disease, and information was obtained ov/ency/article/007297.htm es how much you should height There are three less than 35. less than 40. higher. Class 3 is besity." obtained from the website: ov/ency/article/007196.htm  (3)(8)  mination.  right to and the facility must excident self-determination sident choice, including but its specified in paragraphs (f) is section.  Sident has a right to choose (including sleeping and a care and providers of health ent with his or her interests, an of care and other	F 55		have the ne alleged of current ensure a he	
	assessments, and pla applicable provisions	an of care and other		resident preferences.		

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F 561	facility that are significations of the resident in clinical record review determined that the ficare according to resident for Resident #28 (R28 was admitted to diagnoses that inclus severe morbid obesit [BMI] 70 or greater, at the first of the mental status) asses were cognitively interest of the community of the summer of the property of the pro	ts of his or her life in the cant to the resident.  sident has a right to interact community and participate in both inside and outside the sident has a right to ctivities, including social, unity activities that do not its of other residents in the if is not met as evidenced atterview, staff interview, and facility document, it was acility staff failed to provide ident preference for one of urvey sample, Resident #28.  If to provide bathing a requests and preferences 8).  It the facility on 2/4/2022 with led but were not limited to by (1) and body mass index	F 5	561	4. DON/designee will perform a audit of daily shower completion week x4 weeks. These results a reviewed and discussed by the Interdisciplinary Team through Quality Assurance process and corrective action plans put into as indicated based on review, a with determinations related to ongoing monitoring.  5. Date of Compliance 10/16/20	n 5x will be the place along	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495267		B. WING		C 09/01/2023	
	ROVIDER OR SUPPLIER  DE REHAB & NURSING	I		61	TREET ADDRESS, CITY, STATE, ZIP CODE  14 HASTINGS LANE  1/ARRENTON, VA 20186	1 09/	01/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 561	and totally dependen It documented R28 n stabilize without staff and turning around a to stabilize with staff from a seated to stan and off the toilet and transfers. The assess having any impairme extremities, and using On 8/29/2023 at 12:3 conducted with R28. resided at the facility wanted to get a shown urses aides and the they were trying to get that they could use a had never gotten one only received bed ba facility and there were (certified nursing ass bath due to their size were working to get to they had never been offered a shower been offered a shower been stated that it made the should have to go with were looking to transing was one of the reason.  Review of the ADL do 6/1/2023 to the present documentation only expartial bed baths.	more persons for transfers ton one person for bathing. ot steady, but able to assistance when walking and not steady and only able assistance when moving ading position, moving on for surface to surface sment documented R28 not ants in the upper or lower as a walker and a wheelchair.  33 p.m., an interview was R28 stated that they had for over a year and really wer. R28 stated that the rapy kept telling them that the them a bedside commode as a shower chair but they had this since they were at the e only certain CNA's istants) who would do their so they had to wait until they heir baths. R28 stated that to the shower or been ause of their size. R28 em mad and that no one thout a shower and they fer to another facility and this ns.	F	561			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495267	B. WING		C 09/01/2023
	ROVIDER OR SUPPLIER  DE REHAB & NURSING	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186	1 30/6 1/2020
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETION
F 561	LPN #7 stated that s and the CNA's docur computer. LPN #7 s CNA's who worked w they knew their routin stated that R28 only they knew.  On 8/31/2023 at 11:0 conducted with CNA was totally depender always got bed baths not fit on the shower stated that they were a shower chair so the it had not come in ye one of two obese resishower chair and the the chair for them to stated that the head to get the chair. She bed baths from her aweek when they were the other CNA's were size but she did not a week when they were the other CNA's were size but she did not a wanted showers.  On 9/1/2023 at 8:53 administrator, ASM # nursing and ASM #3 consultant were made and the size in the facility policy "As Equipment" dated 10 " 1. Certain devices with resident mobility	(licensed practical nurse) #7. howers were twice a week mented them in the tated that there were several with R28 the most because he and preferences. LPN #7 received bed baths as far as which are several with R28 the most because he and preferences. LPN #7 received bed baths as far as which are stated that R28 has no staff for bathing and so which are supposed to be getting R28 beg could go to the shower but with the stated that R28 was sidents who needed the efacility was working to buy use for the residents. She of therapy had been working the stated that R28 received and one other aide twice a se working because some of the intimidated by the resident's mind. She stated that R28 a year and had always when the regional nurse is aware of the concern.	F 56		

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		495267	B. WING			C 09/01/2023	
NAME OF PE	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	09/	01/2023
					514 HASTINGS LANE		
BROOKSII	DE REHAB & NURSING	CENTER		١	WARRENTON, VA 20186		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFI TAG		(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 565 SS=E	b. safety devices for to toilet risers, bedside of c. mobility devices (w canes)"  The facility provided p. Needs" dated 9/1/202 facility's environment directed toward assist maintaining and/or act functioning, dignity, a.  No further information.  References: (1) Obesity means we healthy for a given he chronic disease. It ca problems, including d some cancers. This i from the website: https://medlineplus.go. (2) Your BMI estimate weigh based on your classes of obesity: Class 1: BMI of 30 to Class 2: BMI of 35 to Class 3: BMI of 40 or considered "severe of This information was https://medlineplus.go. Resident/Family Ground in the control of	cutensils and equipment; the bathroom (grab bars, commodes, etc.); and theelchairs, walkers, and  colicy "Accommodation of the data staff behaviors are ting the resident in thieving safe independent and wellbeing"  In was provided prior to exit.  cighing more than what is cight. Obesity is a serious, an lead to other health diabetes, heart disease, and anformation was obtained  cov/ency/article/007297.htm  cas how much you should dheight There are three  less than 35. less than 40. higher. Class 3 is desity."  obtained from the website: cov/ency/article/007196.htm up and Response		561			
	§483.10(f)(5) The res	ident has a right to organize					

		IDENTIFICATION NUMBED:		LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
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NAME OF D	ROVIDER OR SUPPLIER	430201		STREET ADDRESS, CITY, STA		/01/2023	
NAIVIE OF F	NOVIDER OR SUFFLIER				II E, ZIF GODE		
BROOKSI	DE REHAB & NURSIN	G CENTER		614 HASTINGS LANE			
				WARRENTON, VA 20186	i		
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F 565	(i) The facility must group, if one exists, reasonable steps, v to make residents a upcoming meetings (ii) Staff, visitors, or resident group or fathe respective grou (iii) The facility mus person who is approgroup and the facility providing assistance requests that result (iv) The facility must resident or family groups concerning in the facility.  (A) The facility must response and ration (B) This should not facility must implement request of the resident of the resident or family groups concerning in the facility must implement of the resident in family member(s) or representative(s) member(s) or representative(s) member(s) or residents in the facility seconcerns expressed	provide a resident or family with private space; and take with the approval of the group, and family members aware of in a timely manner. Other guests may attend mily group meetings only at p's invitation. It provide a designated staff oved by the resident or family the and responding to written from group meetings. It consider the views of a roup and act promptly upon recommendations of such issues of resident care and life to be able to demonstrate their hale for such response. It be able to demonstrate their hale for such response. It be able to demonstrate their hale for such response. It be able to demonstrate their hale for such response. It be able to demonstrate their hale for such response. It be able to demonstrate their hale for such response. It be able to demonstrate their hale for such response. It be able to demonstrate their hale for such response. It is a such that the lent as recommended every ent or family group. It is a such that the lent as recommended every ent or family group. It is a such that the lent as recommended every ent or family group. It is a such that the lent as recommended every ent or family group. It is a such that the lent as recommended every ent or family group. It is a such that the lent as recommended every ent or family group. It is a such that the lent as recommended every ent or family group. It is a such that the lent as recommended every ent or family group.	F 5	resident council a resolved.  2. All residents of potential to be affective deficient practice minutes for Septoreviewed to ensure reviewed to ensure solution of gries.  3. NHA/designer dietary manager, social work staffective grievance process relates to review concerns/grievandays.  4. NHA will review days a week for execute will be reviewed by the Interdiscip the Quality Assure corrective action indicated based determinations remonitoring.	e will educate the , activities staff, and		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 565	Continued From page reviewed, June and J		F 5	565			
	The findings include:						
	concerns about bread Resident Council me respond to and resolve A review of Resident from June 2023 reversions[refereceives her toast for it is a plain white piece when she receives her toasted, it is a plain were leadent of the toast or meals[referedent] does not refere toast or meals[referedent] does not referedent of the toast or meals[referedent] does not referedent of the toast or meals[referedent] statement of the toast or	etings; the facility failed to ve these concerns.  Council meeting minutes aled, in part: "Resident esident] states when she breakfast, it is not toasted, se of bread[resident] stated er toast for breakfast, it is not					
	from July 2023 reveal Concerns/Issues[reshard boiled eggs for Istates when she receives items servedResponsible (Iname of corporal Wednesday, July 28, the toaster]I also to	Council meeting minutes led, in part: "Resident sident] states he would like breakfast at times[resident] sives toast, it is not toasted kfast is often the same nse and follow up: I have the facility staff] on 2023 at 11:00 a.m. [about ld [name of corporate es staff]. I haven't had any					

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(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF (  (EACH CORRECTIVE ACTI  CROSS-REFERENCED TO TI  DEFICIENCE	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 565	updates from theml certain daysThe moof contract dining ser The response and fol (other staff member)  On 8/30/23 at 9:45 a. member) #2, the Reg services. When asked the residents, OSM # not have it in stock." dietician does not bel value, so it is not offer asked if it could be on #2 stated, "No, we arit does not have any not purchase an item	put boiled eggs on for enus are done by the [name vices company] dietician." low up was written by OSM #1, the dietary manager.  m., OSM (other staff ional Director of dining ed if bacon was provided for 2 stated, "No, we have a do OSM #2 stated the corporate ieve bacon has any nutritive red to the residents. When in the alternate menu, OSM e not purchasing it because nutritive value. We would	F	565			
	director, was intervied Resident Council medeverything residents of form for each concern the appropriate deparaconcerns related to form the stated she expect to her within 48 hours to be resolved. She sto [residents'] concern need to come up with stated OSM #1 attend meetings so resident concerns about food if OSM #1's response breakfast menus are concerns, she stated	m., OSM #15, the activities wed. She stated she attends etings, and writes down say. She fills out a concern expressed, and gives it to rtment head. She stated all ood are given to OSM #1. cts the forms to be returned s, and expects the concern tated: "We are here to listen as. As a leadership team, we a some sort of solution." She dis all Resident Council is are able to express directly to her. When asked is about the toaster and the actually resolutions of the tilt's not a resolution, and She added: "The issue with					

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F 565	are reviewed, OSM # menus, set by the corasked if bacon was e stated it is not on the nutritive value. She a long term care. You go bacon and sausage."  On 8/30/23 at 4:17 p. interviewed. She state contract company. She beginning of each Relisten to resident condition the residents also har month menu. She state concerns "right then a her documented resptoast and breakfast mesolutions for the rese how that may not stated residents have breakfast/toast since facility in mid-April 20 informed the facility's company's corporate working correctly, and between them. She in company's corporate employment in April 2 about the broken toas corporate staff. She services in the state of the state	m. with OSM #3, the When asked how the menus 3 stated, they are corporate rorate dietician. When wer on the menu, OSM #3 menu because there is no dded: "You see that a lot in let very little nutrition from m., OSM #1 was ed she is employed by a ne stated she attends the sident Council meeting to cerns about food. She stated we input into the meal of the leted: "We need to know what This is their home. We need ed she answers residents' and there." When asked if onses to the concerns about nenus are satisfactory sidents, she stated: "I can a resolve the issues." She is been complaining about she began work at the 23. She stated she has corporate staff and her staff that the toaster is not different staff and her staff that the toa	F 56		

<b>■ ` '</b>		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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F 565	take it to the people vam in the middle. [The dietician] said bacon won't let me add it to  On 9/1/23 at 8:58 a.m member) #1, the adminterim director of nur regional nurse consultations.  No further information Safe/Clean/Comforta	e stated: "I told them I would who make the menus, but I e corporate contract is an empty calorie, so they the menu."  n., ASM (administrative staff sinistrator, ASM #2, the sing, and ASM #3, the tant, were informed of these in was provided prior to exit. ble/Homelike Environment	F 56		completed for		
SS=D				rooms 144, 147, and 160.  2. All residents of the facili potential to be affected by deficient practice. An audi performed to examine all courrents to ensure cleanling.  3. NHA/designee will educate housekeeping department ensuring privacy curtains at 4. NHA/designee will perform 10 privacy curtains weekly. These results will be reviet discussed by the Interdiscount through the Quality Assuration as indicated based on reviet determinations related to comonitoring.  5. Date of Compliance 10/	ity have the the alleged twas current privacy ness.  cate regarding are clean.  orm an audit of x4 weeks. wed and iplinary Team ance process put into place iew, along with ongoing	1	

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F 584	Continued From pa	ge 20	F 5	84				
	§483.10(i)(3) Clean in good condition;	bed and bath linens that are						
	\ , , , ,	te closet space in each pecified in §483.90 (e)(2)(iv);						
	§483.10(i)(5) Adequences in all areas;	uate and comfortable lighting						
	levels. Facilities init	ortable and safe temperature tially certified after October 1, in a temperature range of 71 to						
	sound levels. This REQUIREMENT by: Based on staff inter and clinical record of facility staff failed to	ne maintenance of comfortable  NT is not met as evidenced  erview, facility document review review, it was determined the to maintain a clean and tent for three of 31 rooms on						
	The findings include	e:						
	homelike environm #23 was a resident food was found who pulled for privacy d	failed to maintain a clean and ent for room 160. Resident in room 160. Dried pureed en the cubicle curtain was uring resident care.						
	AM, with OSM (oth housekeeping. When asked how ro stated, they are cle	er staff member) #8,  coms are cleaned, OSM #8  aned every day. They sweep  curfaces with peroxide multi						

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F 584	#8 stated, "When the clean the curtains. If resident is here, we do to look at the curtain challways, common ar An interview was compounded by the compounded by the compounded by the clean the clean the curtain of th	resident goes home, we the curtain is dirty while the hange the curtain. We are every day. We clean in eas every day."  ducted on 8/31/23 at 2:55 d practical nurse) #9. When he cubicle curtain, LPN #9 ried food. I will contact curtain."  1, ASM (administrative staff inistrator, ASM #2, the d ASM #3, the regional made aware of the findings.  1ty's "Homelike Environment" d, "Residents will be clean, comfortable and t and encouraged to use ings to the extent possible."  1 was provided prior to exit.  1 illed to maintain a clean and to maintain a clean and Room 147A.  2 6 p.m., an observation was curtain in Room 144A. Two ere visible on the lower third curtain. Additional rivacy curtain with the visible 8/29/2023 at 3:34 p.m. and	F 5	i84				

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F 584	black stain was visible privacy curtain and or observed in the center Additional observation the visible stains were p.m. and 8/30/2023 at 10:1 conducted with OSM housekeeping. OSM room was cleaned dawere looked at every.  On 8/31/2023 at 10:1 conducted with CNA were looked at every.  On 8/31/2023 at 10:1 conducted with CNA #7. CNA #7 stated the cleaning they reported. On 8/31/2023 at 10:2 conducted with LPN & LPN #9 stated that the privacy curtains were was working to find on LPN #9 viewed the privacy curtain needed to be homelike. She viewed Room 147A with the and the brown circular privacy curtain and state to be cleaned and was the facility provided in the provided in the facility provided in the provided in the facility provided in the facility provided in the provided in the facility provided in the facility provided in the privacy curtain and state in the facility provided in the facility provided in the facility provided in the privacy curtain and state in the facility provided in the facility prov	curtain in Room 147A. One e on the bottom of the ne brown circular stain was er of the privacy curtain. Ins of the privacy curtain with e made on 8/29/2023 at 3:37 at 1:45 p.m.  1 a.m., an interview was (other staff member) #8, #8 stated that each resident aily and the privacy curtains day and cleaned when dirty.  9 a.m., an interview was (certified nursing assistant) at if privacy curtains needed d it to housekeeping.  7 a.m., an interview was (licensed practical nurse) #9. Ley were not sure how often a cleaned or changed and ut the practice in the facility. Privacy curtain in Room 144A fown stains on the lower third curtain and stated that the cleaned and was not at the privacy curtain in black stain on the bottom ar stain in the center of the tated that the curtain needed as not homelike.  Policy, "Homelike 10/21/2023 documented in a staff and management tent possible, the	F 5	584			

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F 584	On 9/1/2023 at 8:53 a staff member) #1, the interim director of nur regional nurse consuthe above concern.	ke setting. These e: a. clean, sanitary and	F 5	34		
F 600 SS=D	Exploitation The resident has the neglect, misappropria and exploitation as dincludes but is not lim corporal punishment, any physical or chem treat the resident's m  §483.12(a) The facilit §483.12(a)(1) Not us physical abuse, corporativoluntary seclusion This REQUIREMENT by: Based on staff intervand clinical record reprotect the resident's physical abuse by an	m Abuse, Neglect, and right to be free from abuse, stion of resident property, efined in this subpart. This sited to freedom from involuntary seclusion and ical restraint not required to edical symptoms.  y must- e verbal, mental, sexual, or oral punishment, or is not met as evidenced iew, facility document review view, the facility failed to	F 60	<ol> <li>The incident between resand #36 has already occurred therefore, the alleged deficional may not be retroactively controlled.</li> <li>All residents of the facility potential to be affected by the deficient practice. An audity performed of progress note residents since 9/14/2023 to residents with documented behaviors and ensure there intervention in place.</li> <li>DON/designee will educate regarding resident's rights the right to be free from phy by another resident.</li> </ol>	ent practice rrected.  y have the he alleged was s of current o identify aggressive is an ate all staff o include	

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F 600	physical abuse from #36 on 2/14/23 and 4 Resident #65 was ac 5/12/21 with diagnos limited to: Alzheimer' and dementia.  The most recent MD: assessment, a quarte ARD (assessment recoded the resident as the BIMS (brief intervindicating the resider impaired.  A review of the comp 12/17/22, which revehas a behavior proble residents in their where identiated into her roor resident room, trying the bathroom. INTEL necessary to protect others. Approach/Spattention. Remove froalternate location as Resident #36 was ac 2/1/22 with diagnose limited to: Alzheimer symptoms and demer Resident #36's most set) assessment, a quarternate resident resid	protect Resident #65 from another resident, Resident #1/13/23.  Imitted to the facility on is that included but were not is Disease, diabetes mellitus  S (minimum data set) early assessment, with an inference date) of 5/23/23, is scoring a 00 out of 15 on view for mental status) score, in was severely cognitively  Intervene as the rights and safety of eak in a calm manner. Divert om situation and take to needed."  Imitted to the facility on is that included, but were not is Disease, psychotic	F 60	4. DON/designee will peraudit of the progress nor residents to identify doc aggressive behaviors are intervention is in place 3 x4weeks. These results reviewed and discussed Interdisciplinary Team the Quality Assurance processing as indicated based on rewith determinations related ongoing monitoring.  5. Date of Compliance 1	tes of current umented and ensure an ex week will be by the arough the ess and but into place eview, along ted to		

PRINTED: 09/18/2023 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		495267	B. WING	_		09/	01/2023
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
BROOKSI	DE REHAB & NURSING	CENTER			614 HASTINGS LANE		
BROOKSI	DE REHAD & NOROMO	CENTER		1	WARRENTON, VA 20186		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG	•	Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 600	Continued From page	25	_	600			
1 000			Г	000	<b>7</b>		
	•	iew for mental status) score,					
	-	t was severely cognitively					
	impaired.						
	A review of Posident	#26's comprehensive care					
		#36's comprehensive care hich revealed, "FOCUS:					
		oral problem of becoming					
		ive towards other residents					
		rabbing another resident.					
		ential to display the following					
		d physical aggression,					
		er residents, standing on					
	radiator in attempt to						
		rovide redirection away from					
		agitation is occurring in the					
		er possible room change/					
		ne as necessary to protect					
	_	of others. Approach/Speak					
	in a calm manner. Div	vert attention. Remove from					
	situation and take to a	alternate location as needed.					
	Monitor behavior epis	odes and attempt to					
	determine underlying	cause. Consider location,					
		nvolved, and situations.					
	Document behavior a	nd potential causes."					
	_	y synopsis of events dated					
		t approximately 5:30 PM on					
		ed Resident #36 getting up					
	from the table she wa						
	approached [Residen	=					
		p of her head and threw her dents were separated and					
	assesses; no injuries						
		ed, she [Resident #65] was					
		told her to get up from the					
		nt to, so I pulled her up by					
	her hair because she						
	[Resident #65] was u						
	happened."	nable to report wriat					
	паррепеч.						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION  NG	(X3) DATE SURVEY  COMPLETED	
		495267	B. WING _			C <b>09/01/2023</b>
	ROVIDER OR SUPPLIER  DE REHAB & NURSING	CENTER		STREET ADDRESS, CITY, STATE 614 HASTINGS LANE WARRENTON, VA 20186	, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION E ACTION SHOULD B D TO THE APPROPRIA CIENCY)	DATE
F 600	4/13/23 revealed, "[R the floor in her room. disheveled. [Resider room. [Resident #36] [Resident #65] for un #36] pulled [Resident in the face. Resident assessed for injuries [Resident #65] moved. A review of the program 7:43 PM, revealed, "S dining so raised my histing on the floor and her was being pulled members. No injuries (director of nursing, n party) notified. Facility resident."  A review of the Nurse dated 4/12/23 at 10:0 see by staff for facility in face and had hair procomplaints of injuriat baseline. PSYCH: Alzheimer's Dementia Memantine, Depakot follow-up recommend management."	y synopsis of events dated esident #65] was found on Table/belongings appeared at #36's] walker was in the stated, she pulled known reasons. [Resident #65's] hair and slapped her is immediately separated, with no injuries noted and do to another hallway."  The sess note date 2/14/23 at shouting was heard in the lead up and saw resident that hits away by other staff is noted. DON, MD, RP inedical doctor, responsible yContinue to monitor  The Practitioner (NP) note 2 AM, revealed, "Asked to y event. Patient was struck bulled by another resident. The staff is noted. Don's patient appears are continue with Donepezil, e., Seroquel. Geri psychilded for further eval and med	F	500		
	PM with LPN (license asked to define abus- verbal, physical, sexu- the resident stress. A	ducted on 8/31/23 at 1:35 ed practical nurse) #3. When e, LPN #3 stated, any ual, mental act that causes Asked if a resident striking pulling them to the floor was				

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495267	B. WING		C 09/01/2023		
	ROVIDER OR SUPPLIER  DE REHAB & NURSING	CENTER	6	TREET ADDRESS, CITY, STATE, ZIP CODE  14 HASTINGS LANE  VARRENTON, VA 20186	03/01/2023		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION		
F 600	asked about specific Resident #65 and R "For whatever reason #36] targeted [Resident #a65] them and then move hall." There were not once Resident #65 was an interview was copen with LPN #9. We LPN #1 stated, it can financial or mental at When asked if a resum and pulling them to the LPN #1 stated, yes, asked what actions stated they would set them and make sure asked if she had with between Resident #stated, "Not that I can always as a stated they would set them and make sure asked if she had with between Resident #stated, "Not that I can always at the asked if she had with between Resident #stated, "Not that I can always at the asked if she had with between Resident #stated, "Not that I can always at the asked if she had with between Resident #stated, "Not that I can always at the stated, "Not that I can always at the	ed, "Yes, it is abuse." When a interactions between esident #36, LPN #3 stated, in, it appeared that [Resident lent #65]. We would separate ed [Resident #65] to another of further incidents identified was moved.  Inducted on 8/31/23 at 1:55 when asked to define abuse, in be verbal, physical, sexual, cts which impact a resident either floor constituted abuse, that would be abuse. When would be taken, LPN #1 eparate the residents, assess a there was no injury. When messed any interactions 36 and Resident #65, LPN #1	F 600				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENITIFICATION NITIMBED		PLE CONSTRUCTION  IG	COMF	(X3) DATE SURVEY COMPLETED C	
		495267	B. WING _			01/2023	
	ROVIDER OR SUPPLIER  DE REHAB & NURSING	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 600	assess the resident, resident representating and other residents for the resident's plan or reflect interventions to treat any injury of lassessment of the resident,	the facility will immediately notify the physician and we and protect the resident rom further harm or incident. If care will be revised to minimize recurrence and marm identified through	F 6	00			
F 655 SS=D	S483.21 Comprehent Planning §483.21(a) Baseline §483.21(a) Baseline §483.21(a)(1) The faimplement a baseline that includes the instruction of the baseline care plate (i) Be developed with admission.  (ii) Include the minimal necessary to properly including, but not limit (A) Initial goals based (B) Physician orders.  (C) Dietary orders.  (D) Therapy services (E) Social services.  (F) PASARR recommal support of the comprehensive care care plan if the comprehensity in the services of the ser	Care Plans cility must develop and e care plan for each resident ructions needed to provide centered care of the resident al standards of quality care. an must- in 48 hours of a resident's  um healthcare information y care for a resident ited to- d on admission orders.	F 6	<ol> <li>1. Resident #153 and Rehave been discharged from the fact potential to be affected by deficient practice. An auditorial performed of current resistance 9/1/2023 to ensure interventions are in place performed of current resistance makers to ensure the reflects the pacemaker.</li> <li>3. DON/designee will edu Nursing staff regarding debaseline careplan to incluprevention, as well as the pacemaker.</li> </ol>	om the facility.  Ility have the y the alleged lit was dents admitted fall care plan . An audit was dents with e care plan  Icate Licensed eveloping a lide fall		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MUL IDENTIFICATION NUMBER: A. BUILD		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495267	B. WING		C 09/01/2023		
	ROVIDER OR SUPPLIER  DE REHAB & NURSING	G CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION		
F 655	(b) of this section (ethis section).  §483.21(a)(3) The resident and their re of the baseline care limited to: (i) The initial goals (ii) A summary of the dietary instructions. (iii) Any services an administered by the on behalf of the facility Any updated infof the comprehensith This REQUIREMEN by: Based on staff intered and facility docume that the facility staff care plan for two of sample; Residents: The findings included The facility policy, "reviewed. This poliplan of care to meen needs shall be deveronted for the comprehensity in the facility policy, and the facility policy in the facility policy, and the facility policy in the facility policy, and the facility policy in the facility policy. The facility policy in the facility policy. The facility policy in the fa	ements set forth in paragraph excepting paragraph (b)(2)(i) of facility must provide the expresentative with a summary plan that includes but is not of the resident. The resident's medications and and treatments to be a facility and personnel acting sility. Formation based on the details we care plan, as necessary. The is not met as evidenced riview, clinical record review, not review, it was determined failed to develop a baseline 45 residents in the survey #153 and #353.	F 65	4. DON/designee will perfor audit of new admissions to the baseline careplan includinterventions, as well as the presence of a pacemaker a indicated 3x week x4weeks results will be reviewed and discussed by the Interdiscip Team through the Quality Assurance process and corraction plans put into place a indicated based on review, with determinations related ongoing monitoring.  5. Date of Compliance 10/1	ensure des fall es s . These l olinary rective as along to		

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		495267	B. WING _		09	09/01/2023	
	ROVIDER OR SUPPLIER  DE REHAB & NURSING	CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 614 HASTINGS LANE WARRENTON, VA 20186			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 655	needs"  1. The facility staff facare plan for fall previous Resident #153.  Resident #153 was a 9/9/22 and discharge had diagnoses of buildifficulty walking, lac loss. The admission Set) dated 9/13/22 occognitively impaired decisions, scoring a BIMS (Brief Interview A nurse's note dated "Resident called write for assistance to bath was observed with u not appear to be in patransferred safely back any concerns at this Another nurse's note "Call to room by seconsiting on the floor in walk around and I feat pt's (patient's) base redness noted to (R) (R) arm. (L) (left) are bruit and thrill. No blocomplain of pain to (in o open wound or bruith an order for schild in the side of the same care in	ailed to develop a baseline vention with interventions, for admitted to the facility on ad on 9/28/22. The resident a not limited to dementia, k of coordination, and visual /5-day MDS (Minimum Data oded the resident as being in ability to make daily life of our of a possible 15 on the v for Mental Status) exam.  9/21/22 documented, are to her room this morning proom. At that time resident insteady gait post fall but did ain. Resident was ck to her wheelchair without time."  1 dated 9/21/22 documented, and nurse, observed patient her room. "I was trying to ll" Intermittent disorientation eline. Assessed with (right) elbow. Old bruise to m dialysis shunt with positive eeding noted. Pt with R) arm and back. Back with uise noted at this time. Pt eduled am (morning) pain given. Assisted into wc	F 6	55			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495267	B. WING		C 09/01/2023		
	ROVIDER OR SUPPLIER  DE REHAB & NURSING	G CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186	1 09/01/2023		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION		
F 655	under "Mobility/Safe Indoor Mobility (Aml need for assistance room (with or withou crutch, or walker) prexacerbation, or injutesident needed paperson to complete. The "Safety - Reside documented that the gait which was defind difficulty rising from up, bounces to rise; walking, watches the person or aid when unassisted." Under Status" which was derived the bathroom alone. The coded response "Overestimates or for documented the social, "Morse Fall Scon Moderate Risk 25-4 #153 was coded as risk.  A review of the care care plan was starter ("Resident #153) is gait/balance probler care plan included to "(Resident #153) wireview date." This contain any interver	ing assessment dated 9/9/22, ty" documented, "Prior. bulation): Code the resident's with walking from room to it a device such as cane, ior to the current illness, iry. Needed Some Help - irtial assistance from another	F 65	5			

TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  32 dementia and difficulty	614	EET ADDRESS, CITY, STATE, ZIP CODE  HASTINGS LANE  RRENTON, VA 20186  PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD  CROSS-REFERENCED TO THE APPROPE  DEFICIENCY)	BE COMPLETION
TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  32 dementia and difficulty	ID PREFIX TAG	HASTINGS LANE RRENTON, VA 20186  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	N (X5) BE COMPLETION
MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  32 dementia and difficulty	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF	BE COMPLETION
dementia and difficulty	F 655		
cons were dated 9/21/22 curred.  Clinical record failed to fall interventions being  Man interview was 4 (Licensed Practical at if interventions are put in the care plan. She stated do be at risk for falls. She should be developed on entions. She stated, "If the entions, then what was a A care plan should have  M, an interview was the 2 (Administrative Staff of Nursing. She stated that an was not developed. She hission assessment, there are a care area to be care check for interventions to that interventions for falls the added on the baseline  M, ASM #1 the 2 the Director of Nursing, and Nursing.			
	I an interview was 4 (Licensed Practical at if interventions are put in the care plan. She stated d be at risk for falls. She should be developed on ntions. She stated, "If tentions, then what was A care plan should have I, an interview was (2 (Administrative Staff of Nursing. She stated that an was not developed. She hission assessment, there a care area to be care check for interventions to that interventions for falls e added on the baseline	If an interview was 4 (Licensed Practical at if interventions are put in the care plan. She stated d be at risk for falls. She should be developed on intions. She stated, "If tentions, then what was a A care plan should have  If, an interview was a (Administrative Staff of Nursing. She stated that an was not developed. She aliasion assessment, there a care area to be care check for interventions to that interventions for falls a added on the baseline  If, ASM #1 the a the Director of Nursing, and Nurse Consultant were dings. No further	I an interview was 4 (Licensed Practical at if interventions are put in the care plan. She stated d be at risk for falls. She should be developed on intions. She stated, "If tentions, then what was A care plan should have  I, an interview was (2 (Administrative Staff of Nursing. She stated that an was not developed. She aission assessment, there a care area to be care check for interventions to that interventions for falls the added on the baseline  I, ASM #1 the The Director of Nursing, anal Nurse Consultant were dings. No further

PRINTED: 09/18/2023 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495267	B. WING			C 09/01/2023	
NAME OF PE	ROVIDER OR SUPPLIER	400201			STREET ADDRESS, CITY, STATE, ZIP CODE	09/	01/2023
					614 HASTINGS LANE		
BROOKSI	DE REHAB & NURSING	CENTER			WARRENTON, VA 20186		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 655	Continued From page	÷ 33	F	655	5		
	4/3/23 with diagnoses	dmitted to the facility on s that include but are not r and Afib (atrial fibrillation).					
	was implanted in Res review of the baseline revealed, "FOCUS: R impairment to skin int location) related to:incontinence. Patien associated skin dama INTERVENTIONS: Fo treatment of injury.	monitoring. A pacemaker ident #353 on 3/31/23. A care plan dated 12/29/22, resident has potential/actual egrity of the (SPECIFY  The resident has bladder it has MASD (moisture					
	PM with LPN (license asked the purpose of #3 stated it was to init resident based on ado orders. When asked an implanted pacema	on their care plan, LPN #3					
	member) #1, the adm director of nursing and	, ASM (administrative staff inistrator, ASM #2, the d ASM #3, the regional made aware of the findings.					
F 656 SS=E	Develop/Implement C	n was provided prior to exit. Comprehensive Care Plan (3)	F	656	5		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE	
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		495267	B. WING _			09/0	01/2023
	ROVIDER OR SUPPLIER  DE REHAB & NURSING	CENTER		61	TREET ADDRESS, CITY, STATE, ZIP CODE 14 HASTINGS LANE //ARRENTON, VA 20186		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	implement a compreh care plan for each res resident rights set for §483.10(c)(3), that incobjectives and timefra medical, nursing, and needs that are identificassessment. The condescribe the following (i) The services that a or maintain the reside physical, mental, and required under §483.2 (ii) Any services that under §483.24, §483. provided due to the reunder §483.10, includit treatment under §483.3 (iii) Any specialized screhabilitative services provide as a result of recommendations. If a findings of the PASAF rationale in the resider (iv)In consultation with resident's representation (A) The resident's good desired outcomes.  (B) The resident's prefuture discharge. Fact whether the resident's community was assessible call contact agencies entities, for this purpor (C) Discharge plans in	ensive Care Plans cility must develop and ensive person-centered cident, consistent with the ch at §483.10(c)(2) and cludes measurable ames to meet a resident's mental and psychosocial ed in the comprehensive aprehensive care plan must re to be furnished to attain ent's highest practicable psychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required 25 or §483.40 but are not esident's exercise of rights ling the right to refuse and for indicate its on's medical record. The resident and the cive(s)- als for admission and ference and potential for diffices must document as desire to return to the seed and any referrals to and/or other appropriate	F	656	1. Resident #28 non-pharmacolo intervention monitoring has been to MAR (Medication Administration Record). Resident #28's care plateen updated to include diabeted diuretic medication, and anticoage medication. Resident #72's care has been updated to reflect patienced for supervision and occasion assistance with bathing. Resident fluid restriction has been discontinated the careplan has been updated accordingly. Resident #25's daily weight has been discontinued; and weights are now Monday, Wednes and Friday therefore weights are obtained as ordered per careplar Resident #87 and Resident #98 It discharged from the facility.	added on in has s, julant olan ent's onal it #10's nued ted ond esday, now n.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING				(X3) DATE COMP	
		495267	B. WING			C <b>09/01/2023</b>	
NAME OF D	ROVIDER OR SUPPLIER	433201	-		TREET ARRESTO OUT/ OTATE ZIR CORE	09/0	01/2023
	DE REHAB & NURSING	CENTER		61	TREET ADDRESS, CITY, STATE, ZIP CODE  14 HASTINGS LANE  I/ARRENTON, VA 20186		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	section. §483.21(b)(3) The se by the facility, as outli care plan, must- (iii) Be culturally-comply This REQUIREMENT by: Based on observation interviews, clinical recodocument reviews it vertically staff failed to determine the comprehensive corresidents in the surver #72, #10, #98, #25, and The findings include:  1. For Resident #28 to, implement the care non-pharmacological needed pain medicatifor a diagnosis of dials for the use of a diuret the care plan for the use of a diuret th	rvices provided or arranged and by the comprehensive betent and trauma-informed. It is not met as evidenced ans, resident interviews, staff cord reviews and facility was determined that the levelop and/or implement are plan for six of 45 y sample, Residents #28, and #87.  (R28), the facility staff failed are plan for interventions prior to as ions; develop the care plan ic medication; and develop use of an anticoagulant arecent MDS (minimum data assent with an ARD are date) of 6/23/2023, the art of 15 on the BIMS (brief tatus) assessment, t was cognitively intact for	F	656	2. All residents of the facility have potential to be affected by the alled deficient practice. An audit was performed of current residents receiving PRN pain medication to ensure an order for nonpharmacological interventions place. An audit was performed of current resident with a diagnosis diabetes; as well as an order for diuretic and anticoagulant medicates has been performed to ensure an appropriate care plan is in place, audit of current residents was performed to ensure a shower was completed for the current week. A audit of current residents with ord fluid restrictions was performed to ensure the provider is aware of a noncompliance since 9/1/2023. A audit was performed of current residents receiving psychotropic medications to ensure target beh monitoring is in place. An audit of current residents with weight ordewas performed to ensure compliance 9/1/2023. An audit was performed of current residents with order for a helmet to ensure place as per care plan.	eged s is in of ations An dered ony an avior f ers ance	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF D	DOVIDED OD CUDDUED	433207	I B: WING _		TREET ADDRESS CITY STATE ZID CODE	09/0	01/2023
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
BROOKSI	DE REHAB & NURSING	CENTER			IA HASTINGS LANE		
				VV	/ARRENTON, VA 20186		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 656	pain r/t (related to) mobility. Date Initiat 01/10/2023." Under in part, "Provide No interventions such a repositioning, visual 11/11/2022" The failed to evidence a anticoagulant or diu On 8/29/2023 at 12 conducted with R28 medications for pair the nurses for pair the nurses for pair the nurses for pair the nurses for pair the physician order - "Eliquis Tablet 5 M 1 tablet by mouth two (venous thromboem 12/24/2022." - "Furosemide Table mouth two times a 012/5/2022." - "Hydrocodone-Ace Give 1 tablet by mo for Pain. Order Date - "Metformin HCI EF Extended Release 2 by mouth one time a Diabetes Mellitus W Date: 12/13/2022."	care plan for R28 "The resident has chronic ADL (activities of daily living), ed: 11/11/2022. Revision on: "Interventions" it documented in-pharmacological is redirection, distraction, ization, etc. Date Initiated: comprehensive care plan care plan related to diabetes, retic medications.  33 p.m., an interview was . R28 stated that they took in R28 stated that they asked medication when they needed ey tried to reposition them em the medications and it hurt a little less.  Is for R28 documented in part, G (milligram) (Apixaban) Give to times a day for VTE abolism). Order Date:  It 80 MG Give 1 tablet by day for Edema. Order Date:	F	656	3. DON/designee will educate lice nursing staff regarding developmed implementation of the care plan to include nonpharmacological interventions for residents receiving PRN pain medication; care plan interventions for residents with a diagnosis of diabetes, as well as the receiving diuretic and anticoagulate medications; providing showers in accordance with residents' prefers notification of the provider related noncompliance with fluid restriction monitor and record target behaviors symptoms related to psychotropic medication use; obtaining weights order; and placing a device such a helmet per order/care plan.	ent and o ng those int nence; to ons; or s per	

STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE	SURVEY LETED
		495267	B. WING				01/ <b>2023</b>
	ROVIDER OR SUPPLIER	I		6′	TREET ADDRESS, CITY, STATE, ZIP CODE  14 HASTINGS LANE  VARRENTON, VA 20186	1 03/	0172023
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	1.5 MG/0.5ML (millilit mg subcutaneously of (Saturday) related to Without Complication.  Review of the eMAR administration record 7/1/2023-7/31/2023 f non-pharmacological administration of the Hydrocodone-Acetan 4:26 a.m. for a pain le 10:41 a.m. for a pain le 1:39 a.m. for a pain le 1:20 a.m. for a pain le 1:20 a.m. for a pain le 5:01 a.m. for a pain le 6:07 a.m. for a pain le 6:07 a.m. for a pain le 6:07 a.m. for a pain le 1:120 a.m. for a pain le 1:20 a.m. for a pain le 1:20 a.m. for a pain le 1:36 a.m. for a pain le 3:43 a.m. for a pain le 3:43 a.m. for a pain le 3:43 a.m. for a pain le 1:402 a.m. for a pain le 3:43 a.	er) (Dulaglutide) Inject 1.5 one time a day every Sat Type 2 Diabetes Mellitus Is. Order Date: 07/21/2023."  (electronic medication ) for R28 dated ailed to evidence interventions prior to as needed ninophen on 7/2/2023 at level of 9, on 7/6/2023 at level of 9, on 7/14/2023 at evel of 9, on 7/14/2023 at evel of 9, on 7/25/2023 at level of 5, on 7/25/2023 at level of 9, on 7/30/2023 at evel of 9 and 7/31/2023 at evel of 9 and 7/31/2023 at evel of 9.  for R28 dated ailed to evidence interventions prior to as needed ninophen on 8/1/2023 at evel of 2, on 8/2/2023 at level of 3, on 8/6/2023 at evel of 9, on 8/1/2023 at level of 5, on 8/2/2023 at level of 9, on 8/1/2023 at level of 5, on 8/21/2023 at level of 9, and on 8/23/2023 in level of 5.	F	656	4. DON/designee will perform an of current residents receiving PRI medication to ensure an order for nonpharmacological interventions place. DON/designee will perform audit of current residents with a diagnosis of diabetes; as well as current residents with an order for diuretic and anticoagulant medicato ensure an appropriate care plate. DON/designee will perform audit of current residents to ensure shower was completed for the curweek. DON/designee will perform audit of current residents with ord fluid restrictions to ensure the profess aware of any noncompliance. DON/designee will perform an aucurrent residents receiving psychemedications to ensure target behamonitoring is in place. DON/designee will perform an audit of current residents with weight orders to encompliance. DON/designee will pan audit of current residents with order for a helmet to ensure place as per care plan. These audits to performed 3x week x4weeks. The results will be reviewed and discubly the Interdisciplinary Team through the Quality Assurance process are corrective action plans put into plaindicated based on review, along determinations related to ongoing monitoring.  5. Date of Compliance 10/16/2025	N pain s is in the is the is in the is the is the is in the is th	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		, ,	(X3) DATE SURVEY COMPLETED	
		495267	B. WING			C 99/01/2023	
	ROVIDER OR SUPPLIER  DE REHAB & NURSING	CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 614 HASTINGS LANE WARRENTON, VA 20186		0/0 1/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 656	on 8/31/2023 at 2:15 to ASM (administration of the Hydrocodone-Acetar times documented a 2023.  On 8/31/2023 at 3:14 director of nursing stevidence of non-pha offered prior to admin Hydrocodone-Acetar times documented a 2023 to provide.  On 8/31/2023 at 10:2 conducted with LPN LPN #9 stated that the was to create an indirection on a day to the nursing staff were plan and they development of the care plans. She should be implement to see if improvement needs should be add would expect to see on the care plan. She monitor the residents sh place whether or not She stated that residents stated that residents on the care plan. She monitor the residents sh place whether or not She stated that residents stated that residents on the care plan.	5 p.m., a request was made ve staff member) #1, the dence of	F 65	56			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL1 A. BUILDI	IPLE CONSTRUCT	ION	(X3) DATE COMP	SURVEY PLETED
		495267	B. WING _			1	C 01/2023
	ROVIDER OR SUPPLIER  DE REHAB & NURSING	CENTER	·	STREET ADDRE		•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD B ISS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 656	conducted with LPN applans were developed director of nursing an stated that the care pubecause it was the plant of the care needstated that non-pharmattempted prior to as She stated that reside assessed and then the intervention was offer She stated that at time just ask for the medic refusal should be done she did not think that interventions were done of the MDS assessment completed by nursing care plan would be deanticoagulants and did was observed during they would develop the after the assessment She stated that the put oguide the staff how	0 a.m., an interview was #7. LPN #7 stated that care d by the unit manager and d the care plan team. She lan should be implemented an for the residents care and ed to meet their needs. She nacologic interventions were needed pain medications. Lents pain level was lee non-pharmacologic pain red prior to the medication. Les R28 would refuse and leation. She stated that the cumented. She stated that the non-pharmacologic recumented.  T. p.m., an interview was legistered nurse) #2, MDS	F	356			
	"Care plans shall inco	1/2021 documented in part,					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		, ,	(X3) DATE SURVEY COMPLETED	
		495267	B. WING _			C 9/01/2023	
	ROVIDER OR SUPPLIER  DE REHAB & NURSIN	G CENTER	,	STREET ADDRESS, CITY, STATE, ZIP CO 614 HASTINGS LANE WARRENTON, VA 20186	•		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 656	contained in the resassessment and:  a. Are resident orie b. Are behaviorally c. Are measurable; d. Contain timetable needs in accordance assessment"  On 9/1/2023 at 8:53 staff member) #1, tinterim director of negional nurse consthe findings.  No further informati  2. For Resident #7 to implement the coassist with bathing/ On the most recent quarterly assessment reference date) of 6 15 out of 15 on the mental status) asseresident was cognit decisions. The asserequiring supervision hygiene and being assistance of one part (activities of daily lindeficit r/t (related to	independence3. Care plan is are derived from information sident's comprehensive inted; stated; and it is set to meet the resident's it is with the comprehensive inted; and it is a a.m., ASM (administrative interest i	F	356			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		495267	B. WING _			C 99/01/2023	
	ROVIDER OR SUPPLIER	NG CENTER		STREET ADDRESS, CITY, STATE, ZIP C 614 HASTINGS LANE WARRENTON, VA 20186	· · · · · · · · · · · · · · · · · · ·	070 172020	
(X4) ID PREFIX TAG	(EACH DEFICIE	'STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 656	"Bathing/Showerin perform with staff and 11/11/2021. Revision on 8/29/2023 at 1 conducted with R7 times when they dependent of they were schedul supposed to get slawere days when they were going on brearing with the were going on brearing on the ADL 7/1/2023 to the preor shower provide 8/7/2023, 8/17/2023. The clinical record refusals for baths/stadministrator for e R72 on the dates I on 8/31/2023 at 3 director of nursing evidence of a bath dates listed above on 8/31/2023 at 1 conducted with CN #7. CNA #7 stated a week and more she stated that bat documented in the	ns" it documented in part, 19: The resident is able to assistance. Date Initiated: on on: 11/12/2021."  2:32 p.m., an interview was 2: R72 stated that there were id not get their showers when ed. R72 stated that they were nowers twice a week and there ney were scheduled and the m that they did not have time or ak and could not do it.  documentation for R72 from esent failed to evidence a bath d on 7/20/2023, 7/27/2023, 23 or 8/28/2023.  for R72 failed to evidence showers on the dates above.  15 p.m., a request was made ative staff member) #1, the vidence of a bath or shower for isted above.  149 p.m., ASM #2, the interim stated that they did not have or shower for R72 on the	F	556			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED				
		495267	B. WING		C 09/01/2023	
	ROVIDER OR SUPPLIER	G CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 514 HASTINGS LANE WARRENTON, VA 20186		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	O BE COMPLETION	
F 656	bath or shower they notified the nurse.  On 8/31/2023 at 10: conducted with LPN LPN #9 stated that they are sident and shower resident and shower residents on a day the nursing staff well plan and they developed the care plans. She should be implement to see if improvement needs should be ad On 8/31/2023 at 10: conducted with LPN plan should be impleplan for the resident needed to meet their On 8/31/2023 at 4:3 administrator, ASM nursing and ASM #3 consultant were man No further informations.  No further informations. For Resident #10 to implement the coreport non-compliant physician.  On the most recent quarterly assessment reference date) of 7, 15 out of 15 on the light states.	documented that also and  27 a.m., an interview was (licensed practical nurse) #9. he purpose of the care plan lividualized plan for the d how the staff treated the o day basis. She stated that re responsible for the care oped, reviewed and revised estated that the care plan atted because it allowed them not was needed or additional ded.  50 a.m., an interview was #7. She stated that the care emented because it was the s care and part of the care r needs.  1 p.m., ASM #1, the #2, the interim director of	F 656			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			COMPLETED	
		495267	B. WING _				C 01/2023
	ROVIDER OR SUPPLIER  DE REHAB & NURSING	CENTER		STREET ADDRESS 614 HASTINGS L WARRENTON,		1 03/	0 172023
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	(EAC	ROVIDER'S PLAN OF CORRECTION IH CORRECTIVE ACTION SHOULD B S-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	resident was cognitive decisions.  The comprehensive of documented in part, "restriction. Noncompl socks on with eucerin 04/27/2023. Revision "Interventions" it documented in compliance to MI Initiated: 04/27/2023.  The physician orders "Fluid Restriction 200 breakfast, 120cc mor 120cc afternoon med evening meds, 80cc Acute On Chronic Diafailure. Order Date: 0 Review of the eTAR (administration record for R10 documented each shift. The eTAR of 2700cc on 6/4/2022 2360cc on 6/28/2023 evidence notification non-compliance with restrictions.  Review of the eTAR documented inta shift. The eTAR failed to every shift and the example of the eTAR failed to every shift and the example of the eTAR failed to every shift and the example of the eTAR failed to every shift and the example of the eTAR failed to every shift and the example of	ely intact for making daily  sare plan for R10  Noncompliance with fluid sance with keeping non skid se [sic] cream. Date Initiated: on: 04/27/2023." Under smented in part, "Report D (medical doctor). Date  for R10 documented in part, 0cc per day: 600cc sing medpass, 480cc lunch, pass, 480cc dinner, 120cc sextra every shift related to setolic (Congestive) heart 19/02/2021."  electronic treatment of dated 6/1/2023-6/30/2023 sintake amounts totaled for a documented a total amount 3, 2340cc on 6/19/2023 and a The eTAR failed to	F	956			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		I ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495267	B. WING _				C 01/2023
	ROVIDER OR SUPPLIER  DE REHAB & NURSING	CENTER		STREET ADDRESS 614 HASTINGS L WARRENTON,		1 00/	0 1/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EAC	ROVIDER'S PLAN OF CORRECTION CH CORRECTIVE ACTION SHOULD I S-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 656	Review of the eTAR of R10 documented into shift. The eTAR docu 2520cc on 8/2/2023 at The eTAR failed to exphysician of non-comday fluid restrictions.  The clinical record for notification of the phynon-compliance of the dates listed above.  On 8/31/2023 at 10:2 conducted with LPN (LPN #9 stated that the was to create an indiversident and showed residents on a day to the care plan should allowed them to see if or additional needs stored the mail of the care them daily a practitioner if they we educated the residents on the non-compliance of the complete	dated 8/1/2023-8/31/2023 for alke amounts totaled for each amented a total amount of and 3600cc on 8/29/2023. vidence notification of the apliance with the 2000cc per an R10 failed to evidence resician/provider for the effuid restrictions on the resician/provider for the effuid restrictions on the residualized plan for the how the staff treated the day basis. She stated that be implemented because it fimprovement was needed hould be added. She stated were on fluid restrictions they and notified the nurse ent over the limit and the staff that there ation in the progress notes of the nurse practitioner of with fluid restrictions.  Of a.m., an interview was as an interview was and part of the care mented because it was the care and part of the care	F	556			
	staff member) #1, the	p.m., ASM (administrative administrator, ASM #2, the sing and ASM #3, the					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	FIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		495267	B. WING _			C 9/01/2023
	ROVIDER OR SUPPLIER  DE REHAB & NURSING	CENTER		STREET ADDRESS, CITY, STATE, Z 614 HASTINGS LANE WARRENTON, VA 20186	•	3/01/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN X (EACH CORRECTIVE , CROSS-REFERENCED DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 656	regional nurse consulthe concern.  No further information  4. For Resident #98 to implement the commonitor and record ta related to psychotropic.  On the most recent M significant change ass (assessment reference resident scored 5 out interview for mental sindicating the resident making daily decision documented R98 recommedication 6 of the 7 period.  The comprehensive of documented in part, "psychotropic medication as ordered in part, "medications as ordered side effects and effects and effects and effects hift). Date Initiated: Coccurrence of for targ document per facility 06/09/2023. Revision  The physician orders - "Risperidone Oral Target and the concerns	tant were made aware of  a was provided prior to exit.  (R98), the facility staff failed prehensive care plan to rget behavior symptoms in medication use.  (R98) (Minimum data set) a sessment with an ARD received at the provided as sessment with an ARD received as sessment, as sessment, as severely impaired for section and antipsychotic days during the assessment receiving an antipsychotic days during the assessment received as sessment received	F	656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		495267	B. WING _			C 9/01/2023
	ROVIDER OR SUPPLIER  DE REHAB & NURSING	CENTER		STREET ADDRESS, CITY, STATE, ZIP COI 614 HASTINGS LANE WARRENTON, VA 20186		3/01/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 656	monitoring for side eff behavior symptoms fuse.  On 8/31/2023 at 2:15 to ASM (administrative administrator for evide adverse effect monitor to the present.  On 8/31/2023 at 4:00 director of nursing stany evidence of behavioring for R98 to something in place at On 8/31/2023 at 10:2 conducted with LPN LPN #9 stated that the was to create an indirector symptoms.	r R98 failed to evidence fects, effectiveness or target or psychotropic medication  a p.m., a request was made re staff member) #1, the ence of behavior and oring for R98 from 6/1/2023  a p.m., ASM #2, the interim ated that they did not have avior or adverse effect provide and they had put a that point.  7 a.m., an interview was (licensed practical nurse) #9. e purpose of the care plan vidualized plan for the	F 6	56		
	residents on a day to the care plan should allowed them to see or additional needs s that residents who remedications were medications and their the monitoring was directly record and done even on 8/31/2023 at 10:5 conducted with LPN plan should be imples	onitored for behaviors and baseline. She stated that occumented in the clinical me medication administration ry shift.  10 a.m., an interview was 147. She stated that the care mented because it was the care and part of the care				

STATEMENT OF DEFICIENCIES  AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER  DE REHAB & NURSIN	1		STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186	1 09/01/2023
(X4) ID PREFIX TAG	(EACH DEFICIE!	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRICIENCY)	) BE COMPLETION
F 656	administrator, ASM nursing and ASM # consultant were mathematics. For Resident #25 to implement the calordered.  A review of R25's coorders: "7/28/23 Notify prim 2 or more pounds in 5 days." "7/29/23 Hemodialy center]MWF (Moreous) and the following states of R25's were corded on the following states of R25 in August 2.  A review of R25's corevealed, in part: "1 stage renal disease dialysisPre-Post of R25's corevealed, in part: "1 stage renal disease dialysisPre-Post of R25's corevealed, in part: "1 stage renal disease dialysisPre-Post of R25's corevealed, in part: "1 stage renal disease dialysisPre-Post of R25's corevealed, in part: "1 stage renal disease dialysisPre-Post of R25's corevealed, in part: "1 stage renal disease dialysisPre-Post of R25's corevealed, in part: "1 stage renal disease dialysisPre-Post of R25's corevealed, in part: "1 stage renal disease dialysisPre-Post of R25's corevealed, in part: "1 stage renal disease dialysisPre-Post of R25's corevealed, in part: "1 stage renal disease dialysisPre-Post of R25's corevealed, in part: "1 stage renal disease dialysisPre-Post of R25's corevealed, in part: "1 stage renal disease dialysisPre-Post of R25's corevealed, in part: "1 stage renal disease dialysisPre-Post of R25's corevealed, in part: "1 stage renal disease dialysisPre-Post of R25's corevealed, in part: "1 stage renal disease dialysisPre-Post of R25's corevealed, in part: "1 stage renal disease dialysisPre-Post of R25's corevealed, in part: "1 stage renal disease dialysisPre-Post of R25's corevealed, in part: "1 stage renal disease dialysisPre-Post of R25's corevealed, in part: "1 stage renal disease dialysisPre-Post of R25's corevealed, in part: "1 stage renal disease dialysisPre-Post of R25's corevealed, in part: "1 stage renal disease dialysisPre-Post of R25's corevealed, in part: "1 stage renal disease dialysisPre-Post of R25's corevealed, in part: "1 stage renal disease dialysisPre-Post of R25's corevealed, in part: "1	31 p.m., ASM #1, the #2, the interim director of 3, the regional nurse ade aware of the concern.  30 (R25), the facility staff failed are plan to obtain weights as  31 p.m., ASM #1, the #2, the interim director of #3, the regional nurse and aware of the concern.  45 (R25), the facility staff failed are plan to obtain weights as  46 product of the following  47 plan facility staff failed are plan to obtain weights as  48 product of the following  48 plan facility staff failed are plan obtain weight gain of #49 plan facility staff failed #40 plan facilit	F 65	6	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495267	B. WING				C <b>01/2023</b>	
	ROVIDER OR SUPPLIER  DE REHAB & NURSING	G CENTER		614	REET ADDRESS, CITY, STATE, ZIP CODE 4 HASTINGS LANE ARRENTON, VA 20186	1 03/	01/2023	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 656	care plan is to know mark improvements function. She stated responsible for impl  On 8/31/23 at 3:45 staff member) #2, the provided weights frou asked if these weight clinical record, she staked in these unless I requereceived the weight.  On 9/1/23 at 8:58 a member) #1, the addinterim director of no regional nurse consconcerns.  No further information.	She stated the purpose of the the resident's baseline and to or declines in the resident's everyone in the facility is ementing the care plan.  D.m., ASM (administrative ne interim director of nursing, om the dialysis center. When his were a part of R25's stated: "No. We don't get est them." She stated she had	F	656				
	observed lying in be	nes and times, R87 was ad, without a helmet: 8/29/23 at 9.m.; 8/30/23 at 8:46 a.m.						
	order, dated 6/14/23	rders revealed the following 3: "Foam helmet on at all nent and document refusal."						
	updated 6/14/23 rev	are plan dated 1/18/23 and realed, in part: "[R87] has had						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	IPLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED	
		495267	B. WING _			C <b>09/01/2023</b>
	ROVIDER OR SUPPLIER  DE REHAB & NURSING	CENTER	,	STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	
F 656	non-compliant with we times."  On 8/31/23 at 10:26 a assistant) #8 was interest is supposed to have a Even in bed." She sta	emoval/refusals. Patient earing foam helmet at a.m., CNA (certified nursing erviewed. She stated: "[R87] a helmet on all the time. ted she "always" puts a	F 6	56		
	asked for it.  On 8/31/23 at 10:43 at nurse) #11 was intervisupposed to wear a her family thinks it will resident wears it and She stated: "The helm what the family wants the care plan is to know and to mark improver resident's function. SI facility is responsible plan.	a.m., LPN (licensed practical iewed. She stated R87 is elmet at all times "because I help." She stated the still falls and hits her head. net is not working, and it is ." She stated the purpose of ow the resident's baseline nents or declines in the ne stated everyone in the for implementing the care				
	member) #1, the adm interim director of nur regional nurse consul concerns.	a., ASM (administrative staff inistrator, ASM #2, the sing, and ASM #3, the tant, were informed of these a was provided prior to exit.				
F 657 SS=D	Care Plan Timing and CFR(s): 483.21(b)(2)(s) \$483.21(b) Comprehe \$483.21(b)(2) A complete.	Revision i)-(iii)	F 6	57		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUF A. BUILDING COMPLETI				
		495267	B. WING _			C 01/2023
	ROVIDER OR SUPPLIER  DE REHAB & NURSING	CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 614 HASTINGS LANE WARRENTON, VA 20186		
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F 657	includes but is not lim (A) The attending phy (B) A registered nurse resident. (C) A nurse aide with resident. (D) A member of food (E) To the extent pract the resident and the resident and their An explanation must medical record if the and their resident rep not practicable for the resident's care plan. (F) Other appropriate disciplines as determ or as requested by th (iii)Reviewed and rev team after each asse comprehensive and of assessments. This REQUIREMENT by: Based on resident in clinical record review review, it was determ failed to review and/of three of 45 residents Residents #153, #65.  The findings include:  The facility policy, "C Objectives" was revied documented, "Care p and objectives that le	ssessment. terdisciplinary team, that nited to ysician. e with responsibility for the responsibility for the d and nutrition services staff. cticable, the participation of resident's representative(s). be included in a resident's participation of the resident resentative is determined e development of the staff or professionals in ined by the resident's needs e resident. ised by the interdisciplinary ssment, including both the quarterly review  is not met as evidenced terview, staff interview, , and facility document ined that the facility staff or revise the care plan for in the survey sample; and #50.	F 6	1. Resident #153 has been from the facility. Resident plan was updated to reflect intervention of a room char from physical abused resident. Resident # 50's updated to reflect the resident and active smoker.  2. All residents of the fact potential to be affected by deficient practice. An audity performed of current residents experiencing a fall within weeks to ensure review/or care plan. An audit was procurrent residents experied aggression from another past two weeks to ensure was updated accordingly performed of current resist smoke to ensure the care addresses smoking status.	t #65's care ect the ange to protect from another care plan was sident no longer  illity have the y the alleged dit was dents the past two revision of the performed of incing physical resident in the ethe care plan c. An audit was dents that e plan	

SEITHER OF SIT MEDIONITE	NIEDICAID SERVICES	_		ONID NO. 0930-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	495267	B. WING		09/01/2023
NAME OF PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	
BROOKSIDE REHAB & NURSIN	G CENTER		14 HASTINGS LANE	
		V	VARRENTON, VA 20186	
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outcome for a spect opportunity2. When the documented as to wachieved and what have been establish modified according are reviewed/revise significant change in When the desired cachieved"  1. For Resident #1 review and/or revise 9/23/22 and 9/24/22 Resident #153 was 9/9/22 and discharge had diagnoses of bidifficulty walking, lalloss. The admission Set) dated 9/13/22 cognitively impaired decisions, scoring a BIMS (Brief Interview A nurse's note date [patient] was found R [right] side lying patient] was found R [right] side lying patient] was sessment perform (skin tear) to R fa (find cleaned with NS (note in the residual content of the content of the cleaned with NS (note in the content of the cleaned with NS (note in the content of the cleaned with NS (note in the content of the cleaned with NS (note in the content of the cleaned with NS (note in the content of the content of the content of the cleaned with NS (note in the content of the content	s are defined as the desired iffic resident problem or the goals and objectives are esident's clinical record will be why the results were not new goals and objectives ned. Care plans will be ly5. Goals and objectives and a. When there has been a nother resident's condition; b. butcome has not been	F 657	3 DON/designee will educate	ing/revising ignee will regarding protect the rom ensed on of residents  care plantience a fall lent to intervention ysical is week perform an y smoke or sure in 3x week ereviewed iplinary urance plans put on review, ted to

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1	PLE CONSTRUCTION  IG	' '	(X3) DATE SURVEY COMPLETED	
		495267	B. WING			C 09/01/2023
	ROVIDER OR SUPPLIER  DE REHAB & NURSING	l		STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186	•	09/01/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 657	initiated."  A nurse's note dated informed by CNA tha Upon entering the roand was assisted bacasked if she hurt any skin assessment don observed. Will continually and is at risk for additional gait/balance problem the interventions were rurther review of the any evidence of being after either of the above falls also failed the care plan was reveither of the above falls also failed the care plan was reveither of the above falls also failed the care plan and add new conducted with LPN Nurse). She stated to interdisciplinary team care plan and add new conducted with ASM Member) the Director there was no evidence with as no evidence was no evidence.	9/24/22 documented, "Was to resident was on the floor. Om. She was able to stand ook to bed. Replied "No" when where. Vital signs taken, e., no new changes ue to observe."  Dolan revealed one dated on 9/21/22 included: had an actual fall on 9/21/22 tional falls r/t [related to] ins, Vision impairment" All it dated 9/21/22.  Care plan failed to reveal greviewed and/or revised ove two falls.  By reports for each of the disto to reveal any evidence that viewed and/or revised after ills.  PM an interview was #4 (Licensed Practical that usually, after a fall, the in will review the resident and ew interventions if needed.  M, an interview was #2 (Administrative Staff of Nursing. She stated that the of the care plan being after the above two falls.	F6	57		

PRINTED: 09/18/2023 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE COMP	SURVEY LETED	
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NAME OF P	ROVIDER OR SUPPLIER		1		STREET ADDRESS, CITY, STATE, ZIP CODE	09/	01/2023
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BROOKSI	DE REHAB & NURSING	CENTER			WARRENTON, VA 20186		
(V4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	ID	<u> </u>	PROVIDER'S PLAN OF CORRECTION		(X5)
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F 657	Continued From page	53	_	65	7		
1 007				05			
		2 the Director of Nursing, onal Nurse Consultant were					
	made aware of the fin						
	information was provi	_					
	·						
		the facility failed to revise					
	resident abuse occur	are plan after resident to					
	resident abuse occurr	ed.					
	Resident #65 was ad	mitted to the facility on					
		es that included but were not					
	limited to: Alzheimer's	s Disease and dementia.					
	TI I IMPO						
	The most recent MDS	,					
		rly assessment, with an erence date) of 5/23/23,					
		s scoring a 00 out of 15 on					
		iew for mental status) score,					
	,	t was severely cognitively					
	impaired.						
		rehensive care plan dated					
	has a behavior proble	aled, "FOCUS: The resident					
		elchairs, inviting another					
		n, spending time in another					
		to help another resident use					
		RVENTIONS: Intervene as					
	necessary to protect t	the rights and safety of					
		eak in a calm manner. Divert					
		om situation and take to					
	alternate location as r	needed."					
	A review of the facility	synopsis of events dated					
	_	approximately 5:30 PM on					
		ed [Resident #36] getting up					
	from the table she wa						
	approached [Residen						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		495267	B. WING		C 09/01/2023
	ROVIDER OR SUPPLIER  DE REHAB & NURSING	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186	1 00/01/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETION
F 657	on the floor. The res assesses; no injuries [Resident #36] report sitting at a table and table, she did not wa her hair because she [Resident #65] was un happened."  A review of the facility 4/13/23 revealed, "[Resident #66] for un disheveled. Resident room. [Resident #36] [Resident #65] for un #36] pulled [Resident in the face. Resident assessed for injuries [Resident #65] move.  An interview was corned with LPN (license asked the purpose of stated, it is to develop actions the resident rasked who revises the they all can revise the a resident is the recip resident, should the costated, yes, of course An interview was corned with LPN #9. When asked if a resident rasked with the recip resident, should the costated, yes, of course the stated, yes, of course they all can revise the a resident is the recip resident, should the costated, yes, of course they all can revise they	op of her head and threw her idents were separated and noted. When asked, ted, she [Resident #65] was I told her to get up from the nt to, so I pulled her up by esteals everything. Inable to report what  I gevent synopsis dated tesident #65] was found on Table/belongings appeared to the pulled known reasons. [Resident to the pul	F 65		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	LE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER  DE REHAB & NURSING	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186		
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F 657	On 9/1/23 at 9:55 Al member) #1, the ad director of nursing a nurse consultant was A review of the facility policy, revealed, "Cargoals and objectives highest obtainable let No further information 3. For Resident #50 to review and revise regarding smoking.  On the most recent set) assessment, wireference date) of 4, assessed as not curn active smoker. Date Initiate The Safety-Resident documented in part, tobacco products? Non 8/31/2023 at 10: conducted with LPN LPN #9 stated that the was to create an incresident and shower	ons to protect the resident.  M, ASM (administrative staff ministrator, ASM #2, the nd ASM #3, the regional s made aware of the findings.  ty's "Care Plan and Goals" are plans shall incorporate is that lead to the resident's evel of independence."  on was provided prior to exit.  (R50), the facility staff failed the comprehensive care plan annual MDS (minimum data then an ARD (assessment /18/2023, the resident was rently using tobacco.  care plan for R50 "Smoking: [Name of R50] is ed: 03/31/2020."  t Evaluation dated 6/4/2023 "Does the resident use	F 65	7		

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION  3	(X3) DATE SURVEY COMPLETED		
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F 658 SS=D	the care plans. She should be implement to see if improvement needs should be add not smoke and they smoked. She stated accurate and needed On 9/1/2023 at 8:53 staff member) #1, the interim director of nurregional nurse consultate findings.  No further information Services Provided M CFR(s): 483.21(b)(3) Comproved The services provide as outlined by the comust- (i) Meet professional This REQUIREMENT by: Based on staff interview, and clinical refailed to follow profest three of 45 residents Residents #6, #253, The findings include:  1. For Resident #6 (F	ped, reviewed and revised stated that the care plan ed because it allowed them t was needed or additional ed. She stated that R50 did were unsure if they had ever that R50's care plan was not to be revised.  a.m., ASM (administrative administrator, ASM #2, the raing, and ASM #3, the litant were made aware of the was provided prior to exit. Eact Professional Standards (i)  The ensive Care Plans dor arranged by the facility, is not met as evidenced riews, facility document ecord review, the facility staff asional standards of care for in the survey sample, and #303.	F 65		in was om reaction din and Resident om the ave the alleged as a receiving notified of t an audit t residents ents		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED					
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		495267	B. WING			1	01/2023
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
BROOKSI	DE REHAB & NURSING	CENTER			14 HASTINGS LANE		
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F 658	medical record reveal Erythromycin (1)."  A review of R6's prov following order, writte Oral Tablet 250 MG (1) mouth at bedtime for pulmonary disease) et abs today, 1 tab days:  A review of R6's Augu administration record Azithromycin as order Areview of R6's prog following note dated 8. The system has ident for the following order 250 MG (milligrams) bedtime for copd exact today, 1 tab days 2-5.  Further review of R6's reveal evidence that a up on the alert regard Azithromycin.  On 8/30/23 at 1:38 p. member) #11, a regist director of quality for interviewed. When as a resident has a docu Erythromycin and is p stated: "They are in the do not dispense it." A pharmacy records an communication with the statement of the statemen	gies listed on the electronic led, in part: "Allergies:  ider's orders revealed the n 8/1/23: "Azithromycin (2) milligrams)Give 1 tablet by copd (chronic obstructive exacerbation for 5 Days. 2 s 2-5."  Just 2023 MAR (medication of the exacerbation for 5 Days. 2 s 2-5."  Just 2023 MAR (medication of the exacerbation for 5 Days. 2 s 2-5."  Just 2023 MAR (medication of the exacerbation for 5 Days. 2 s 2-5."  Just 2023 MAR (medication of the exacerbation for 5 Days. 2 tablet exacerbation for 5 Days. 3 tablet exacerbation for 5 Days. 4 tablet by exac	F	658	3. DON/Designee to educate licentrursing staff regarding provider notification of any potential allergy alerts. DON/Designee to educate licensed nursing staff regarding obtaining orders to monitor PT/INF resident receiving coumadin. DON/Designee to educate license nursing staff regarding administrate medications within the allowable timeframe and notify provider if medications are given out of timeform the discussion of the provider antibiotics to monitor for potential allergy and provider notification 3x week x4weeks. DON/Designee to audit current residents receiving coumadin to energy the provider notification of the timeframe to ensure provider notification of th	rame.  given eeks. d Team ocess o w, to	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION	COMPLETE		
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	ROVIDER OR SUPPLIER  DE REHAB & NURSING	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186			
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F 658	commonly used med pharmacy records in member entered the the Omnicell (automa system) machine and administer to R6, ever sent the alert regardistated the pharmacy approval code for a rethat is not a narcotic "Our records show we and we held it due to evidence anyone from us to say the allergy resolved. We would unless that had happed on 8/30/23 at 4:39 penurse) #2, the nurse Azithromycin on 8/1/2 stated if a medication to see if it is available R6's August 2023 Macadinistered the Azith stated he could not removed it from Omninot remember seeing regarding a possible on 8/31/23 at 7:05 a administered the Azithre is a problem will medication, "the phasistated if there is possible on the pharmacy about the pharmacy about the stated in the pharmacy about the pharmac	nicell (machine containing ications)." She stated the dicated a facility staff resident's information into ated medication dispensing diremoved the medication to en after the pharmacy had ng a possible allergy. She is not required to give an nurse to access a medication in Omnicell. She stated: the ereceived the order on 8/1 the allergy. I don't have any method the facility followed up with information had been not dispense the medication mened."  I.m., LPN (licensed practical who administered the 23, was interviewed. LPN #2 is not available, they check in Omnicell. After looking at AR, LPN #2 stated they had thromycin as ordered. He emember whether or not he nicell, and he stated he did go the pharmacy alert allergy.	F 65	58			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '		(X3) DATE SURVEY COMPLETED	
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stated she document in the progress notes nurses told her that the for the Azithromycin to She stated she could her this.  On 8/31/23 at 11:11 at staff member) #5, the stated she did not rerethe potential allergy for stated: "I can't remendent contact me. If I had k would have changed my part ordering it."  On 9/1/23 at 8:58 a.m member) #1, the adminterim director of nur regional nurse consucton concerns.  No further information NOTES  (1) "Erythromycin is used infections caused by of the respiratory trace pneumonia, Legionnal infection), and pertus serious infection that coughing); diphtheria throat); sexually transincluding syphilis; and gynecological, urinary	s the phone call with the NP. She stated one of the ne NP had given permission to be administered to R6. The not recall which nurse told num., ASM (administrative NP, was interviewed. She nember being notified about the permission of the nurses who nown about this allergy, I git. I consider it a mistake on the number of th	F 65	3		
~	CORRECTION  ROVIDER OR SUPPLIER  SUMMARY ST. (EACH DEFICIENC REGULATORY OR I  Continued From page stated she documents in the progress notes nurses told her that the for the Azithromycin to She stated she could her this.  On 8/31/23 at 11:11 a staff member) #5, the stated she did not rerethe potential allergy for stated: "I can't remember contact me. If I had known would have changed my part ordering it."  On 9/1/23 at 8:58 a.m member) #1, the adminterim director of nur regional nurse consult concerns.  No further information  NOTES (1) "Erythromycin is used infections caused by of the respiratory trace pneumonia, Legionna infection), and pertus serious infection that coughing); diphtheria throat); sexually transincluding syphilis; and gynecological, urinary also is used to prever Erythromycin is in a content of the content of the prevention of t	A95267  ROVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 59 stated she documents the phone call with the NP in the progress notes. She stated one of the nurses told her that the NP had given permission for the Azithromycin to be administered to R6. She stated she could not recall which nurse told her this.  On 8/31/23 at 11:11 a.m., ASM (administrative staff member) #5, the NP, was interviewed. She stated she did not remember being notified about the potential allergy for R6 until 8/30/23. She stated: "I can't remember all of the nurses who contact me. If I had known about this allergy, I would have changed it. I consider it a mistake on my part ordering it."  On 9/1/23 at 8:58 a.m., ASM (administrative staff member) #1, the administrator, ASM #2, the interim director of nursing, and ASM #3, the regional nurse consultant, were informed of these concerns.  No further information was provided prior to exit.	A BUILDING  495267  B. WING  BONIDER OR SUPPLIER  DE REHAB & NURSING CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 59  stated she documents the phone call with the NP in the progress notes. She stated one of the nurses told her that the NP had given permission for the Azithromycin to be administered to R6. She stated she could not recall which nurse told her this.  On 8/31/23 at 11:11 a.m., ASM (administrative staff member) #5, the NP, was interviewed. She stated she did not remember being notified about the potential allergy for R6 until 8/30/23. She stated: "It can't remember all of the nurses who contact me. If I had known about this allergy, I would have changed it. I consider it a mistake on my part ordering it."  On 9/1/23 at 8:58 a.m., ASM (administrative staff member) #1, the administrator, ASM #2, the interim director of nursing, and ASM #3, the regional nurse consultant, were informed of these concerns.  No further information was provided prior to exit.  NOTES  (1) "Erythromycin is used to treat certain infections caused by bacteria, such as infections of the respiratory tract, including bronchitis, pneumonia, Legionnaires' disease (a type of lung infection), and pertussis (whooping cough; a serious infection that can cause severe coughing); diphtheria (a serious infection in the throat); sexually transmitted diseases (STD), including syphilis; and ear, intestine, gynecological, urinary tract, and skin infections. It also is used to prevent recurrent rheumatic fever. Erythromycin is in a class of medications called	A BUILDING  495267  BY WING  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICENCY MUST BE PRECEDED BY FULL RESULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 59  stated she documents the phone call with the NP in the progress notes. She stated one of the nurses told her that the NP had given permission for the Azithromycin to be administered to R6. She stated she could not recall which nurse told her this.  On 8/31/23 at 11:11 a.m., ASM (administrative staff member) #5, the NP, was interviewed. She stated of not remember all of the nurses who contact me. If I had known about this allergy, I would have changed it. I consider it a mistake on my part ordering it."  On 9/1/23 at 8:58 a.m., ASM (administrative staff member) #1, the administrator, ASM #2, the interim director of nursing, and ASM #3, the regional nurse consultant, were informed of these concerns.  No further information was provided prior to exit.  NOTES (1) "Erythromycin is used to treat certain infections caused by bacteria, such as infections of the respiratory tract, including bynonchilis, preumonia, Legionaniers' disease (a type of lung infection), and pertussis (whooping cough; a serious infection in the throat); sexually transmitted diseases (STD), including syphilis; and ear, intestine, gynecological, urinary tract, and skin infections. It also is used to prevent recurrent rheumatic fever. Epythromycin is in a class of medications called	

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F 658	from the website https://medlineplus.gtml#:~:text=Erythron 20treat,a%20serious (2) "Azithromycin is infections, such as a sexually transmitted infections of the ears and reproductive orgused to treat or prev Mycobacterium aviutype of lung infection with human immuno Azithromycin is in a macrolide antibiotics growth of bacteria."	This information was taken gov/druginfo/meds/a682381.h nycin%20is%20used%20to% s%20infection%20in%20the.  used to treat certain bacterial bronchitis; pneumonia; diseases (STD); and s, lungs, sinuses, skin, throat, gans. Azithromycin also is	F 65	3		
	failed to follow a problood test and failed of blood testing equivariant A review of R253's part (all notes written member) #5, the nurotherwise noted: "8/14/23 Hx (history thrombosis) (2). Cor INR."	ntinue with Warfarin (3). Start top Warfarin. Start INR ge to Xarelto (4) 10				

PRINTED: 09/18/2023 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495267	B. WING			C	
NAME OF B	201/1252 02 01/221/52	493207	B. WING			09/	01/2023
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
BROOKSI	DE REHAB & NURSING	CENTER			614 HASTINGS LANE		
				'	WARRENTON, VA 20186		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 658	Continued From page	e 61	F	658			
	"8/19/23 Have pt (patimachine supplies."	ient) check INR with her					
		op warfarin. INR done on ed to NP or recorded in					
	"8/25/23 INR reported written by a nurse whitten interview at the time of						
	part:	ovider's orders revealed, in time for bridge to Xarelto					
	"8/19/23 Have patient machine/supplies. On						
	"8/28/23 PT/INR One	time only."					
		53's clinical record revealed NR was done on 8/14/23, /28/23.					
	she received Warfarin	) for August 2023 revealed n 2.5 mg (milligrams) on and Warfarin 3 mgs on					
	nurse) #9 was intervieusually gives verbal of she is responsible for NP has given it to her member to verify the of	m., LPN (licensed practical ewed. She stated the NP orders to the staff. She stated putting the order in as the r, and getting another staff order. She stated if a farin, the resident needs a					

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER  DE REHAB & NURSING			STREET ADDRESS, CITY, STATE, ZIP C 614 HASTINGS LANE WARRENTON, VA 20186	TY, STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 658	PT/INR test at least v has a point of care IN staff members to get resident's bedside.  On 9/1/23 at 8:33 a.n. She stated she usual given to her by the nushe was not aware of R253. After checking stated: "Oh, I see sor they weren't done." State the resident was obtaining the INR lev facility did any kind of the resident's compet to determine the machon of the properties of the interimal director of nurregional nurse consuconcerns. ASM #2 standard have been evaluated the INR machine corrown INR level on 8/2 resident's machine all prior to usage to ensuaccurate.  No further information NOTES  (1) "Prothrombin time international normalizatested to assess the international norm	weekly. She stated the facility IR test machine that enables this test done quickly at the machine test done quickly at the machine test done quickly at the machine for the resident's orders, she me now. I'm not sure why the stated she was aware to use her own machine for el, but did not think the fassessment to determine tency to use the machine or hine's accuracy.  In., ASM (administrative staff ministrator, ASM #2, the resing, and ASM #3, the leant, were informed of these ated the resident should for her competence to use tectly prior to obtaining her 5/23. She stated the so needed to be calibrated are the reading was  In was provided prior to exit.  In (PT) and the associated ted ratio (INR) are routinely risk of bleeding or onitor response to	Fé	558			

	TATEMENT OF DEFICIENCIES  ND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION  A. BUILDING		, , ,	(X3) DATE SURVEY COMPLETED		
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F 658	(2) "Thrombosis is the formation of a blood deep vein thrombosis in one of the larger, the muscles. Deep voccurs in the lower leand dissolves on its symptoms like pain a diagnosed with DVT avoid serious complembolism. This can away from its original lungs in the bloodstream thrombosis increase operations such as a surgery. Because of this kind of surgery at the prevent blood clot information is taken Health website https://www.ncbi.nlm.  (3) "Warfarin is used forming or growing lavessels. It is prescribly types of irregular her prosthetic (replacem valves, and people valtack. Warfarin is all	n.nih.gov/pmc/articles/PMC55  ne medical term for the clot in a blood vessel. In s (DVT), the blood clot forms deeper veins that run through ein thrombosis usually eg. It often goes unnoticed own. But it may cause and swelling. If someone is they will need treatment to ecations such as pulmonary occur if the blood clot breaks all site and is carried to the eam. The risk of deep vein a safter more major they or hip replacement this, people who have had are usually given medication is from forming. This from the National Institutes of in.nih.gov/books/NBK425364/.	F 65	58		
	lung). Warfarin is in anticoagulants ('bloo decreasing the clotti	r embolism (a blood clot in the a class of medications called od thinners'). It works by ng ability of the blood." This from the National Institutes of				

	TEMENT OF DEFICIENCIES  (X1) PROVIDER/SUPPLIER/CLIA  (X2) MULTIPLE CONSTRUCTION  A. BUILDING  A. BUILDING		, ,	(X3) DATE SURVEY COMPLETED			
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 658	Health website https://medlineplus.grtml.  3. For Resident #303 failed to administer A standards of medicat timeframes.  The physician orders part, "Apixaban Table tablet by mouth two trolots. Order Date: 08.  The eMAR for R303 documented the Apix administration at 9:00 day.  On 8/30/2023 at 1:12 to ASM (administrativadministrator, for evicadministration with action 12/1/2022-12/31  Review of the facility Audit report" for R303 12/1/2022-12/31/2022 scheduled for 9:00 a. on 12/11/2022, at 10:10:48 a.m. on 12/18/21/24/2022. It furthe scheduled for 5:00 p. on 12/11/2022, at 6:29 p.m. on 12/18/2022, at 6:57 p.m. on 12/12/21/21/21/2022, at 6:49 p. 10:42 p.m. on 12/23/31	ov/druginfo/meds/a682277.h  (R303), the facility staff pixaban within professional ion administration practice  for R303 documented in at 5 MG (milligram) Give 1 imes a day for prevent blood (25/2022."  dated 12/1/2022-12/31/2022 aban scheduled for 0 a.m. and 5:00 p.m. each  p.m., a request was made the staff member) #1, the dence of medication diministration times for R303 in increase and in items for R303 in items and	F 6	58			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	G CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186			
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F 658	of the physician of the dates listed above.  On 9/1/2023 at 8:39 conducted with LPN LPN #8 stated that radministered within after the scheduled medication was give timeframes then the practitioner and the documented it in the documented it in the According to Fundarincredibly easy) Lipt 2007 page 172, "Retimes established for follow these times comedications as order on 9/1/2023 at 8:53 administrator, ASM nursing and ASM #3 consultant were made and possibly causing the chance and possibly causing by heart valve diseat prevent deep vein the usually in the leg) at a blood clot in the luter of the condition in the luter of the cond	a.m., an interview was (licensed practical nurse) #8. medications should be an hour before or an hour time. She stated that if the en outside of these y notified the nurse responsible party and e progress notes.  mentals of Nursing (made bincott Williams and Wilkins, gardless of the administration r a patient, you'll need to arefullyadminister all ered by the physician"  a.m., ASM #1, the #2, the interim director of	F 658			

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	IPLE CONSTRUCTION  NG		PLETED
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(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ( (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 676 SS=E	happening again aft completed. Apixaba called factor Xa inhil the action of a certa helps blood clots to obtained from the whttps://medlineplus.gtml Activities Daily Livin. CFR(s): 483.24(a)(1  §483.24(a) Based or assessment of a respective resident's needs and provide the necessare ensure that a reside daily living do not directly of the individual's clithat such diminution includes the facility of the section where ability to carry living, including those of this section  §483.24(b) Activities The facility must product of the paractivities of daily living activities of daily living da	or prevent DVT and PE from er the initial treatment is in is in a class of medications bitors. It works by blocking in natural substance that form. This information was ebsite: gov/druginfo/meds/a613032.h g (ADLs)/Mntn Abilities (b)(b)(1)-(5)(i)-(iii)  In the comprehensive eident and consistent with the dichoices, the facility must ary care and services to int's abilities in activities of minish unless circumstances inical condition demonstrate was unavoidable. This ensuring that:  I dent is given the appropriate exes to maintain or improve his out the activities of daily be specified in paragraph (b)  Sof daily living.  Sof daily living.		1.Resident #72 shower schedupdated to reflect assigned shadys, resident has received sischeduled. Resident #303 had discharged from the facility.  2. All residents of the facility.  2. All residents of the facility high potential to be affected by the deficient practice. An audit was performed of current residents current week to ensure the shaden completed.  3. DON/designee will educate Nursing staff on providing shower/bathing according to requests and preferences and documenting accordingly.  4. DON/designee to audit for completion 5x week x4 weeks results will be reviewed and do by the Interdisciplinary Team the Quality Assurance process corrective action plans put intendicated based on review, also	ave the alleged is for the ower has all esident is though is and oplace as ong with	
		ity-transfer and ambulation,		determinations related to ong monitoring.  5. Date of Compliance 10/16/	oing	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	09/	01/2023
				6	614 HASTINGS LANE		
BROOKSI	DE REHAB & NURSING	CENTER		٧	WARRENTON, VA 20186		
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F 676	Continued From page	e 67	F	676			
	§483.24(b)(3) Elimina	ition-toileting,					
	§483.24(b)(4) Dining- snacks,	eating, including meals and					
	This REQUIREMENT by: Based on resident in clinical record review review, it was determ provide evidence of p daily living) for two of sample, Residents #7 The findings include:  1. For Resident #72 (to evidence a bath or	ommunication systems.  is not met as evidenced  terview, staff interview, and facility document ined the facility staff failed to roviding ADLs (activities of 45 residents in the survey					
	quarterly assessment reference date) of 6/1 15 out of 15 on the BI mental status) assess resident was cognitive decisions. The asses requiring supervision hygiene and being incassistance of one per On 8/29/2023 at 12:3.	ely intact for making daily ssment documented R72 of one person for personal dependent in bathing with					

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F 676	they were scheduled supposed to get show were days when they staff would tell them to were going on break.  Review of the ADL do 7/1/2023-7/31/2023 f shower was provided. The documentation fo 7/27/2023 had an "X".  Review of the ADL do 8/1/2023-8/31/2023 f shower was provided 8/28/2023. The documentation for the ADL do 8/1/2023-8/31/2023 f shower was provided 8/28/2023 was blank "NA." The documentation applicable."  The clinical record for refusals for baths/shower the comprehensive of documented in part, '(activities of daily living deficit r/t (related to) Initiated: 11/11/2021. Under "Interventions' "Bathing/Showering: perform with staff ass 11/11/2021. Revision On 8/31/2023 at 2:15 to ASM (administration).	not get their showers when R72 stated that they were wers twice a week and there were scheduled and the that they did not have time or and could not do it.  Documentation for R72 from ailed to evidence a bath or 1 on 7/20/2023, 7/27/2023. Or 7/20/2023 was blank and in the area.  Documentation for R72 from ailed to evidence a bath or 1 on 8/7/2023, 8/17/2023 or 1 on 8/7/2023, 8/17/2023 or 1 on 8/7/2023, 8/17/2023 and 1 on 8/7/2023 documented atton key evidenced "NA-Not or R72 failed to evidence owers on the dates above.  Documentation for R72 from ailed to evidence a bath or 1 on 8/7/2023 and 1 on 8/7/2023 and 1 on 8/7/2023 documented atton key evidenced "NA-Not or R72 failed to evidence owers on the dates above.  Documentation for R72 from ailed to evidence of R72 has an ADL or 1 on 1	F 67	76			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE	TION SHOULD BI THE APPROPRIA	DATE
F 676	director of nursing state evidence of a bath or dates listed above to On 8/31/2023 at 10:1 conducted with CNA #7. CNA #7 stated that week and more ofte She stated that baths documented in the codocumentation and if bath or shower they onotified the nurse. Si	p.m., ASM #2, the interim ated that they did not have shower for R72 on the provide.  9 a.m., an interview was (certified nursing assistant) at showers were given twice en if needed or requested.	F6	376		
	conducted with CNA evidenced the care the what was done on the stated that "NA" means scheduled the showers of it was not given and the prn (as needed) so the facility policy, "Ac (ADLs)" dated 10/1/2 "Residents will be proposed and services as approximation in the proposed for the services of the ser	ctivities of Daily Living 021 documented in part, ovided with care, treatment, opriate to maintain or o carry out activities of daily ents who are unable to carry living independently will necessary to maintain good				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495267	B. WING _			C <b>09/01/2023</b>
	ROVIDER OR SUPPLIER  DE REHAB & NURSING	CENTER		STREET ADDRESS, CITY, STAT 614 HASTINGS LANE WARRENTON, VA 20186	E, ZIP CODE	33/3/1122
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORRECTION CROSS-REFERENCE	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIA FICIENCY)	
F 676	including appropriate with: a. Hygiene (batt and oral care); i. Eac or shower baths as o than twice weekly or Residents preference conditions prohibit tul a sponge bath daily  On 8/31/2023 at 4:31 administrator, ASM # nursing and ASM #3, consultant were mad  No further information  2. For Resident #303 failed to evidence a bon 12/12/2022, 12/15 12/26/2022, 12/29/20  On the most recent N quarterly assessment reference date) of 12 assessed as requiring for personal hygiene  Review of the ADL do 12/1/2022-12/31/202 shower was provided 12/19/2022, 12/26/20 documentation for 12 12/19/2022, and 12/2 12/26/2022 had an "N documentation key e applicable."	support and assistance ning, dressing, grooming, h resident shall receive tub ften as needed, but not less as required by state law. and/or whose medical or shower baths shall have "  p.m., ASM #1, the 2, the interim director of the regional nurse aware of the concern.  was provided prior to exit.  (R303), the facility staff ath or shower was provided h/2022, 12/19/2022, 12/2 and 1/2/2023.  MDS (minimum data set) a twith an ARD (assessment h/15/2022, the resident was group supervision of one person and bathing.  Documentation for R303 from 2 failed to evidence a bath or on 12/12/2022, 12/15/2022, 12/29/2022. The h/12/2022, 12/15/2022, 19/2022 was blank and NA" in the area. The	F	576		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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F 676	shower was provide documentation for 1 The documentation applicable."  The clinical record for refusals for baths/sh. The comprehensive documented in part, selfcare performance by) Acute and chron failure), Type 2 DM fibrillation, ETOH (alfalling, COPD (chron disease), Homeless medical treatment. In Revision on: 01/12/2 On 8/31/2023 at 2:1 to ASM (administration and sevidence of a bath of dates listed above to the conducted with CNA #7. CNA #7 stated to a week and more of She stated that bath documented in the conducted with conducted with conducted and compensation and sevidence of a documentation and sevidence of the conducted with conducted with conducted with conducted with conducted in the conducted in the conducted in the conducted and compensation and sevidence and compensation and sevidence of the conducted with	d on 1/2/2023. The //2/2023 documented "NA." key evidenced "NA-Not  or R303 failed to evidence flowers on the dates above.  care plan for R303 "(Name of R72) has an ADL e deficit AEB (as evidenced flowers mellitus), Atrial (cohol) abuse, H/O (history of) floodstructive pulmonary flowers, non compliance with floate Initiated: 08/25/2022. 2023."  5 p.m., a request was made five staff member) #1, the floence of a bath or shower for sted above.  9 p.m., ASM #2, the interim floated that they did not have for shower for R303 on the floor provide.  19 a.m., an interview was floor (certified nursing assistant) float showers were given twice float flowers were floor requested. floor or showers were	F 676				

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F 677 SS=E	conducted with CNA evidenced the care the what was done on the stated that "NA" means scheduled the shower so it was not given and the prn (as needed) so the pr	1 a.m., an interview was #5. CNA #5 stated that they ey provided by documenting e ADL documentation. She at that the computer had ror bath on the wrong day ad should be documented in hower area.  p.m., ASM #1, the 2, the interim director of the regional nurse e aware of the concern.  In was provided prior to exit. or Dependent Residents  ent who is unable to carry iving receives the necessary good nutrition, grooming, and giene;  is not met as evidenced  terview, staff interview, ew, and clinical record ff failed to provide ADL 199 care for dependent 45 residents in the survey 15, #60, and #28.	F 677		to er, ence. s the eged the er has	

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F 677	quarterly assessmen reference date) of 8/3 cognitively intact for 1 was coded as requiri of staff for toileting ar being completely dep for bathing.  On 8/29/23 at 11:57 a She stated the staff habout getting me cleas her scheduled showed A review of R6's POO July and August 2023 following ADLs on the Bathing: 7/7, 7/9, 7/17/23, 7/25, 7/26, 7/27, 8/20, 8/25, 8/26, and Morning Personal Hy 7/12, 7/28, 7/28, 7/30.  Evening Personal Hy 7/17, 7/18, 7/19, 7/20, 7/27, 7/28, 8/11, 8/16, 8/17, 8/19, 8/20, 8/25, 8/26, 8/27.  Shower (as schedule 7/20, 7/27, 7/31.  On 8/31/23 at 10:26 assistant) #8 was intertasks are included in	MDS (minimum data set), a t with an ARD (assessment 3/23, R6 was coded as being making daily decisions. She ng the extensive assistance and personal hygiene, and as bendent on staff assistance a.m., R6 was interviewed. as not "been very good aned up in the mornings." not always get a shower on er days.  C (point of care) records for 3 revealed no evidence of the e following dates: 1, 7/13, 7/16, 7/20, 7/21, 7, 7/28, 8/9, 8/10, 8/13, 8/14,	F 6	<ul> <li>4. DON/designee to audition completion 5x week x4 results will be reviewed by the Interdisciplinary the Quality Assurance procedure action plans procedure as indicated based on rewith determinations relamonitoring.</li> <li>5. Date of Compliance 1</li> </ul>	weeks. These and discussed Feam through process and put into place eview, along thed to ongoing		

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  (X2) MULTIPLE CONSTRUCTION  A. BUILDING  A. BUILDING		1, ,	(X3) DATE SURVEY COMPLETED			
		495267	B. WING			C <b>09/01/2023</b>
	ROVIDER OR SUPPLIER  DE REHAB & NURSING	I		STREET ADDRESS, CITY, STATE, ZIP CO. 614 HASTINGS LANE WARRENTON, VA 20186	DE	09/01/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 677	the resident's face, h parts, applying deode combing hair, applying brushing the resident provides evidence of signing off the task of computer. She stated every shift. Sometime what's going on with On 8/31/23 at 10:43 and nurse) #11 was interested are primarily responsif a resident refuses of the CNA will report it sign off their work on computer.  On 9/1/23 at 8:58 a.m member) #1, the adminterim director of nurregional nurse consuctoncerns.  A review of the facility Living (ADLs)," reveal be provided with care appropriate to maintain carry out activities of are unable to carry or independently will red to maintain good nuttipersonal and oral hygoe given proper daily including skin, nail, h resident shall receive often as needed, but	ands, legs, feet, and private brant in the mornings, and lotion to dry skin, and its teeth. She stated she what she has done by in the POC record on the it: "I try to get to everybody, es it's hard, depending on other residents on the unit."  a.m., LPN (licensed practical viewed. She stated the CNAs ible for ADL care. She stated or the CNA has a concern, to her. Otherwise, the CNAs the POC record on the  a.m., ASM (administrative staff inistrator, ASM #2, the rsing, and ASM #3, the ltant, were informed of these  y policy, "Activities of Daily aled, in part: "Residents will be, treatment, and services as an or improve their ability to daily livingResidents who ut activities of daily living beeive the services necessary	F	577		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION  G		LETED
		495267	B. WING			C 01/2023
	ROVIDER OR SUPPLIER  DE REHAB & NURSING	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186	1 00/	0 172020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 677	care as needed."  No further information  2. For Resident #60 (to evidence a bath or 7/4/2023, 7/18/2023, 8/18/2023 (and to evidence a bath or 7/4/2023, 8/18/2023 (by 18/2023)  On the most recent N annual assessment or reference date) of 7/2 (by 15 out of 15 on the B mental status) asses resident was cognitive decisions. The asses requiring limited assis personal hygiene and one person for bathin on 8/29/2023 at 1:03 (by 18/20/2023) conducted with R60. In received showers so they were supposed like some of the staff they just had to go to themselves up some review of the ADL do 7/1/2023-7/31/2023 from the staff they just had to go to 17/1/2023-7/31/2023 from 7/28/2023 was blank.	g and grooming as ints shall be assisted with oral in was provided prior to exit.  (R60), the facility staff failed shower was provided on 7/21/2023, 7/28/2023, and 8/29/2023.  MDS (minimum data set) an with an ARD (assessment 21/2023, the resident scored all MS (brief interview for sment, indicating the rely intact for making daily assment documented R60 stance of one person for dextensive assistance of ag.  8 p.m., an interview was R60 stated that they metimes but not as often as to. R60 stated that they felt did not care very much and the sink and wash times.  Documentation for R60 from failed to evidence a bath or 7/4/2023, 7/18/2023, 223. The documentation for and 7/4/2023, 7/21/2023 in "NA" in the area. The	F 6	77		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	LE CONSTRUCTION	(X3) DATE S	ETED
		495267	B. WING		09/0	; )1/2023
	ROVIDER OR SUPPLIER  DE REHAB & NURSING			STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186	1 09/0	112023
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 677	Continued From pag	•	F 67	7		
	8/1/2023-8/31/2023 shower provided on 8/29/2023. The doc	documentation for R60 from failed to evidence a bath or 8/1/2023, 8/18/2023 and sumentation for 8/1/2023, 1/2023 documented "NA." The evidenced "NA-Not				
		or R60 failed to evidence nowers on the dates above.				
	(activities of daily liv	"(Name of R72) has an ADL ing) self-care performance recent hospitalization on mobility. Date Initiated:				
	to ASM (administrat	5 p.m., a request was made ive staff member) #1, the dence of a bath or shower for ted above.				
	director of nursing,	9 p.m., ASM #2, the interim stated that they did not have or shower for R60 on the provide.				
	conducted with CNA #7. CNA #7 stated a week and more of She stated that bath documented in the of documentation and bath or shower they notified the nurse.					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495267	B. WING			l	C
		493201	B: WiiNO			09/	01/2023
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
BROOKSI	DE REHAB & NURSING	CENTER			614 HASTINGS LANE		
				'	WARRENTON, VA 20186		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 677	Continued From page happen.		F	677	7		
	conducted with CNA at evidenced the care the what was done on the stated that "NA" mean scheduled the shower	1 a.m., an interview was #5. CNA #5 stated that they bey provided by documenting a ADL documentation. She are that the computer had are or bath on the wrong day and should be documented in hower area.					
	nursing and ASM #3,	2, the interim director of					
	No further information	was provided prior to exit.					
	to evidence a shower completed on 7/10/20	R28), the facility staff failed and/or a complete bed bath 123, 7/20/2023, 7/24/2023, 8/10/2023, 8/14/2023, and					
	quarterly assessment reference date) of 6/2 14 out of 15 on the BI mental status) assess were cognitively intac Section G coded R28 assistance of two or and totally dependent On 8/29/2023 at 12:32 conducted with R28. resided at the facility of the section of th	IDS (minimum data set), a with an ARD (assessment 3/2023, the resident scored MS (brief interview for sment, indicating that they t for making daily decisions. as requiring extensive more persons for transfers on one person for bathing.  3 p.m., an interview was R28 stated that they had for over a year and really					
		er. R28 stated that they had hs since they were at the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		495267	B. WING			C 9/01/2023		
	ROVIDER OR SUPPLIER  DE REHAB & NURSING	CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 614 HASTINGS LANE WARRENTON, VA 20186		0/01/2020		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE		
F 677	(certified nursing assibath due to their size were working to get made them mad and shower or been offe size. R28 stated that without a shower and transfer to another face Review of the ADL of 7/1/2023-7/31/2023 bed bath or shower 7/20/2023, 7/24/202 The documentation 7/31/2023 was bland 7/10/2023 and 7/24/documentation key experience of the ADL of 8/1/2023-8/31/2023 bed bath or shower 8/14/2023, 8/21/202 documentation for 8/14/2023, 8/21/202 documentation for 8/14/2023 doc	re only certain CNA's sistants) who would do their e so they had to wait until they their baths. R28 stated that it d they had never been to the red a shower because of their at no one should have to go d they were looking to acility in the Richmond area.  Idocumentation for R28 from failed to evidence a complete provided on 7/10/2023, 3, 7/27/2023, and 7/31/2023. for 7/20/2023, 7/27/2023 and c. The documentation for 2023 documented "PB." The evidenced "PB- Partial bath."  Idocumentation for R28 from failed to evidence a complete provided on 8/10/2023, 3 and 8/28/2023. The resident of 8/14/2023 and ted "PB." The documentation for 8/14/2023 and ted "PB." The documentation Partial bath."  The R28 failed to evidence a complete provided on 8/14/2023 and ted "PB." The documentation Partial bath."  The R28 failed to evidence a complete provided on 8/14/2023 and ted "PB." The documentation Partial bath. The documentation Partial bath. The documentation Partial bath is an ADL according to the resident has an ADL according to the resident h	F 67	77				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION  G	, ,	(X3) DATE SURVEY COMPLETED	
		495267	B. WING _			C 9/01/2023	
	ROVIDER OR SUPPLIER  DE REHAB & NURSING	CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 614 HASTINGS LANE WARRENTON, VA 20186		03/01/2020	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL FREGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 677	Continued From pag R28 on the dates list On 8/31/2023 at 3:49 director of nursing strevidence of a bath or dates listed above to On 8/31/2023 at 10:10 conducted with CNA #7. CNA #7 stated that week and more off. She stated that baths documented in the ordocumentation and it bath or shower they notified the nurse. S ADL documentation in happen.  On 8/31/2023 at 10:50 conducted with LPN LPN #7 stated that stand the CNA's documented in the CNA's documented with LPN LPN #7 stated that stand the CNA's documenter. LPN #7 s CNA's who worked withey knew their routing the conducted with their routing the conducted with the CNA's documented with the CNA's who worked with the conducted with the cond	e 79 ed above.  9 p.m., ASM #2, the interim ated that they did not have reshower for R28 on the provide.  19 a.m., an interview was (certified nursing assistant) and showers were given twice en if needed or requested. For showers were computer in the ADL at the resident refused the documented that also and the stated that "NA" on the meant that the activity did not so a.m., an interview was (licensed practical nurse) #7. Thowers were twice a week	F 6	DEFICIENCY		DAIL	
	conducted with CNA evidenced the care the what was done on the stated that "NA" means cheduled the showers of it was not given at the prn (as needed) that R28 was totally of the evidence of the conduction of the care of th	21 a.m., an interview was #5. CNA #5 stated that they ney provided by documenting e ADL documentation. She int that the computer had er or bath on the wrong day nd should be documented in shower area. CNA #5 stated dependent on staff for got bed baths. She stated					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION  IG	(X3) DATE SURVEY COMPLETED
		495267	B. WING _		C 09/01/2023
	ROVIDER OR SUPPLIER  DE REHAB & NURSING	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186	03/01/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 684 SS=G	shower chair so they had not come in yet. one of two obese res shower chair and the the chair for them to stated that the head to get the chair. She bed baths from her a week when they wer the other CNA's were size but she did not rhad been here over a wanted showers.  On 8/31/2023 at 4:3 administrator, ASM # nursing and ASM #3 consultant were mad No further information Quality of Care CFR(s): 483.25  § 483.25 Quality of a Quality of care is a function and the residents received accordance with profipractice, the compression care plan, and the residents received accordance with profipractice, the compression and the residents received accordance with profipractice, the compression and the residents received accordance with profipractice, the compression and the residents received accordance with profipractice, the compression and the residents received accordance with profipractice, the compression and the residents received accordance with profipractice, the compression of the compress	seed to be getting R28 a could go to the shower but it She stated that R28 was sidents who needed the facility was working to buy use for the residents. She of therapy had been working stated that R28 received and one other aide twice a e working because some of e intimidated by the resident's mind. She stated that R28 a year and had always  I. p.m., ASM #1, the f2, the interim director of the regional nurse le aware of the concern.  In was provided prior to exit.  In was provided prior to exit.  In are undamental principle that that and care provided to sed on the comprehensive dent, the facility must ensure extreatment and care in fessional standards of thensive person-centered	F 6		nave the alleged ecent skin ents were to d as

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ATIONI NILIMBED.		ULTIPLE CONSTRUCTION		
		495267	B. WING				01/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS,	CITY, STATE, ZIP CODE	1 03/	01/2023
22221				614 HASTINGS LA	.NE		
BROOKS	IDE REHAB & NURSIN	GCENTER		WARRENTON, V	A 20186		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH	OVIDER'S PLAN OF CORRECTION I CORRECTIVE ACTION SHOULD I REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	and/or monitor a ch for one of 45 reside Residents #254. Fo staff failed to asses resident's right great tear. Three days aff resident was transfinecrotic right great with antibiotics. The monitoring resulted The findings include For Resident #254 identified a skin tea 8/26/23. The facility assessment or mor the resident was se afternoon of 8/29/2 toe. The lack of ass resulted in harm to On the most recent admission assessm reference date) of 8 being severely coglidaily decisions, have the BIMS (brief inter was admitted to the including diabetes, (2).  On 8/29/23 at 12:08 sitting in a wheelch daughter was seateright leg was elevated leg down to the ank red/purple/black, ar	ange in a resident's condition onts in the survey sample, or Resident #254, the facility is and monitor a diabetic at toe after identifying a skin ter identifying the skin tear, the erred to the hospital with a toe and received treatment is lack of assessment and in harm to Resident #254.  (R254), the facility staff or on her right great toe on a staff failed to evidence further intoring of the skin tear until ent to the hospital in the late is with a necrotic (1) right great sessment and monitoring	F	current res skin impair treatment/i weeks. The and discus Team throi process ar into place a along with ongoing m	esignee to perform an sidents' skin assessmerments and correspondence for each ese results will be revised by the Interdiscip ugh the Quality Assurant corrective action plass indicated based on determinations related ionitoring.  Compliance 10/16/202	ents for ding ( x 4 iewed linary ance ans put to ding	

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495267	B. WING			l	01/ <b>2023</b>
NAME OF PI	ROVIDER OR SUPPLIER		1		STREET ADDRESS, CITY, STATE, ZIP CODE	09/	01/2023
					614 HASTINGS LANE		
BROOKSI	DE REHAB & NURSING	CENTER		,	WARRENTON, VA 20186		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 684	Continued From page	e 82	F	684			
	-	54] had a bloody sock over			•		
		lowed it to a nurse." She					
	stated the weekend n	urse told her that the nurse					
		e list to be seen by the					
		Monday, 8/28/23. She					
		4 every day, and there has					
		of dressing on the toe. ed she was waiting for the					
	nurse to come in and	· ·					
		m., R254 was lying in her					
		pe was visible, and was still					
	red/purple/black, and	wet.					
	_	inical record revealed the					
	following progress no						
		8 p.m." Nursing Note Text: esident's great toe on right					
		<0.5cm (centimeters) x					
		sident stated that she does					
	not remember how sk	kin tear happened. Cleansed					
		nser and applied bacitracin.					
		)and [name of primary					
	ı · · ·	Will continue to monitor."					
	#2.	by RN (registered nurse)					
	<i>112</i> .						
	"8/26/2023 15:21 (3:2	21 p.m.) Nursing Note Text:					
		umented. weekly wound					
	assessment triggered	l. <b>"</b>					
	"8/29/2023 1635 (4:3	5 p.m.) Transfer to hospital."					
	"8/29/2023 22:11 (10:	:11 p.m.)					
	eINTERACTSumma						
	Situation: The Chang	e In Condition/s reported on					
	thisEvaluation are/v	· · · · · · · · · · · · · · · · · · ·					
		Change in skin color or					
	conditionOutcomes	of Physical Assessment:					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		(X3) DATE SURVEY COMPLETED		
		495267	B. WING _			1	C 01/2023
	ROVIDER OR SUPPLIER  DE REHAB & NURSING	CENTER		614 H	ASTINGS LANE RENTON, VA 20186	1 03/	0 172020
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 684	Positive findings report evaluation for this charmon for the skin tear, and rassessment or monite great toe between 8/2 is a solution for the skin tear, and rassessment or monite great toe between 8/2 is a solution for the skin tear, and rassessment or monite great toe between 8/2 is a solution for this charmon for the skin tear, and rassessment or monite great toe between 8/2 is a solution Primary care provider notes for this charmon for the skin tear, and rassessment or monite great toe between 8/2 is a solution	rited on the resident/patient ange in condition were: tion: Increased confusion Skin Status Evaluation: y Care Provider Feedback: or responded with the state to send the resident to the state significant to send the resident shower on her toe. upon toe was observed. physician was given to send the mergency room). RP as in the building and a phone call follow-up was ted for hypernatremia (high to [sic] toe, dehydration, UTI in)."  seekly Skin Observation ed, in part: "Are there any so, surgical incisions, skin so or other skin conditions or other skin conditions."  sincal record (orders, [medication administration evidence of an order for care	F	684			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	IPLE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		495267	B. WING _			C <b>09/01/2023</b>	
	ROVIDER OR SUPPLIER  DE REHAB & NURSING	CENTER	•	STREET ADDRESS, CITY, STATE, ZIP 614 HASTINGS LANE WARRENTON, VA 20186	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
F 684	the local hospital who 8/29/23 revealed, in seen in the Emergen of black toes on her in has been going on. It days prior Physica (musculoskeletal): Bli toes The patient pristatus, concerning for sepsis, although ong daughter. Concerns agangrenous changes most consistent with On 8/31/23 at 10:43 nurse) #11 was intervidentifies that a residus assess the injury and treatment orders. She assessment form, and so it will show up on stated skin tears shot facility staff until they this is especially impediabetes and neuropoon On 8/31/23 at 11:11 astaff member) #5, a rinterviewed. She staft the skin tear by way medical record softwo She stated: "I don't renotifications."	gency Room records from ere R254 was admitted on part: "The patientwho is cy Department for concerns right foot, unsure how long it Daughter first noticed it four all ExaminationMSK ack first and second right esents with altered mental reacute infection, possibly oing for three weeks per for foot ulceration vs. on right toesPresentation foot infection, UTI."  a.m., LPN (licensed practical viewed. She stated if she ent has a skin tear, she is notifies the NP to obtain the completes a skin denters the treatment order the TAR for follow up. She uld be monitored by the are resolved. She stated ortant for resident who have athy.  a.m., ASM (administrative nurse practitioner, was ted RN #2 texted her about of the facility's electronic are on Saturday, 8/26/23. espond to those routine ated she did not see the or 8/29/23. She stated: "I 4's] toes."	F	584			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495267	B. WING		C 09/01/2023	
	ROVIDER OR SUPPLIER  DE REHAB & NURSING	G CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186	1 0000 112020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETIC	
F 684	informed of these co for harm to R254. A not have standing o On 8/31/23 at 4:13 p She stated R254's of Saturday, 8/26/23, the was bloody. She stated in removing the resister on the top of the around toward the sign was still intact, but the toe. She stated she wound cleanser and ointment but no band on the resident and the clinical record. Sign was a routine text. Understanding that the software triggers and follow up, and the winjury and determines stated there is no lissee on the NP's new stated: "I figured with would trigger a visit."  On 9/1/23 at 8:14 a. nursing, was asked evidence to present the hospital had det peripheral vascular."	gional nurse consultant, were oncerns, and of the concern SM #2 stated the facility does refers for skin tears.  o.m., RN #2 was interviewed. laughter notified her on that the resident's right sock ated the daughter assisted her dent's sock. There was a skin e right great toe, extending ide of the toe. The toenail there was dried blood on the cleaned the dried blood with applied an antibiotic dage. She put a clean sock made the required notes in the stated she notified ASM. She stated it is her the electronic medical record formal wound assessment for found nurse would look at the eap roper treatment. She to fresidents for the NP to the tvisit to the facility. She had menotifying the NP, that "  m., ASM #2, the director of if the facility had additional regarding R254. She stated ermined the resident had disease, of which the facility	F 684			
	facility staff was awa and peripheral neuro were aware of that." place to monitor this	aware. When asked if the are that R254 had diabetes opathy, she stated: "Yes, we When asked what was put in a diabetic resident, who had a ASM #2 did not answer.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
						С	
		495267	B. WING			09/	01/2023
	ROVIDER OR SUPPLIER  DE REHAB & NURSING	CENTER		6	TREET ADDRESS, CITY, STATE, ZIP CODE  14 HASTINGS LANE  VARRENTON, VA 20186		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page	≥ 86	F	684			
	in part: "Skin Tearis by mechanical forces depthStaff will be en any observation of a contegrity including preservation, or bruiseCof impaired skin integrity including preservation, or bruiseCof impaired skin integrity including preservation of impaired skin integrity statementsTreatment physician/practitioner interventions and treat the physician/practition the treatments will be resident's medical reconstruction intervention the resident's medical reconstruction for the resident's medical reconstruction in the reco	es Management," revealed, a traumatic wound causedSeverity may vary by necouraged to promptly report change in the resident's skin sence of a skin tear, Observations of new areas rity will be reported to the for further evaluation and ts will be ordered by theResident centered atments will be prescribed by oner and administration of documented in the cordTreatments, including ons, will be documented in I record."  In was provided prior to exit.  The was provided prior to exit.					

` '		IDENTIFICATION NUMBED:		2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILDI		<del></del>	С		
		495267	B. WING			l '	01/2023	
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE			
BROOKSI	DE REHAB & NURSING	CENTER		614 HASTINGS LANE				
				WARRENTON, VA 20186				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 686 F 686 SS=D	Treatment/Svcs to Pr CFR(s): 483.25(b) (1) Pressure States on the compressional standard pressure ulcers and culcers unless the individemonstrates that the (ii) A resident with prenecessary treatment with professional starr promote healing, prevnew ulcers from deverthis REQUIREMENT by:  Based on observation document review, and was determined that implement treatments prevent and treat a presidents in the surversidents in the surversidents in the surversidents.  The findings include:  1. For Resident #7 (Relevate the resident's injury.  On the most recent May quarterly assessment reference date) of 7/3	event/Heal Pressure Ulcer (i)(ii)  grity re ulcers. Thensive assessment of a factor of a f		686 686	<ol> <li>Resident #7 order for heels up times has been discontinued. Ref #87 and Resident #98 have disc from the facility.</li> <li>All residents have the potential affected by the alleged deficient practice. An audit of current reside with orders to float heels has been conducted to ensure an offloading device is in place. An audit of curresidents with pressure injuries heen conducted to ensure a treatorder is in place and said treatment order corresponds with recent provider communication.</li> <li>DON/Designee will educate light nursing staff regarding obtaining treatment orders.</li> <li>DON/Designee will perform an of residents with orders to float hensure an offloading device is in 3x week x 4 weeks. DON/design perform an audit to ensure reside with pressure injuries to ensure to a treatment order in place and sate treatment order corresponds to the recent provider communication 3x 4 weeks.</li> <li>Date of Compliance 10/16/202</li> </ol>	esident harged  Ito be dents en ig rrent nas tment ent ovider  censed  n audit neels to place ee will ents here is aid he bx week		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION  IG	COMPLETED	
		495267	B. WING _		C 09/01/2023
	ROVIDER OR SUPPLIER	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186	1 03/01/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODER (DEFICIENCY)	JLD BE COMPLETION
F 686	coded as being at ris as having no unheal  On the following date observed lying in becontact with the mat 12:25 p.m. and 3:41 and 1:07 p.m.  A review of R7's Braidentify pressure inju R7 scored 19, indicadeveloping a pressure order, written 1/17/2 heels and float off beconder, written 1/17/2 heels and float off beconder for it." She statimportant for residents' heels need order for it." She statimportant for resider asked about R7's neshe stated: "I don't the floated because stime." She stated the which residents have floated.  On 8/31/23 at 12:56 nurse) #5, the wound She stated if a reside for developing a presheels should be float or NP (nurse practition).	sk for a pressure injury, and ed pressure injuries.  es and times, R7 was d, with bed heels in direct tress surface: 8/29/23 at p.m.; 8/30/23 at 8:46 a.m.  den Scale assessment to ury risk dated 7/3/23 revealed ting she was at low risk of re injury.  ers revealed the following 3: "Skin prep to bilateral ed every shift for preventive."  a.m., CNA (certified nursing terviewed. She stated: "All d to be floated if they have an ted floating heels is especially attended to have her heels floated, nink she needs her heels to she is not in the bed all the enurses inform CNAs about the orders for heels to be  p.m., LPN (licensed practical d nurse, was interviewed. ent is in bed and has a risk assure injury, the resident's ted. She stated the physician oner) will often write an order is to be floated. She stated the	F 6	86	

PRINTED: 09/18/2023 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		405267	B. WING			С	
		495267	B. WING			09/	01/2023
	ROVIDER OR SUPPLIER  DE REHAB & NURSING	CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 686	Continued From page	e 89	F	686	6		
	On 9/1/23 at 8:58 a.m	n., ASM (administrative staff ninistrator, ASM #2, the					
	-	rsing, and ASM #3, the					
		tant, were informed of these					
		/ policy, "Pressure Injury gement," revealed, in part:					
		essure ulcer/injury risk					
	assessment will be in						
	•	ePreventative interventions					
	will be implemented b						
	assessment, other rel preferences. Such int	lated factors and resident					
	E	sure reducing/relieving					
	-	evices that assist with					
	pressure redistribution						
	No further information	n was provided prior to exit.					
	2. For Resident #87 (	R87), the facility staff failed					
		nt for a pressure injury until					
	four days after it was	identified.					
	A review of R87's pro	gress note revealed the					
	following note dated 6	•					
	-	today at [6:00 p.m.] from					
		al]Skin has scattered ody, stage 4 sacral pressure					
	wound (1) reported by						
	Further review of the	resident's clinical record,					
	including orders, skin						
		ation records) and TARs					
	•	tion records) failed to reveal					
	evidence for orders for pressure injury until 6	or the treatment of the					
	pressure injury until 0	∥ 1 <del>1</del> 1∠J.					
	A review of the nurse	practitioner's note dated					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495267	B. WING _				01/ <b>2023</b>
	ROVIDER OR SUPPLIER  DE REHAB & NURSING	CENTER		614 HAS	ADDRESS, CITY, STATE, ZIP CODE TINGS LANE ENTON, VA 20186	1 00/	0 172020
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 686	6/12/23 at 2:08 p.m. r "Endorses pain sec (assessment and phy wound care."  A review of R87's car revealed, in part: [R8' skin integrityFollow the prevention of skin  On 8/31/23 at 10:43 a nurse) #11 was interv the admitting nurse for with a pressure injury practitioner) or physic treatment order come hospital, she will let the the recommended tree treatment for the wou soon as possible.  On 8/31/23 at 11:11 a staff member) #5, a n interviewed. She state with a pressure injury come with orders to to the hospital. She state between when the res facility and when the there should be woun stated: "That's somet do." She stated she of before the physician of admission history and participate in that pro- assess or write treatm	evealed, in part: ondary to sacral ulcerA&P sical) decubitus ulcer -  e plan dated 6/10/23  7] has actual impairment to facility policies/protocols for breakdown."  a.m., LPN (licensed practical iewed. She stated if she is or a resident who comes in , she notifies the NP (nurse ian. She states if a is from the discharging he NP know that and initiate atment. She stated the and should be initiated as  a.m., ASM (administrative urse practitioner, was ed if a resident is admitted , the resident should ideally reat the pressure injury from ed if there is a time lapse sident is admitted to the NP first sees the resident d care happening. She hing I expect the facility to ften sees the resident comes in to do the I physical, and she does not cess. She stated she did not	F	986			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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NAME OF P	ROVIDER OR SUPPLIER	433201	D. WING	S	TREET ADDRESS, CITY, STATE, ZIP CODE	09/	01/2023
BROOKSI	DE REHAB & NURSING	CENTER			14 HASTINGS LANE		
	0.11.11.4.15.4.07	WATER FAIR OF RESIDENCIES		V	VARRENTON, VA 20186		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 686	nurse, was interviewed admitted with a press come with orders from the order from the ho implemented immedia resident can be seen nurse or doctor. She not come with orders should be notified and nurse an order for the She stated: "It's not obefore pressure injury.  On 9/1/23 at 8:33 a.m admitting nurse, was resident is admitted with should come with the She stated she would contact the NP to conhad a pressure injury orders from the disch NP to get orders in plaseen by a facility provokay to wait a few da responsible for this."  On 9/1/23 at 8:58 a.m member) #1, the adminterim director of nur regional nurse consultant concerns.  A review of the facility Prevention and Mana "Treatments will be ophysician/practitioner"	co.m., LPN #5, the wound ed. She stated if a resident is sure injury, "they should in the hospital." She stated spital should be ately at the facility until the by the resident's wound stated if the resident does from the hospital, the NP d should give the admitting e pressure injury treatment. It is pressure injury treatment. It is not yet a pressure injury, orders in the resident from the hospital. It is find those orders and inmunicate that the resident in She stated if there are no larging hospital, she calls the lace until the resident can be wider. She stated: "It is not ye. The admitting nurse is in., ASM (administrative staff ininistrator, ASM #2, the resing, and ASM #3, the latent, were informed of these in yellow, "Pressure Injury agement," revealed, in part: redered by the included in individual in individual.	F	686			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	COMPLETED	
		495267	B. WING		C 09/01/2023	
	ROVIDER OR SUPPLIER  DE REHAB & NURSING	G CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186	1 03/01/2020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDERICIENCY)	D BE COMPLETION	
F 686	resident."  No further information  NOTES (1) "Full-thickness is exposed or directly tendon, ligament, can slough and/or escherolled edges), under often occur. Depth is lough or escharolled edges, under often occur. Depth is slough or escharolles this is an Unstainformation was obtainformation was obtainformation was obtainformation was obtainformation.  3. For Resident #98 to transcribe a physical properties of the proper	ge 92 Int will be specific for each on was provided prior to exit.  kin and tissue loss with palpable fascia, muscle, artilage or bone in the ulcer. ar may be visible. Epibole formining and/or tunneling varies by anatomical location. obscures the extent of tissue ligeable Pressure Injury." This ained from the website om/npiap.com/resource/resm p_pressure_injury_stages.pdf  (R98), the facility staff failed ician's order for a change in reatment in a timely manner.	F 686	, , , , , , , , , , , , , , , , , , ,		
	significant change a (assessment reference resident was assess pressure injury but in pressure injuries.  The physician order - "Cleanse right and wound cleanser and foam dressing QD (every impairment. Order ID 08/16/2023. End Da - "Cleanse buttock of the pressure of th	MDS (minimum data set), a ssessment with an ARD nee date) of 7/6/2023, the sed as being at risk for not having any current as for R98 documented in part, left buttocks open areas with apply Calcium Alginate with day). Every day shift for skin pate: 08/15/2023. Start Date: ote: 08/30/2023."				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ´	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495267	B. WING _			1	C / <b>01/2023</b>
	ROVIDER OR SUPPLIER  DE REHAB & NURSING	CENTER		614 HA	T ADDRESS, CITY, STATE, ZIP CODE ASTINGS LANE RENTON, VA 20186	, 30.	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 686	every day. Every day shift for skin impairms Start Date: 08/30/202  The eTAR (electronic record) for R98 dated documented the Calc the right and left butto 8/16/2023-8/29/2023 8/30/2023. The eTAR with foam dressing truthe buttocks beginning. The wound physician 8/15/2023 documente Right Buttock is a De (2) Persistent non-bla or purple discoloration measurements are 20/200 width with no measurements are 20/200 width with no measurements are 20/200 measurements are 30/200 no me	treatment administration I 8/1/2023-8/31/2023 sium Alginate treatment to bocks completed each day and discontinued on R documented the honey eatment to the open area on g on 8/30/2023.  assessment dated ed in part, " Wound #2 ep Tissue Pressure Injury anchable deep red, maroon nInitial wound encounter cm (centimeter) length x easurable depth, with an cm Wound #3 Left Buttock essure Injury (2) Persistent red, maroon or purple wound encounter cm length x 2cm width with , with an area of 6 sq assessment further d Orders: Wound #2 Right essing: Apply: - Calcium very day) Wound Orders: ek: Wound dressing: Apply: am/QD"	F	686			
	8/21/2023 documente Sacral is an unstagea observed Subseque measurements are 30	ed in part, "Wound #2 able pressure injury					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	TIPLE CONSTRUCTION  NG	, ,	COMPLETED	
		495267	B. WING			C
	ROVIDER OR SUPPLIER  DE REHAB & NURSING			STREET ADDRESS, CITY, STATE, ZIP C 614 HASTINGS LANE WARRENTON, VA 20186	ODE	09/01/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 686	Note: this wound is fr wounds that evolved Wounds have joined Wound Orders: Wour Dressing- Apply: - ho The wound physician 8/29/2023 documente	om L and R buttock DTI into one sacral wound. now thus one wound nd #2 Sacral: Wound ney foam daily"	F	586		
	Subsequent wound e 3.5cm length x 7cm v depth, with an area o	ncounter measurements are vidth with no measurable f 24.5 sq cm Wound Sacral Wound Dressing-				
	conducted with LPN is stated that the wound and rounded with res list. LPN #4 stated the documented the mean that they wanted to me that they wanted to me that they carried with they used that list to same day or the next wound physician dictuploaded them into the records pulled them is stated that only mediate wound physicians she was not sure if an see if there was any notes. She reviewed	surements and any changes nake to treatments on the list them during rounds and make changes to orders the day. She stated that the ated their wound notes and neir system where medical nto the medical record. She cal records had access to a system to get the notes and nyone reviewed the notes to changes to the orders in the the wound physician's note				
	not mention changing and they had not revi stated that she had re wound physician note	stated that the physician did g the treatment on that day ewed the written note. She eviewed the 8/29/2023 e and noticed that the changed so she had clarified				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495267	B. WING		C	
	ROVIDER OR SUPPLIER  DE REHAB & NURSIN		STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186		09/01/2023	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 686	on 8/30/2023. She there was no check physician's notes we medical records just. The facility policy "Management" docureferral is made to a wound consultant winformation to the number of the pressure ulcer/ir recommendation for care of the pressure. On 8/31/2023 at 4:3 staff member) #1, to interim director of number of the findings.  No further information in the findings in the swin. Puthe severity of sympostage. Stage IV is the same of the when pressed. This is forming. The skir soft. Stage II: The sore. The area arour irritated. Stage III: open, sunken hole.	Pressure Injury Prevention and a wound consultant: d. The will provide timely and accurate dursing facility on the status of njury and will provide to reatment and consultant and accurate dursing facility on the status of njury and will provide or change in treatment and	F 68			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION ILDING		(X3) DATE SURVEY COMPLETED	
		495267	B. WING _			C 01/2023	
	ROVIDER OR SUPPLIER  DE REHAB & NURSING	G CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 614 HASTINGS LANE WARRENTON, VA 20186		<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT) CROSS-REFERENCED TO TO DEFICIENCE	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 689 SS=D	pressure ulcer has a damage to the musto tendons and joint obtained from the whttps://medlineplus.00740.htm.  (2) DTI- deep tissue Pressure sores that below the skin. This The area may be damay be a blood-fille type of skin injury cor IV pressure sore. obtained from the whttps://medlineplus.00740.htm  Free of Accident Ha CFR(s): 483.25(d)(1)  §483.25(d) Accident The facility must en §483.25(d)(1) The ras free of accident I sylvanian sylvanian saccidents.  This REQUIREMEN by:  Based on observat record review, and the implement intervent sylvanian sylv	crater. Stage IV: The become so deep that there is cle and bone, and sometimes is. This information was rebsite: gov/ency/patientinstructions/0  e injury develop in the tissue deep is called a deep tissue injury. There is called a deep tissue injury. There is an quickly become a stage III. This information was rebsite: gov/ency/patientinstructions/0  izards/Supervision/Devices 1)(2)  ts. sure that - esident environment remains hazards as is possible; and resident receives adequate sistance devices to prevent  it is not met as evidenced ion, staff interview, clinical facility document review, it it the facility staff failed to cions for residents in the	F 6		der was written ell helmet when otential to be deficient performed of nelmets to ace. educate licensed		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	LE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		495267	B. WING		ng	C / <b>01/2023</b>	
	ROVIDER OR SUPPLIER  DE REHAB & NURSING	CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 614 HASTINGS LANE WARRENTON, VA 20186		10 112023	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 689	apply a physician-ord On the most recent M quarterly assessment reference date) of 7/3 being moderately implecisions, having soo BIMS (brief interview coded as having had during the look back) On the following date observed lying in bed at 12:25 p.m. and 3:4 and 1:07 p.m.  A review of R7's orde order, dated 6/14/23: times. Check placem A review of R7's care updated 6/14/23 reve an actual fallFoam request. Document re non-compliant with w times."  On 8/31/23 at 10:26 a assistant) #8 was inte is supposed to have a Even in bed." She sta helmet on R7 becaus asked for it.	the facility staff failed to lered helmet to the resident.  MDS (minimum data set), a twith an ARD (assessment 30/23, R7 was coded as paired for making daily bred nine out of 15 on the for mental status). She was two falls without injuries period.	F 68	4. DON/Designee will per audit of residents with orensure helmet is in place 3x week x 4 weeks. DOI will perform an audit to residents with pressure ensure there is a treatment corresponds to the rece communication 3x week 5. Date of Compliance 1	rders to e as ordered N/designee ensure injuries to ent order in at order nt provider ax 4 weeks.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495267	B. WING _			09/0	01/2023
	ROVIDER OR SUPPLIER  DE REHAB & NURSING	CENTER		614	REET ADDRESS, CITY, STATE, ZIP CODE 4 HASTINGS LANE ARRENTON, VA 20186		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 689	her family thinks it will resident wears it and She stated: "The helm what the family wants On 9/1/23 at 8:58 a.m member) #1, the adminterim director of nur regional nurse consul concerns.  No further information	elmet at all times "because I help." She stated the still falls and hits her head. net is not working, and it is ."  1., ASM (administrative staff inistrator, ASM #2, the sing, and ASM #3, the tant, were informed of these	F6				
F 692 SS=D	(Includes naso-gastric both percutaneous er percutaneous endosce enteral fluids). Based comprehensive assessensure that a residen §483.25(g)(1) Maintai of nutritional status, sidesirable body weigh balance, unless the redemonstrates that this preferences indicate of §483.25(g)(2) Is offer maintain proper hydra §483.25(g)(3) Is offer there is a nutritional provider orders a their	nutrition and hydration. c and gastrostomy tubes, idoscopic gastrostomy and opic jejunostomy, and I on a resident's isment, the facility must t- ins acceptable parameters uch as usual body weight or it range and electrolyte esident's clinical condition is is not possible or resident otherwise; ed sufficient fluid intake to ation and health; ed a therapeutic diet when roblem and the health care	F6	92	<ol> <li>Resident #10 fluid restrictions been discontinued.</li> <li>All residents of the facility hav potential to be affected by the all deficient practice. An audit of curresidents with fluid restrictions haven conducted to ensure the prhas been notified of noncompliar since 9/1/2023.</li> <li>DON/Designee will educate lighter regarding reporting resident noncompliance with fluid restrictions the provider.</li> </ol>	e the leged rrent as rovider nce censed ent	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION  G	(X3) DATE : COMPI	
		495267	B. WING _		09/1	01/2023
	ROVIDER OR SUPPLIER  DE REHAB & NURSING	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186		5 17 20 20
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 692	and facility document that the facility staff fanon-compliance with physician for one of a sample, Resident #10 (Rample, Review of Resident Rample, Review of the eTAR administration record for R10 documented each shift. The eTAR of 2700cc on 6/4/202 2360cc on 6/28/2023 evidence notification non-compliance with restrictions.  Review of the eTAR documented into shift. The eTAR failed to expect the shift into shift.	riew, clinical record review to review it was determined ailed to report fluid restrictions to the 45 residents in the survey 0.  10), the facility staff failed to be with fluid restrictions to the control of the control of the with fluid restrictions to the control of the contro	F 6	92 4. DON/Designee will of residents with fluid ensure any identified reported to the provid x4weeks. These resulted reviewed and discuss Interdisciplinary Team Quality Assurance procorrective action plans indicated based on redeterminations related monitoring.  5. Date of Compliance	restrictions to noncompliance is er 3x week lts will be led by the n through the locess and s put into place as leview, along with d to ongoing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION	COMPLETED		
		495267	B. WING _			C 09/01/2023	
	ROVIDER OR SUPPLIER  DE REHAB & NURSING	CENTER		STREET ADDRESS, CITY, STATE, ZIP 614 HASTINGS LANE WARRENTON, VA 20186		3010 112020	
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F 692	day fluid restrictions.  Review of the eTAR of R10 documented inta shift. The eTAR docu 2520cc on 8/2/2023 at The eTAR failed to exphysician of non-comday fluid restrictions.  The clinical record for notification of the phy non-compliance of the dates listed above.  The comprehensive of documented in part, "restriction. Noncompl socks on with eucerin 04/27/2023. Revision "Interventions" it documented to MI Initiated: 04/27/2023.  On 8/31/2023 at 10:2 conducted with LPN (She stated that when restrictions they revie the nurse practitioner and educated the res should be documental regarding notification the non-compliance of the facility policy "Residual control of the properties of the pro	lated 8/1/2023-8/31/2023 for ke amounts totaled for each mented a total amount of and 3600cc on 8/29/2023. idence notification of the pliance with the 2000cc per R10 failed to evidence sician/provider for the effluid restrictions on the are plan for R10 Noncompliance with fluid fance with keeping non skid for estical cream. Date Initiated: on: 04/27/2023." Under mented in part, "Report of (medical doctor). Date of the daily and notified if they went over the limit fident. She stated that there tion in the progress notes of the nurse practitioner of the fident of the dated 10/01/2021 dance on monitoring	F	692			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495267	B. WING _			C 09/01/2023	
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	03/	0 1/2023
BROOKSI	DE REHAB & NURSING	CENTER	614 HASTINGS LANE WARRENTON, VA 20186				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 692 F 695 SS=D	On 8/31/2023 at 4:31 staff member) #1, the interim director of nur regional nurse consulthe concern.  No further information Respiratory/Tracheos CFR(s): 483.25(i)  § 483.25(i) Respirator tracheostomy care and tracheostomy care and tracheostomy care and tracheol succare, consistent with practice, the compreherand 483.65 of this sult This REQUIREMENT by:  Based on observation document review, and facility staff failed to nequipment in a sanitar residents, Residents;  The findings include:  1. For Resident #6 (R	p.m., ASM (administrative administrator, ASM #2, the sing and ASM #3, the tant were made aware of a was provided prior to exit. Itomy Care and Suctioning and tracheal suctioning. It was a resident who e, including tracheostomy etioning, is provided such professional standards of the ensive person-centered ats' goals and preferences, popart. It is not met as evidenced who, staff interview, facility declinical record review, the maintain respiratory ry manner for two of 45		692	1. Resident #6 and Resident #253 nebulizer masks were placed in st bags during the time of survey.  2. All residents of the facility have potential to be affected by the alle deficient practice. An audit of curresident with ordered nebulizers heen performed to ensure proper storage of the nebulizer mask.  3. DON/designee will educate lice nurses regarding the appropriate storage of nebulizer masks.  4. DON/designee will perform an acurrent residents with ordered nebulizers to ensure proper storage the nebulizer mask 3xweek x 4 we These results will be reviewed and discussed by the Interdisciplinary through the Quality Assurance pro and corrective action plans put int place as indicated based on review	the ged ent as nsed audit of ge of eeks. d Team ocess o	
	mask was observed to across the nebulizer ra.m. and 3:36 p.m.; a	s and times, R6's nebulizer to be uncovered and lying machine: 8/29/23 at 11:57 nd 8/30/23 at 8:19 a.m. rs revealed the following			<ul><li>along with determinations related ongoing monitoring.</li><li>5. Date of Compliance: 10/16/202</li></ul>		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495267	B. WING		C <b>09/01/2023</b>	
	ROVIDER OR SUPPLIER  DE REHAB & NURSING	G CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186		03/01/2023	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION	
F 695	Solution (1) 0.5-2.5 milliliter) 3 ml inhale SOB (shortness of be failure/COPD (chror disease."  A review of R6's Augadministration record the medication as of the medication as	"Ipratropium-Albuterol MG/3ML (milligrams per orally three times a day for oreath)/respiratory nic obstructive pulmonary  gust 2023 MAR (medication d) revealed she had received rdered.  a.m., LPN (licensed practical rviewed. She stated nebulizer ecially the nebulizer mask, fiter each use and stored in a ted this is necessary to om collecting bacteria and an infection for the resident.  m., ASM (administrative staff ministrator, ASM #2, the ursing, and ASM #3, the ultant, were informed of these  ty policy, "Oral Inhalation ealed, in part: "When terinse and disinfect the tallow the components to air paper towelWhen etely dry, store in a plastic bag ident's name and the date."  on was provided prior to exit.	F 69	5		
	(1) "Ipratropium oral wheezing, shortness	inhalation is used to prevent s of breath, coughing, and cople with chronic obstructive				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF PR	OVIDER OR SUPPLIER	400201			STREET ADDRESS, CITY, STATE, ZIP CODE	1 09/	01/2023
BROOKSID	DE REHAB & NURSING	CENTER			314 HASTINGS LANE VARRENTON, VA 20186		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	that affect the lungs a bronchitis (swelling of to the lungs) and empsacs in the lungs)Ip solution (liquid) to inh nebulizer (machine th mist that can be inhal taken from the websit https://medlineplus.gotml#:~:text=Ipratropiu 0is%20used,to%20th physema%20(.  2. For Resident #253 failed to store the nebmanner.  On the following date nebulizer mask was cand lying across the rat 12:01 p.m. and 3:2 a.m.  A review of R253's or order dated 8/15/23: A Nebulization Solution (milligrams/milliliter) Conebulizer four times a A review of R253's Auadministration record received the medicati On 8/31/23 at 10:43 a nurse) #11 was intervequipment, and especials in the large of the solution (milligrams) #11 was intervequipment, and especials in the large of the solution (milligrams) #11 was intervequipment, and especials in the large of th	COPD; a group of diseases and airways) such as chronic of the air passages that lead onlysema (damage to the air ratropium comes as a ale by mouth using a fact turns medication into a ed)." This information is the cov/druginfo/meds/a695021.h m%20oral%20inhalation%2 e%20lungs)%20and%20em  (R253), the facility staff coulizer mask in a sanitary  s and times, R253's observed to be uncovered the bulizer machine: 8/29/23 9 p.m.; and 8/30/23 at 8:40  ders revealed the following Albuterol Sulfate (1) (2.5 MG/3ML) 0.083% 3 ml inhale orally via a day."  Ligust 2023 MAR (medication or revealed the resident had	F	695			

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED
		495267	B. WING _		C 09/01/2023
	ROVIDER OR SUPPLIER  DE REHAB & NURSING	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186	1 33/0 112323
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ( (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE COMPLETION
F 695	prevent the mask from possibly resulting in a On 9/1/23 at 8:58 a.m member) #1, the adminterim director of nur regional nurse consuconcerns.  No further information Reference: (1) Albuterol is used to breathing, wheezing, coughing, and chest diseases such as ast pulmonary disease (0 that affect the lungs a comes as a solution (using a special jet nemedication into a missinformation is taken finttps://medlineplus.gottml.	ed this is necessary to m collecting bacteria and an infection for the resident.  In., ASM (administrative staff hinistrator, ASM #2, the sing, and ASM #3, the stant, were informed of these in was provided prior to exit.  In o prevent and treat difficulty shortness of breath, sightness caused by lung hima and chronic obstructive COPD; a group of diseases and airways)Albuterol liquid) to inhale by mouth bulizer (machine that turns to that can be inhaled)." This	F6		
F 697 SS=E	provided to residents consistent with profes the comprehensive p and the residents' go This REQUIREMENT by: Based on resident in	ure that pain management is who require such services, ssional standards of practice, erson-centered care plan,	F6	<ol> <li>1. Resident #28 non-pharma intervention monitoring has to MAR (Medication Adminis Record).</li> <li>2. All residents of the facility potential to be affected by the deficient practice. An audit or residents receiving pain medicated will be performed to non-pharmacological interventioning is available on Market Parket</li> </ol>	have the e alleged f current lication as ensure ntion

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP O		01/2023	
BROOKSI	DE REHAB & NURSING	CENTER		614 HASTINGS LANE WARRENTON, VA 20186			
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F 697	failed to provide a coprogram for one of 48 sample, Resident #28 The findings include:  For Resident #28 (R2 implement a complete program including no interventions prior to pain medications.  Resident #28's most set), a quarterly asse (assessment reference resident scored 14 or interview for mental sindicating the resident making daily decision documented R28 recemedication, not receivinterventions for pain. On 8/29/2023 at 12:3 conducted with R28. medications for pain. the nurses for pain mit and sometimes the before they gave their sometimes it made it.  The physician orders "Hydrocodone-Aceta (milligram) Give 1 table as needed for Pain. On the control of the pain of the physician orders as needed for Pain. On the control of the physician orders are needed for Pain. On the program of the physician orders are needed for Pain. On the program of the physician orders are needed for Pain. On the program of the physician orders are needed for Pain. On the program of the physician orders are needed for Pain. On the program of the physician orders are needed for Pain. On the program of the physician orders are needed for Pain. On the program of the physician orders are needed for Pain. On the program of the physician orders are needed for Pain. On the program of the physician orders are needed for Pain. On the program of the physician orders are needed for Pain.	nined that the facility staff implete pain management of residents in the survey in the survey in the pain management in the pain management in the pain management in the pharmacological administration of as needed in the pain management in the pharmacological administration of as needed in the pain in the pharmacological in the pharmacologic	F6	<ul> <li>3. DON/ designee will nursing staff regarding nonpharmacological in to administration of PR medications.</li> <li>4. DON/designee will pof residents receiving pas needed to ensure non-pharmacological ir monitoring is available results will be reviewed by the Interdisciplinary the Quality Assurance corrective action plans indicated based on revideterminations related monitoring.</li> <li>5. Date of Compliance</li> </ul>	the providing terventions prior IN pain  perform an audit pain medication on MAR. These d and discussed Team through process and put into place as iew, along with to ongoing		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
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	ROVIDER OR SUPPLIER  DE REHAB & NURSING	L		6	TREET ADDRESS, CITY, STATE, ZIP CODE  14 HASTINGS LANE  VARRENTON, VA 20186	1 09/0	01/2023
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F 697	4:26 a.m. for a pain let 10:41 a.m. for a pain let 10:41 a.m. for a pain let 4:55 a.m. for a pain let 4:55 a.m. for a pain let 3:55 a.m. for a pain let 11:20 a.m. for a pain let 5:01 a.m. for a pain let 6:07 a.m. for a pain let 6:07 a.m. for a pain let 6:07 a.m. for a pain let 8/1/2023-8/31/2023 fa non-pharmacological administration of the a Hydrocodone-Acetam 2:07 a.m. for a pain level of a.m	ailed to evidence interventions prior to as needed ninophen on 7/2/2023 at level of 9, on 7/6/2023 at level of 9, on 7/14/2023 at level of 9, on 7/14/2023 at level of 9, on 7/19/2023 at level of 3, on 7/25/2023 at level of 9, on 7/25/2023 at level of 9, on 7/30/2023 at level of 9, on 7/30/2023 at level of 9 and 7/31/2023 at level of 9 and 7/31/2023 at level of 9.  For R28 dated ailed to evidence interventions prior to as needed ninophen on 8/1/2023 at level of 2, on 8/2/2023 at level of 3, on 8/6/2023 at 1:16 of 9, on 8/7/2023 at 2:05 of 2, on 8/11/2023 at 2:05 of 5, on 8/11/2023 at 3:43 of 9, and on 8/23/2023 at level of 5.  The series of the series of the series of 5 on 8/21/2023 at 3:43 of 9, and on 8/23/2023 at level of 5.  The series of the series of the series of 5 on 8/21/2023 at 3:43 of 9, and on 8/23/2023 at level of 5.  The series of the series of the series of 5 on 8/21/2023 at 3:43 of 9, and on 8/23/2023 at level of 5.	F	697			

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495267	B. WING _			C 09/01/2023	
	ROVIDER OR SUPPLIER  DE REHAB & NURSING	CENTER		STREET ADDRESS, CITY, STAT 614 HASTINGS LANE WARRENTON, VA 20186	E, ZIP CODE	33/3 1/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	X (EACH CORRECTI CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIAT FICIENCY)	(X5) COMPLETION DATE	
F 697	01/10/2023." Under "I in part, "Provide Non-interventions such as repositioning, visualiz 11/11/2022"  On 8/31/2023 at 2:15 to ASM (administrativ administrator for evide non-pharmacological administration of the a Hydrocodone-Acetam times documented ab 2023.  On 8/31/2023 at 3:14 director of nursing state evidence of non-phar offered prior to admin Hydrocodone-Acetam times documented ab 2023 to provide.  On 8/31/2023 at 10:5 conducted with LPN 4 non-pharmacologic in prior to as needed pathat residents pain levithe non-pharmacolog offered prior to the metimes R28 would refurmedication. She state documented. She state documented. She state of the part of th	nterventions" it documented pharmacological redirection, distraction, ation, etc. Date Initiated:  p.m., a request was made e staff member) #1, the ence of interventions offered prior to	F	697			
	On 9/1/2023 at 8:53 a administrator, ASM #3 nursing, and ASM #3	2, the interim director of					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G	(X3) DATE COMP	
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	ROVIDER OR SUPPLIER  DE REHAB & NURSING	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186		0 172023
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 698 SS=E	No further informatio On 9/1/2023 at 2:59 policy "Fall Protocols pain management policy devidence guidance of non-pharmacological Dialysis CFR(s): 483.25(I) §483.25(I) Dialysis. The facility must ensure dialysis receiving dialysis receivith professional state comprehensive perset the residents' goals at This REQUIREMENT by: Based on staff interview, and clinical refailed to monitor weig receiving dialysis, for survey sample, Resident #25 (R2 dialysis, the facility steper the provider's orders: "7/28/23 Notify prima"	e aware of the findings.  In was provided prior to exit.  In p.m., ASM #1 provided the  If dated 10/1/2021 as their blicy. The policy failed to in pain management and use cal interventions.  In the policy failed to in pain management and use cal interventions.  In the policy failed to in pain management and use cal interventions.  In the policy failed to in pain management and use cal interventions.  In the policy failed to in pain management and use cal interventions.  In the policy failed to in the policy failed to obtain weights  In the policy failed to obtain weights  In the policy failed to obtain weights	F 69	1. Resident #25 daily we	reight d to be Inesday, and  illity have the y the alleged dit of current and there are daily weights  ucate licensed ing weights per  form an audit allysis to ensure order 3xweek will be by the rough the ss and ut into place as w, along with ongoing	

	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		1, ,	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER  DE REHAB & NURSING	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186	•	3370 172020
(X4) ID PREFIX TAG	(EACH DEFICIENC	IATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 698	center]MWF (Mondon A review of R25's we recorded on the follor 8/2, 8/4, 8/10, 8/13, 3 clinical record reveal for R25 in August 20 A review of R25's carevealed, in part: "The stage renal disease) dialysisPre-Post dialysi	sis at [name of dialysis day, Wednesday, Friday."  sights revealed weights wing dates in August 2023: 8/18, 8/21, and 8/23. The ed no other weights recorded 23.  The plan dated 6/26/23 are resident has ESRD (end and receives alysis weights."  a.m., LPN (licensed practical viewed. After reviewing R25's are provider for weight gain, eights recorded in the medical lif the order is to notify the changes over one day, then and the resident every day." It is no way to follow the ses the resident had been  a.m., ASM (administrative are interim director of nursing, and the dialysis center. When the dialysis center when the dialysis center. When the way and the dialysis center when the dialysis center. When the way are a part of R25's tated: "No. We don't get set them." She stated she had	F 69	98		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER  DE REHAB & NURSING	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186	,
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
F 698 F 710 SS=D	information related to ordered by the provid No further information Resident's Care Supe CFR(s): 483.30(a)(1)	y policy, "Weight rvention," revealed no obtaining daily weights as er. In was provided prior to exit. ervised by a Physician (2)	F 69	10 1. Resident #87 and Resident #2 been discharged from the facility	·.
	recommendation that a facility. Each reside care of a physician. A assistant, nurse pract specialist must provide immediate care and respecialist must provide immediate care and respecialist must ensure \$483.30(a) (Physician The facility must ensure \$483.30(a)(1) The medical care of reside physician is unavailated that REQUIREMENT by:  Based on observation interview, facility document of the f	sonally approve in writing a an individual be admitted to ent must remain under the A physician, physician itioner, or clinical nurse the orders for the resident's needs.  Supervision.  The that-  The dical care of each resident spician;  The physician supervises the ents when their attending one.  This is not met as evidenced on, family interview, staffument review, and clinical control in the survey.		<ol> <li>All residents have the potential affected by this deficient practice audit of current residents with sk tears/pressure injuries to ensure provider completed an assessme impairment and a treatment order place.</li> <li>Medical Director/designee will the Nurse Practitioner regarding need for assessment and treatmorder for skin tears and pressure tears/pressure injuries to ensure has completed an assessment at treatment order is in place. Thes will be reviewed and discussed the Interdisciplinary Team through the Quality Assurance process and corrective action plans put into present indicated based on review, along determinations related to ongoin monitoring.</li> <li>Date of compliance: 10/16/202</li> </ol>	e. An in the ent of the er is in  educate the ent e injuries.  a audit of of skin the NP nd a e results by the ne lace as g with g

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION		X3) DATE SURVEY COMPLETED
		495267	B. WING _			C <b>09/01/2023</b>
	ROVIDER OR SUPPLIER  DE REHAB & NURSING	CENTER	1	STREET ADDRESS, CITY, STATE, 2 614 HASTINGS LANE WARRENTON, VA 20186	ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION EACTION SHOULD BE TO THE APPROPRIAT EIENCY)	(X5) COMPLETION DATE
F 710	practitioner) failed to a resident who had refailed to assess the retear.  On the most recent Madmission assessmereference date) of 8/1 being severely cognit daily decisions, havin the BIMS (brief interv was admitted to the faincluding diabetes, de (1).  On 8/29/23 at 12:08 psitting in a wheelchair daughter was seated right leg was elevated leg down to the ankle red/purple/black, and it. There was no dres daughter stated: [R25 the weekend and I sh stated the weekend mould put R254 on the nurse practitioner on stated she visits R254 never been any type R254's daughter state nurse to come in and	the facility NP (nurse respond to notification about received a skin tear, and resident following the skin and resident following the skin and with an ARD (assessment 1/23, R254 was coded as rively impaired for making g scored one out of 15 on riew for mental status). R254 recility with diagnoses rementia, and polyneuropathy and a blanket covered the R254's right great toe was stoe was shiny with fluid on ring on the toes. R254's right great toe was toe was shiny with fluid on ring on the toes. R254's right great toe was toe was shiny with fluid on ring on the toes. R254's right great toe was toe was shiny with fluid on ring on the toes. R254's right great toe was toe was shiny with fluid on ring on the toes. R254's right great toe was toe was shiny with fluid on ring on the toes. R254's right great toe was shiny with fluid on ring on the toes. R254's right great toe was shiny with fluid on ring on the toes. R254's right great toe was shiny with fluid on ring on the toes. R254's right great toe was shiny with fluid on ring on the toes. R254's right great toe was shiny with fluid on ring on the toes. R254's right great toe was shiny with fluid on ring on the toes. R254's right great toe was shiny with fluid on ring on the toes. R254's right great toe was toe was shiny with fluid on ring on the toes. R254's right great toe was toe was shiny with fluid on ring on the toes. R254's right great toe was toe was shiny with fluid on ring on the toes. R254's right great toe was shiny with fluid on ring on the toes. R254's right great toe was toe was shiny with fluid on ring on the toes. R254's right great toe was shiny with fluid on ring on the toes. R254's right great toe was shiny with fluid on ring on the resident recipies ring on ring	F7	710		
	A review of R254's cli following progress no	nical record revealed the tes:				

PRINTED: 09/18/2023 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '		E CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED	
		495267	B. WING			C 09/01/2023		
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	09/	01/2023	
DD COKO	DE DELLAD & MUDOINO	05N75D		(	614 HASTINGS LANE			
BROOKSI	DE REHAB & NURSING	CENTER		١	WARRENTON, VA 20186			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 710	"8/26/2023 14:18 (2:1 Skin tear found on Refoot. Tear measures < 0.5cm x < 0.5cm. Renot remember how skw/ (with) wound clear NP(nurse practitioner physician] informed. \text{This note was written #2.}  "8/26/2023 15:21 (3:2 skin assessment doct assessment triggered "8/29/2023 22:11 (10:eINTERACTSumma Situation: The Chang thisEvaluation are/v Confused, or Drowsy conditionOutcomes Positive findings repoevaluation for this chamber Mental Status Evalua (e.g. disorientation) DiscolorationPrimar Primary Care Provide following feedback: A. Recommendations emergency [room]."  "8/29/2023 22:41 (10:main primary Care Provide following feedback: A. Recommendations emergency [room]."	8 p.m." Nursing Note Text: esident's great toe on right co.5cm (centimeters) x sident stated that she does kin tear happened. Cleansed user and applied bacitracin. )and [name of primary Will continue to monitor." by RN (registered nurse)  21 p.m.) Nursing Note Text: umented. weekly wound l."  21 p.m.) ary for Providers e In Condition/s reported on vere: Tired, Weak, Change in skin color or of Physical Assessment: rited on the resident/patient ange in condition were: tion: Increased confusion Skin Status Evaluation: ry Care Provider Feedback: er responded with the set to send the resident to the set on her toe. upon toe was observed. physician was given to send the mergency room). RP	F	710				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION  G	, ,	MPLETED
		495267	B. WING			C 09/01/2023
	ROVIDER OR SUPPLIER  DE REHAB & NURSING	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186	,	373 172020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 710	Continued From page		F 71	10		
		ted for hypernatremia (high ic [sic] toe, dehydration, UTI n."				
	dated 8/26/23 reveals bruises, open wounds tears, reddened area	reekly Skin Observation ed, in part: "Are there any s, surgical incisions, skin s or other skin conditions r. Skin Tear Location: Right kin condition? Yes."				
	record] and TAR [trearecord]) revealed no of the skin tear, and rassessment or monitogreat toe between 8/2	[medication administration atment administration evidence of an order for care				
	be seen did not revea had been flagged by	ook with information lents on the unit needed to al any evidence that R254 the facility staff for the NP to the NP was in the building.				
	the local hospital who 8/29/23 revealed, in p old female who is see Department for conce right foot, unsure how Daughter first noticed ExaminationMSK ( and second right toes altered mental status infection, possibly se	gency Room records from ere R254 was admitted on part: "The patient is a 79 year en in the Emergency erns of black toes on her or long it has been going on. I it four days priorPhysical musculoskeletal): Black first sThe patient presents with or concerning for acute psis, although ongoing for ghter. Concerns for foot				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '	LE CONSTRUCTION  B	(X3) DATE SURVEY COMPLETED	
		495267	B. WING		C 09/01/2023	
	ROVIDER OR SUPPLIER  DE REHAB & NURSING	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186	1 03/0 1/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION	
F 710	ulceration vs. gangrePresentation most UTI."  On 8/31/23 at 10:43 nurse) #11 was interidentifies that a residuscess the injury and treatment orders. Shassessment form, are so it will show up on stated skin tears shot facility staff until they this is especially impediabetes and neuropediabetes and neuropediabetes and neuropediabetes. The skin tear by way medical record softwoods and the skin tear by way medical record softwoods. She stated: "I don't renotifications." She stated: "I don't renotifications." She stated: toes." She stated the notebook on the unit about R254. She stated: toes." She stated the notebook on the unit about R254. She stated: toes." She stated the notebook on the unit about R254. She stated: toes." She stated the notebook on the unit about R254. She stated: toes." She stated the notebook on the unit about R254. She stated: toes." She stated the notebook on the unit about R254. She stated: toes." She stated the notebook on the unit about R254. She stated: toes." She stated the notebook on the unit about R254. She stated: toes." She sta	a.m., LPN (licensed practical viewed. She stated if she dent has a skin tear, she do notifies the NP to obtain the completes a skin and enters the treatment order the TAR for follow up. She would be monitored by the vare resolved. She stated fortant for resident who have wathy.  a.m., ASM (administrative nurse practitioner, was ted RN #2 texted her about of the facility's electronic vare on Saturday, 8/26/23. The sespond to those routine the stated she did not give any estident on 8/28/23 or "I never looked at [R254's] the stated she was not aware that the regarding any concerns the stated: "As soon as I saw the stated: "As soon	F 71			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		405267	B. WING			С		
NAME OF D	ROVIDER OR SUPPLIER	495267	B. WING		TREET ADDRESS, CITY, STATE, ZIP CODE	09/	01/2023	
	DE REHAB & NURSING	CENTER		6	TREET ADDRESS, CITY, STATE, ZIP CODE 14 HASTINGS LANE VARRENTON, VA 20186			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 710	She stated R254's da Saturday, 8/26/23, that was bloody. She stated in removing the reside tear on the top of the around toward the side was still intact, but the toe. She stated she cowound cleanser and a cointment but no band on the resident and must the clinical record. She stated that the clinical record. She stated there is no list see on the NP's next stated there is no list see on the NP's next stated: "I figured with would trigger a visit."  On 9/1/23 at 8:58 a.m physician/provider su was requested. No fu provided prior to exit.  NOTES  (1) "Peripheral neuron peripheral nervous sy into mononeuropathics and polyneuropathics numbness and pares often accompanied by painful." This informat website	m., RN #2 was interviewed.  Inughter notified her on at the resident's right sock and the daughter assisted her ent's sock. There was a skin right great toe, extending the of the toe. The toenail there was dried blood on the the leaned the dried blood with the applied an antibiotic the age. She put a clean sock that and the required notes in the stated she notified ASM the stated it is her the electronic medical record that wound assessment for the und nurse would look at the the aproper treatment. She to residents for the NP to to visit to the facility. She the me notifying the NP, that  The policy regarding the prevision of resident care ther information was  The pathies are diseases of the testem that can be divided these, multifocal neuropathies, the symptoms usually include thesia. These symptoms are the yweakness and can be	F	710				

	OF DEFICIENCIES  CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION  IG	_	(X3) DATE SURVEY COMPLETED
		495267	B. WING _			C <b>09/01/2023</b>
	ROVIDER OR SUPPLIER  DE REHAB & NURSING	CENTER		STREET ADDRESS, CITY, S 614 HASTINGS LANE WARRENTON, VA 201		33/01/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRI	R'S PLAN OF CORRECTION ECTIVE ACTION SHOULD B ENCED TO THE APPROPRIA DEFICIENCY)	DATE
F 710	Continued From page	e 116	F 7	10		
		R87), the nurse practitioner and provide treatment injury.				
	following note dated of "Resident presented [name of local hospital bruising all over the bruising orders, skin (medication administration administration administration administration orders for ord	ogress note revealed the 6/10/23 at 11:06 p.m.: today at [6:00 p.m.] from al]Skin has scattered body, stage 4 sacral pressure y discharging facility."  Tresident's clinical record, assessments, MARs ration records) and TARs ation records) failed to reveal or the treatment of the 5/14/23.  practitioner's note dated revealed, in part: "[Age and ain secondary to sacral ment and physical) decubitus				
	On 8/31/23 at 10:43 a nurse) #11 was intervite admitting nurse for with a pressure injury practitioner) or physic treatment order come hospital, she will let the recommended treatment for the wou soon as possible.	es from the discharging the NP know that, and initiate eatment. She stated the and should be initiated as				
	staff member) #5, a r	a.m., ASM (administrative nurse practitioner, was ed if a resident is admitted				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495267	B. WING		C 09/01/2023
	ROVIDER OR SUPPLIER  DE REHAB & NURSING	G CENTER	6	TREET ADDRESS, CITY, STATE, ZIP CODE 14 HASTINGS LANE VARRENTON, VA 20186	03/01/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 710	come with orders to the hospital. She stated there should be wou stated: "That's some do." She stated she before the physician admission history ar participate in that pressure injury when 8/12/23.  On 8/31/23 at 12:56 nurse, was interview admitted with a pressure with orders from the himplemented immediately and the order from the himplemented immediately at the order from the himplemented immediately and the order of the order or doctor. She not come with orders should be notified an urse an order for the She stated: "It's not before pressure injurion orders from the discount of the NP to contact the NP to contact the NP to contact the NP to get orders in processing the orders of the orders of the NP to get orders in processing the orders of the orders of the NP to get orders in processing the orders of the orders of the orders of the orders of the NP to get orders in processing the orders of the order or the order of the order or the order of the o	treat the pressure injury from ated if there is a time lapse esident is admitted to the NP first sees the resident, and care happening. She ething I expect the facility to often sees the resident a comes in to do the nd physical, and she does not occess. She stated she did not ement orders for R87's in she saw the resident on p.m., LPN #5, the wound wed. She stated if a resident is esure injury, "they should om the hospital." She stated ospital should be liately at the facility until the in by the resident's wound estated if the resident does is from the hospital, the NP and should give the admitting the pressure injury treatment. okay to wait a few days	F 710		

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		495267	B. WING			C 09/01/2023	
NAME OF PE	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1 09/	01/2023
					614 HASTINGS LANE		
BROOKSII	DE REHAB & NURSING	CENTER			WARRENTON, VA 20186		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	· · · · · · · · · · · · · · · · · · ·		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE		
F 710	Continued From page	e 118	F	710			
		ys. The admitting nurse is		, ,,			
	responsible for this."	yo. The damitting hards is					
	On 9/1/23 at 8:58 a.m	n., ASM (administrative staff					
	member) #1, the adm	inistrator, ASM #2, the					
		sing, and ASM #3, the					
	regional nurse consul concerns.	tant, were informed of these					
	concerns.						
	A review of the facility	policy, "Pressure Injury					
	Prevention and Management," revealed, in part:						
	"Treatments will be or						
		unless established and ding orders by an individual					
	physician/practitioner						
		will be specific for each					
	resident."						
	No further information	n was provided prior to exit.					
	NOTES						
		n and tissue loss with					
		alpable fascia, muscle,					
		tilage or bone in the ulcer. may be visible. Epibole					
		mining and/or tunneling					
	` '	ries by anatomical location.					
		scures the extent of tissue					
		eable Pressure Injury." This					
	information was obtai	ned from the website m/npiap.com/resource/resm					
		_pressure_injury_stages.pdf					
F 732			F	732	2		
SS=C	CFR(s): 483.35(g)(1)-	-(4)					
	§483.35(g) Nurse Sta	offing Information.					
		equirements. The facility					
		•					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	
		495267	B. WING				
		495267	B. WING _			09/0	01/2023
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
BROOKSI	DE REHAB & NURSING	CENTER			4 HASTINGS LANE		
				W	ARRENTON, VA 20186		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 732	basis: (i) Facility name. (ii) The current date. (iii) The total number by the following cate unlicensed nursing s resident care per shift (A) Registered nurses (B) Licensed practical vocational nurses (as (C) Certified nurse ai (iv) Resident census. §483.35(g)(2) Posting (i) The facility must proposed field in paragrapidally basis at the begin (ii) Data must be posted (B) In a prominent plaresidents and visitors §483.35(g)(3) Public staffing data. The farm written request, make available to the public exceed the community \$483.35(g)(4) Facility requirements. The farm posted daily nurse staffing data is months, or as require greater. This REQUIREMENT by: Based on observation document review, the	and the actual hours worked gories of licensed and taff directly responsible for ft:  s. al nurses or licensed s defined under State law). des. g requirements. ost the nurse staffing data oh (g)(1) of this section on a ginning of each shift. ted as follows: ole format. acce readily accessible to s. access to posted nurse cility must, upon oral or enurse staffing data of for review at a cost not to day standard.	F7	732	<ol> <li>The deficient practice could retroactively corrected.</li> <li>NHA/designee will perform a of 30-days of nursing staffing p to ensure completion. Findings presented to the Quality Assurance/Process Improveme review and analysis.</li> <li>NHA/designee will reeducate staffing coordinator on the requto post staffing.</li> <li>NHA/designee will perform a of the nursing staffing informati ensure it is posted three (3) tim week for one (1) month and the (1) a week for three (3) months results will be reviewed and disby the Interdisciplinary Team the Quality Assurance process corrective action plans put into as indicated based on review, a with determinations related to comonitoring.</li> <li>Date of Compliance 10/16/26</li> </ol>	in audit osting s will be ent for e the uirement on to les a en once is These is cussed and place along ongoing	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495267	B. WING		C 09/01/2023
	ROVIDER OR SUPPLIER  DE REHAB & NURSING	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186	,
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 732 F 757 SS=D	of the posted nursing posting was located at desk. The posted stat 8/28/23. No staffing in be seen.  On 8/31/23 at 10:21 at staff member) #1, the interviewed. She state staffing coordinator, a coordinator had just so she stated: "I am respond staffing information. It is she stated corporate facility on the morning gotten distracted from information.  No further information. Drug Regimen is Free CFR(s): 483.45(d) Unnecession.	a.m., observation was made staffing information. The at the front receptionist's fing information was dated information for 8/29/23 could a.m., ASM (administrative administrator, was ed she is filling in for the and that a new staffing started training on 8/28/23. Consible for posting the During the week, I put it up to morning. I try to get it up should be up before them." staff had arrived at the g of 8/29/23 and she had in posting the staffing and was provided prior to exit. The form Unnecessary Drugs et any Drugs-General.	F 73:	<ol> <li>Resident #253 Coumadin and have been discontinued.</li> <li>All current residents have the</li> </ol>	
		y); or		potential to be affected by the all deficient practice. An audit was performed, and no current residence receiving Coumadin or requiling at this time.	ents

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT		CONSTRUCTION		LETED
		495267	B. WING _			l	C 01/2023
	ROVIDER OR SUPPLIER  DE REHAB & NURSING	CENTER		61	REET ADDRESS, CITY, STATE, ZIP CODE 4 HASTINGS LANE ARRENTON, VA 20186		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 757	§483.45(d)(4) Without use; or  §483.45(d)(5) In the processed consequences which reduced or discontinution of the processed of the paragraphs section.  This REQUIREMENT by:  Based on staff intervive review, and clinical refailed to complete lab administration of an urone of 45 residents in Resident #253.  The findings include:  For Resident #253 (Robtain INR (internation levels for Resident #25) and in the physician.  A review of R253's propart (all notes written member) #5, the nurse otherwise noted:  "8/14/23 Hx (history)	t adequate monitoring; or t adequate indications for its  presence of adverse indicate the dose should be red; or  mbinations of the reasons (d)(1) through (5) of this  is not met as evidenced rews, facility document foord review, the facility staff foratory testing to prevent fora	F 7	57	3. DON/Designee to educate lice nursing staff regarding performing tests to include INRS per order.  4. DON/Designee to audit current residents receiving coumadin to ensure PT/INR is completed per order weekly x4weeks. These rewill be reviewed and discussed by Interdisciplinary Team through the Quality Assurance process and corrective action plans put into plass indicated based on review, allowith determinations related to ongoing monitoring.  5. Date of Compliance: 10/16/202	g lab t sults y the e ace ong	

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495267	B. WING			I	01/2023
	ROVIDER OR SUPPLIER  DE REHAB & NURSING	L		6	TREET ADDRESS, CITY, STATE, ZIP CODE  14 HASTINGS LANE  VARRENTON, VA 20186	1 03/	0 172023
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 757	"8/21/23 Hx DVTSto Saturday? not reported progress notes."  "8/25/23 INR reported written by a nurse wh interview at the time of A review of R253's pr part:  "8/14/23 PT/INR One when INR > 3."  "8/19/23 Have patient machine/supplies. Or  "8/28/23 PT/INR One Further review of R25 no evidence that PT/I 8/17/23, 8/19/23, or 8  A review of R253's Madministration record she received Warfarir 8/15/23 and 8/16/23, 8/23/23 through 8/29/  On 8/31/23 at 3:06 p. nurse) #9 was intervie usually gives verbal of she is responsible for	ient) check INR with her  pp warfarin. INR done on ed to NP or recorded in  It to be 1.3." This note was o was unavailable for of the survey.  ovider's orders revealed, in  time for bridge to Xarelto  It check INR with her he time only."  time only."  itime only."  itime only."  ARS (medication of or August 2023 revealed in 2.5 mg (milligrams) on and Warfarin 3 mgs on	F	757			

I		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495267	B. WING		C 09/01/2023
	ROVIDER OR SUPPLIER	CENTER	6	STREET ADDRESS, CITY, STATE, ZIP CODE M4 HASTINGS LANE NARRENTON, VA 20186	1 00.00
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDERICIENCY)	D BE COMPLETION
F 757	resident is taking Wa PT/INR test at least has a point of care II staff members to get resident's bedside.  On 9/1/23 at 8:33 a. She stated she usua given to her by the man she was not aware of R253. After checking stated: "Oh, I see so they weren't done."  On 9/1/23 at 8:58 a. member) #1, the addinterim director of nu regional nurse conscioncerns.  No further information.  NOTES (1) "Prothrombin time international normality tested to assess the thrombosis and to manticoagulant therap information is taken Health website https://www.ncbi.nlm.69083/.  (2) "Thrombosis is the formation of a blood deep vein thrombosis."	e order. She stated if a arfarin, the resident needs a weekly. She stated the facility NR test machine that enables a this test done quickly at the m., LPN #8 was interviewed. Ally puts in the verbal orders nurse practitioner. She stated of any orders for Warfarin for go the resident's orders, she ame now. I'm not sure why m., ASM (administrative staff ministrator, ASM #2, the ursing, and ASM #3, the altant, were informed of these on was provided prior to exit.  The (PT) and the associated ized ratio (INR) are routinely risk of bleeding or nonitor response to	F 757		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	' '	SURVEY PLETED
		495267	B. WING			C / <b>01/2023</b>
	ROVIDER OR SUPPLIER  DE REHAB & NURSING	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 758	and dissolves on its of symptoms like pain and diagnosed with DVT, avoid serious complice embolism. This can of away from its original lungs in the bloodstreethrombosis increases operations such as known surgery. Because of the this kind of surgery and to prevent blood clots information is taken from the least well as the surgery. Warfarin is used forming or growing larvessels. It is prescribe types of irregular hear prosthetic (replacement valves, and people whattack. Warfarin is alsvenous thrombosis (svein) and pulmonary fung). Warfarin is in a anticoagulants ('blood decreasing the clottin information is taken from the least well in	g. It often goes unnoticed wn. But it may cause and swelling. If someone is they will need treatment to sations such as pulmonary occur if the blood clot breaks site and is carried to the am. The risk of deep vein after more major nee or hip replacement his, people who have had be usually given medication from forming. This from the National Institutes of which is people with certain reger in your blood and blood	F 75			
SS=E	CFR(s): 483.45(c)(3)( §483.45(e) Psychotro §483.45(c)(3) A psych					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL		CONSTRUCTION	(X3) DATE COMP	
		495267	B. WING			09/	01/2023
NAME OF P	ROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	3172020
BROOKSI	DE REHAB & NURSING	CENTER		614 HASTINGS LANE WARRENTON, VA 20186			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 758	processes and behave but are not limited to, categories: (i) Anti-psychotic; (ii) Anti-psychotic; (iii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic  Based on a comprehe resident, the facility management of the facility managem	ensive assessment of a nust ensure that ints who have not used the not given these drugs in sinecessary to treat a diagnosed and documented ints who use psychotropic in dose reductions, and ins, unless clinically effort to discontinue these in sinecessary to treat a diagnosed and documented ints who use psychotropic in dose reductions, and ins, unless clinically effort to discontinue these ints do not receive ursuant to a PRN order in is necessary to treat a sindition that is documented and interest or psychotropic drugs. Except as provided in intending physician or er believes that it is RN order to be extended or she should document their ent's medical record and	F	758	<ol> <li>Resident #98 discharged from facility.</li> <li>All residents of the facility have potential to be affected by the alled deficient practice. An audit of curriesidents receiving psychotropic medications has been conducted ensure there are orders in place to monitor for adverse effects, as we behaviors.</li> <li>DON/designee to educate licer nursing staff regarding monitoring adverse effects and targeted behavioral symptoms for residents receiving psychotropic medication.</li> <li>DON/designee will perform an 10% of residents receiving psychomedications to ensure there are on place to monitor for adverse effects as well as targeted behavioral symptoms 3xweek x 4weeks. The results will be reviewed and discurbly the Interdisciplinary Team through the Quality Assurance process are corrective action plans put into plaindicated based on review, along determinations related to ongoing monitoring.</li> <li>Date of Compliance: 10/16/202</li> </ol>	e the eged ent to o ell as as avioral audit of otropic orders fects, se assed augh ace as with	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	( (EACH CORRECT CROSS-REFERENCE)	PLAN OF CORRECTION TIVE ACTION SHOULD B CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 758	drugs are limited to 14 renewed unless the a prescribing practitions the appropriateness of This REQUIREMENT by:  Based on staff interviand facility document that the facility staff for psychotropic medic behavior monitoring for survey sample, Resident #98 (R9 monitor for adverse e behavioral symptoms medication use.  On the most recent M significant change ass (assessment reference resident scored 5 out interview for mental s indicating the resident making daily decision documented R98 recemedication 6 of the 7 period.  The physician orders - "Risperidone Oral Ta (Risperidone) Give 1 day for Anxiety. Order	rders for anti-psychotic 4 days and cannot be ttending physician or er evaluates the resident for of that medication.  is not met as evidenced  iew, clinical record review review, it was determined ailed to evidence monitoring cation adverse effects and or one of 45 residents in the ent #98.  8), the facility staff failed to ffects and record targeted related to anti-psychotic  IDS (minimum data set) a sessment with an ARD se date) of 7/6/2023, the of 15 on the BIMS (brief tatus) assessment, t was severely impaired for s. The assessment eiving an antipsychotic days during the assessment  for R98 documented in part, ablet 2 MG (milligram) tablet by mouth one time a r Date: 7/1/2023."	F	758			
	The clinical record for	R98 failed to evidence					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		1, ,	E SURVEY IPLETED
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	ROVIDER OR SUPPLIER  DE REHAB & NURSING	L		STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186	<u> </u>	9/01/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 758	monitoring for side ef behavior symptoms for use.  The comprehensive of documented in part, "psychotropic medicat Date Initiated: 06/09/208/09/2023." Under 'documented in part, "medications as orders side effects and effects shift). Date Initiated: 0 occurrence of for targ document per facility 06/09/2023. Revision  On 8/31/2023 at 2:15 to ASM (administrative administrator for evide adverse effect monitor to the present.  On 8/31/2023 at 4:00 director of nursing state any evidence of behamonitoring for R98 to something in place at On 8/31/2023 at 10:2 conducted with LPN (LPN #9 stated that repsychotropic medicate behaviors and any characteristical record, type administration record	fects, effectiveness or target or psychotropic medication  care plan for R98 ((Name of R98) uses ions r/t (related to) Anxiety. 2023. Revision on:  'Interventions" it Administer Psychotropic ed by physician. Monitor for tiveness Q-Shift. (every 26/01/2023 Monitor/record et behavior symptoms and protocol. Date Initiated: on: 08/30/2023."  p.m., a request was made e staff member) #1, the ence of behavior and wring for R98 from 6/1/2023  p.m., ASM #2, the interim ated that they did not have evior or adverse effect provide and they had put at that point.  7 a.m., an interview was [licensed practical nurse) #9. sidents who received ions were monitored for langes in their baseline. She oring was documented in bically on the medication	F 75	58		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF PR	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	0 1/2020
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				V	VARRENTON, VA 20186		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 758	documented in part, " are prescribed for bel documentation may ir a. Rationale for use; b. Potential underlying c. Other approaches a to the use of antipsyc medications; d. Potential risks and discussed with the re- e. Specific target beh outcomes; f. Dosage; g. Duration; h. Monitoring for effica- consequences; and i. Plans (if applicable) reduction"  On 8/31/2023 at 4:31 administrator, ASM # nursing and ASM #3,	itoring" dated 10/2/2021  210. When medications navioral symptoms, nclude:  g causes of the behavior; and interventions tried prior chotic or psychoactive  benefits of medications as sident and/or family; aviors and expected  acy and adverse  for gradual dose  p.m., ASM #1, the 2, the interim director of	F	758			
F 812 SS=E		n was provided prior to exit. fore/Prepare/Serve-Sanitary 2)	F	812			
	§483.60(i) Food safet The facility must -	ry requirements.					
	state or local authoriti (i) This may include for	ed satisfactory by federal, ies. ood items obtained directly subject to applicable State					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		CONSTRUCTION	(X3) DATE	
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	ROVIDER OR SUPPLIER  DE REHAB & NURSING	CENTER		61	TREET ADDRESS, CITY, STATE, ZIP CODE  14 HASTINGS LANE  /ARRENTON, VA 20186		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 812	facilities from using prigardens, subject to consume safe growing and food (iii) This provision does from consuming foods §483.60(i)(2) - Store, serve food in accordant standards for food see This REQUIREMENT by:  Based on observation facility document reviet the facility staff failed sanitary manner. The and dispose of opened areas.  The findings include:  The facility staff failed opened food identified kitchen observation.  On 8/29/23 at 11:00 A conducted in the main bag of approximately torn open. There was opened or expiration In the dry storage are three pounds of dried plastic bag that had be no label on bag indicate when it expired.  An interview was conducted.  An interview was conducted of the opened.	s not prohibit or prevent roduce grown in facility ompliance with applicable d-handling practices. es not preclude residents is not procured by the facility.  prepare, distribute and ince with professional rvice safety.  is not met as evidenced is not met as evidenced ew, it was determined that to maintain the kitchen in a facility staff failed to date and food in one of one kitchen in the determined that is defined in the facility task.  It to date and dispose of diduring the facility task.  AM, an observation was an kitchen. In the freezer, one 12 hamburger patties was no label on bag of date	F	312	<ol> <li>The Dietary Services Manager immediately disposed of both iten were not labeled.</li> <li>The DSM conducted an audit of dry storage as well as the walk-in refrigerator and freezer to confirm was labeled per policy and process.</li> <li>DSM reeducated all dietary states the facility's policy entitled "Recei and Storage of Food," specifically relates to dating and labeling food.</li> <li>DSM/designee will conduct an three (3) times a week for one (1) and then weekly for four (4) week confirm that food is dated and lab according to policy. These results reviewed and discussed by the Interdisciplinary Team through the Quality Assurance process and corrective action plans put into plaindicated based on review, along determinations related to ongoing monitoring.</li> <li>Date of Compliance 10/16/202</li> </ol>	of the food dure.  of on ving ving as it d.  audit week is to beled will be ee ace as with	

PRINTED: 09/18/2023 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

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	ROVIDER OR SUPPLIER  DE REHAB & NURSING	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186		
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F 812	of hamburger patties stated, they should not like this, they should have the stated in the closure.  The ASM (administrated administrator, ASM #3, the regional aware of the finding of the facility's "Receiving policy, revealed the factored in bins will be repackaging, labeled ar Such foods will be rot out" system. All foods freezer will be covere by date)."	and noodles, OSM #1 ot have opened these bags have a date and be secured  tive staff member) #1, the 2, the director of nursing and nurse consultant was made on 8/30/23 at 5:00 PM.  Ing and Storage of Food" following, "Dry foods that are removed from original and dated ("use by" date). Itated using a "first in - first as stored in the refrigerator or d, labeled and dated ("use	F8	812		
F 813 SS=C	S483.60(i)(3) Have a storage of foods brou and other visitors to e storage, handling, and This REQUIREMENT by: Based on observation facility document reviet the facility staff failed regarding the use and	policy regarding use and ght to residents by family ensure safe and sanitary d consumption.  is not met as evidenced ons, staff interview, and ew, it was determined that to evidence a policy d storage of food brought to and other visitors to ensure	F 8	<ol> <li>1. Facility policy entitled "Resid to Make Personal Dietary, Food Meal Choices" located on Septe 2023.</li> <li>2. All residents have the potent affected by this deficient practic residents affected at this time.</li> <li>3. The NHA/designee will reed staff on the facility policy entitle Resident Right to Make Person Dietary, Food and Meal Choice</li> </ol>	and mber 21, all to be e. No cate all f	

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	PLE CONSTRUCTION		(X3) DATE COMP	
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	ROVIDER OR SUPPLIER  DE REHAB & NURSING	CENTER		STREET ADDRESS, C 614 HASTINGS LAN WARRENTON, VA		1 09/1	01/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH (	VIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD BI EFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 838 SS=D	was made for the faci Brought From Home".  On 8/30/23 at approxi (administrative staff madministrator, stated twill ask dietary service).  On 8/30/23 at approxi the administrator, stated for the administrator	aM during entrance /30/23 at 9:00 AM, a request lity's policy on "Food  imately 12:00 PM, ASM nember) #1, the they do not have a policy but es if they had a policy.  imately 3:00 PM, ASM #1, ted there is no policy.  imistrator, ASM #2, the d ASM #3, the regional made aware of the finding //.  I was provided prior to exit.  (3)  sessment. luct and document a ent to determine what ary to care for its residents ofth day-to-day operations e facility must review and ent, as necessary, and at cility must also review and ent whenever there is, or the change that would require a on to any part of this lity assessment must	F8	resident acc the facility in council for t will be revie Interdisciplin Quality Ass corrective a indicated ba determination monitoring.  5.Date of C  1. The Inter on 9/26/202 Facility Ass of residents 2. IDT revie Assessmen Quality Ass Improveme  3. NHA ree Facility Ass relates to design to the second contents  3. NHA ree Facility Ass relates to design to the second contents  3. NHA ree Facility Ass relates to design to the second contents  3. NHA ree Facility Ass relates to design to the second contents  4. The Inter on 9/26/202 Facility Ass of residents  5. The Inter on 9/26/202 Facility Ass of residents  6. The Inter on 9/26/202 Facility Ass of residents  6. The Inter on 9/26/202 Facility Ass of residents  6. The Inter on 9/26/202 Facility Ass of residents  6. The Inter on 9/26/202 Facility Ass of residents  6. The Inter on 9/26/202 Facility Ass of residents  6. The Inter on 9/26/202 Facility Ass of residents  6. The Inter on 9/26/202 Facility Ass of residents  6. The Inter on 9/26/202 Facility Ass of residents  6. The Inter on 9/26/202 Facility Ass of residents  6. The Inter on 9/26/202 Facility Ass of residents  6. The Inter on 9/26/202 Facility Ass of residents  6. The Inter on 9/26/202 Facility Ass of residents  6. The Inter on 9/26/202 Facility Ass of residents  6. The Inter on 9/26/202 Facility Ass of residents  7. The Inter on 9/26/202 Facility Ass of residents  8. The Inter on 9/26/202 Facility Ass of residents  9. The Inter on 9/26/202 Facility Ass of residents  9. The Inter on 9/26/202 Facility Ass of residents  9. The Inter on 9/26/202 Facility Ass of residents  9. The Inter on 9/26/202 Facility Ass of residents  9. The Inter on 9/26/202 Facility Ass of residents  9. The Inter on 9/26/202 Facility Ass of residents  9. The Inter on 9/26/202 Facility Ass of residents  9. The Inter on 9/26/202 Facility Ass of residents  9. The Inter on 9/26/202 Facility Ass of residents  9. The Inter on 9/26/202 Facility Ass of residents  9. The Inter on 9/26/202 Facility Ass of residents	rdisciplinary Team (ID- 23 to review and updates essment to incorporates over 500 lbs. ewed the entire Facility at. Findings forwarded surance/Process ent for review and analy ducated the IDT on the essment, specifically a ocumenting the resount to care for residents	ide of it esults y the esults y the esults of it esults y the esults of it esults it esults of i	
	3 100.10(0)(1) THE IAC	ility's resident population,					

AND DI AN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIF	PLE CONSTRUCTION  G	COMF	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER  DE REHAB & NURSING	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186		0112020
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F 838	resident capacity; (ii) The care required considering the types physical and cognitive and other pertinent fathat population; (iii) The staff competer provide the level and resident population; (iv) The physical enviservices, and other pertinent are necessary to (v) Any ethnic, cultural may potentially affect facility, including, but food and nutrition ser \$483.70(e)(2) The fact but not limited to, (i) All buildings and/or and vehicles; (ii) Equipment (medic (iii) Services provided pharmacy, and specific) All personnel, including and those contract), and volunte education and/or trainer lated to resident cat (v) Contracts, memory or other agreements services or equipmer normal operations and (vi) Health information	by the resident population of diseases, conditions, edisabilities, overall acuity, acts that are present within encies that are necessary to types of care needed for the discontinuous factors that are providerations of the care for this population; and all, or religious factors that the care provided by the not limited to, activities and evices.  Cility's resources, including or other physical structures and encies that are provided by the not limited to, activities and evices.  Cility's resources, including or other physical structures and and non-medical); discontinuous fice rehabilitation therapies; luding managers, staff (both evices, as well as their ening and any competencies re; andums of understanding, with third parties to provide at to the facility during both and emergencies; and in technology resources, electronically managing	F 83	Assessment monthly for the months. These results will and discussed by the Interest Team through the Quality process and corrective act put into place as indicated review, along with determine the determined to ongoing monitors. Date of Compliance 10	three (3) If the reviewed predisciplinary Assurance ction plans d based on hinations oring.	

L' :		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER  DE REHAB & NURSING	CENTER	6	STREET ADDRESS, CITY, STATE, ZIP CODE S14 HASTINGS LANE WARRENTON, VA 20186	, 22.3		
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F 838	all-hazards approach This REQUIREMENT by: Based on resident in clinical record review was determined that maintain an accurate assessment for care survey sample, Resid The findings include: For Resident #28 (R2 maintain an accurate assessment for care than 500 lbs.  R28 was admitted to diagnoses that include severe morbid obesit [BMI] 70 or greater, a On the most recent in quarterly assessmen reference date) of 6/2 14 out of 15 on the B mental status) asses were cognitively intace On 8/29/2023 at 12:3	ty-based and k assessment, utilizing an and its root met as evidenced atterview, staff interview, and facility document, it the facility staff failed to and complete facility of one of 45 residents in the dent #28.  28), the facility staff failed to and complete facility of bariatric residents greater the facility on 2/4/2022 with led but were not limited to by (1) and body mass index adult (2).  MDS (minimum data set), a the with an ARD (assessment 23/2023, the resident scored IMS (brief interview for sment, indicating that they can be a set of the making daily decisions.	F 838				
	resided at the facility that they had a baria had never been able	R28 stated that they had for over a year. R28 stated tric bed and wheelchair but to use the shower because facility not having a shower					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495267	B. WING			C 09/01/2023	
	ROVIDER OR SUPPLIER  DE REHAB & NURSING			STREET ADDRESS, CITY, STATE, ZIP CO 614 HASTINGS LANE WARRENTON, VA 20186		J9/0 1/2023	
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F 838	chair for them.  Review of R28's weig admission weight of 52 current weight of 559  Review of the facility entrance dated 5/27/2 1/12/2023 and QAPI performance improve 7/19/2023 documented Resident Profile: Clin 300lbs to 500lbs" To documented an "x" in The "Skill Identification "Red- The facility is uservices"  On 8/31/2023 at 4:30 conducted with ASM member) #1, the admitted when they review reflected the current in time. She stated that assessment should refin the building.  On 8/31/2023 at 4:31 administrator, ASM # nursing and ASM #3, consultant were made.  No further information References:  (1) Obesity means were residually administrator was references:	assessment provided on 2021 with an update on (quality assurance ment) review date of ed in part, "Part 1: Our ical Skill Bariatric Care-The assessment a column labeled "Red." on key documented in part, nable to provide these  p.m., an interview was (administrative staff inistrator. ASM #1 stated wed the facility assessment it residents in the facility at that the current facility effect the residents that were  p.m., ASM #1, the 2, the interim director of	F	338			
	chronic disease. It ca	- ·					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		495267	B. WING _		1	C <b>/01/2023</b>
	ROVIDER OR SUPPLIER  DE REHAB & NURSING	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186	1 03	01/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 842 SS=D	from the website: https://medlineplus.g  (2) Your BMI estimat weigh based on your classes of obesity: Class 1: BMI of 30 to Class 2: BMI of 35 to Class 3: BMI of 40 o considered "severe of This information was https://medlineplus.g Resident Records - I CFR(s): 483.20(f)(5)  §483.20(f)(5) Reside (i) A facility may not resident-identifiable accordance with a confident accordance with a confident of the extent to do so.  §483.70(i) Medical resident must maintain medical that are- (i) Complete; (ii) Accurately docum (iii) Readily accessib (iv) Systematically or §483.70(i)(2) The face	information was obtained pov/ency/article/007297.htm  es how much you should height There are three pless than 35. less than 40. In higher. Class 3 is pobesity." To obtained from the website: pov/ency/article/007196.htm dentifiable Information Helease information that is to the public. Helease information that is to an agent only in portract under which the agent disclose the information the facility itself is permitted  Hecords. Herords on each resident  Hented; He; and	F8		ntial to be ent esidents y lack of lity, and tion from esident repancies. rrent se been nt for IDT nursing tation; as ing staff	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495267	B. WING _			C 01/2023	
	ROVIDER OR SUPPLIER  DE REHAB & NURSING	CENTER	•	STREET ADDRESS, CITY, STATE, ZII 614 HASTINGS LANE WARRENTON, VA 20186			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE	
F 842	records, except when (i) To the individual, or representative where (ii) Required by Law; (iii) For treatment, par operations, as permit with 45 CFR 164.506 (iv) For public health neglect, or domestic activities, judicial and law enforcement purpurposes, research produced examiners, for a serious threat to he by and in compliance §483.70(i)(3) The factorecord information agunauthorized use.  §483.70(i)(4) Medical for- (i) The period of time (ii) Five years from the there is no requireme (iii) For a minor, 3 years legal age under State §483.70(i)(5) The med (i) Sufficient informati (ii) A record of the research provided; (iv) The results of any and resident review edeterminations conductive determinations determinations conductive determinations conductive determinations conductive determinations conductive determinations conductive determinations conductive determ	n or storage method of the release is- r their resident permitted by applicable law;  yment, or health care ted by and in compliance; activities, reporting of abuse, violence, health oversight administrative proceedings, toses, organ donation urposes, or to coroners, uneral directors, and to avertable at the or safety as permitted with 45 CFR 164.512.  Illity must safeguard medical ainst loss, destruction, or  records must be retained  required by State law; or edate of discharge when not in State law; or ars after a resident reaches alaw.  dical record must containon to identify the resident; sident's assessments; we plan of care and services  y preadmission screening valuations and	F 8	4. DON/designee will audit of POC complia 4 weeks. Audit progr week x4weeks to enseen added under R management for IDT These results will be discussed by the Interest through the Querocess and corrective put into place as individual review, along with derelated to ongoing mediated to ongoing mediated to ongoing mediated to compliance.	ance 5x week x ress notes 5x sure falls have tisk to review. reviewed and erdisciplinary uality Assurance ve action plans icated based on eterminations ionitoring.		

PRINTED: 09/18/2023 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495267	B. WING			l	C 01/2023
	ROVIDER OR SUPPLIER  DE REHAB & NURSING	CENTER	,	61	REET ADDRESS, CITY, STATE, ZIP CODE 4 HASTINGS LANE ARRENTON, VA 20186		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 842	services reports as real This REQUIREMENT by: Based on staff intervand facility document the facility staff failed accurate documentat Resident #353 and #8 The findings include:  1. For Resident #353 evidence complete ar for bladder and bowe and personal hygiene Resident #353 was a 4/3/23 with diagnoses limited to: pacemake (diabetes mellitus) and Resident #353's most data set) assessment assessment, with an of 4/8/23, coded the rational formation of the BIMS (brief score, indicating the rimpaired. MDS Section coded the resident as bathing, extensive as transfers, locomotion supervision for eating H-Bowel and Bladde always incontinent for	ogy and other diagnostic equired under §483.50.  is not met as evidenced eiew, clinical record review review, it was determined to provide complete and ion for two of 45 residents, 98.  the facility staff failed to accurate documentation I elimination, bed mobility, e.  dmitted to the facility on a that include but are not a that include but are not a that include but are not a trecent MDS (minimum assessment reference date resident as scoring 13 out of a interview for mental status) resident was not cognitively for G- Functional Status: a total dependence with sistance with bed mobility, a dressing and hygiene; and A review of MDS Section are coded the resident as a bowel and bladder.	F	842			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
		495267	B. WING _				C 01/2023
	ROVIDER OR SUPPLIER  DE REHAB & NURSING	CENTER	,	614 HA	T ADDRESS, CITY, STATE, ZIP CODE ASTINGS LANE RENTON, VA 20186	,	
(X4) ID PREFIX TAG			ID PREFI TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 842	potential/actual impai (SPECIFY location) re has bladder incontine (moisture associated area. INTERVENTION for treatment of injury incontinence episode area per treatment."  A review of the ADL (a record for April 2023 and bowel elimination hygiene documentation 2 out of 15 evening sl shifts.  An interview was comply with CNA (certifient When asked where be elimination, bed mobin was documented, CN documented on the A means if there is missistated it just means the document. When ask complete, CNA #3 stated in the complete was document on the complete was document in the complete was document in the complete was not documented in the total it was not documented in the tota	rment to skin integrity of the elated to: The resident nce. Patient has MASD skin damage) to coccyx NS: Follow facility protocols. Clean peri-area with each Apply zinc oxide to coccyx activities of daily living) revealed missing bladder and bed mobility and personal on for 1 out of 14 day shifts, nifts and 3 out of 13 night adder and bowel lity, and personal hygiene A #3 stated it is DL form. Asked what it sing documentation, CNA #3 ney did not have time to seed if the record was ated, no, it is not complete.  ducted on 9/1/23 at 10:15 then asked where bladder and personal inted, CNA #4 stated they outer on the CNA/ADL form.	F	342			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
		495267	B. WING			C 09/01/2023	
	ROVIDER OR SUPPLIER  DE REHAB & NURSING	CENTER		6	TREET ADDRESS, CITY, STATE, ZIP CODE  14 HASTINGS LANE  VARRENTON, VA 20186	1 03/	0172020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 842	member) #1, the admidirector of nursing an nurse consultant was  A review of the facility Documentation" policity services provided to toward the care plan resident's medical, physychosocial condition resident's medical recident's medical recident's medical record with the medical record with opinionated or speculaccurate."  No further information  2. For Resident #98 (to document a fall in the document a fall in the document and the previous as (assessment reference resident was assessed ince the previous as The progress notes for "6/27/2023 08:00 (8) results confirm left high dislocation. Order from send to ER (emergence sent to (Name of hos sheet, current orders)	I, ASM (administrative staff inistrator, ASM #2, the d ASM #3, the regional made aware of the findings.  I's "Charting and y, which revealed, "All the resident, progress goals, or any changes in the physical, functional, or in, will be documented in the cord. The medical record will in between the regarding the resident's se to care. Documentation in Il be objective (not lative), complete, and  In was provided prior to exit.  R98), the facility staff failed the clinical record.  IDS (minimum data set), a sessment with an ARD be date) of 7/6/2023, the ed as not having any falls sessment.  In R98 documented in part, and in the cord in part	F	842			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION	COME	(X3) DATE SURVEY COMPLETED C	
		495267	B. WING			/ <b>01/2023</b>	
	ROVIDER OR SUPPLIER  DE REHAB & NURSING	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186		70 172020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 842	Resident visited by Nain. New order of Streceived. STAT X-ray health imagery. RP (notified."  - "6/26/2023 10:01 ((interdisciplinary teat post fall. Adding intereview goals, visual). The progress notes adocumentation of the 6/26/2023.  The assessments fared documentation of the meeting on 6/26/2023.  The assessments fared documentation of the meeting on 6/26/2023.  The fall investigation documented in part, placed in bed by CN on duty and later resistation fell in front of left side. Staff's carn noted helped into who (range of motion) doextremities denies pawheel chair for contidistress noted. (Nartext. R/P (responsib notified 6/26/2023)	In 1:08 a.m.) Note Text:  In P and complains of left hip of the party and complains of left hip of the party and complains of left hip of the party and the party of the party	F 84				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495267	B. WING _			C 09/01/2023	
	ROVIDER OR SUPPLIER  DE REHAB & NURSING	CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 614 HASTINGS LANE WARRENTON, VA 20186	•	03/01/2023	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 883 SS=E	met to review fall. Ad therapy review goals. walker Not Part of the Consumption of the	ding intervention to have Visual cue to be placed on the medical record"  7 a.m., an interview was licensed practical nurse) #9. Then a resident has a fall the resident and based on the fied the family and the nurse that they put any new and updated the care plan. The documented the fall in the completed the risk that all falls should be redical record and a post fall the documented the resident the beaccurate.  7 a.m., an interview was that they put any new and updated the care plan. The documented the fall in the completed the risk that all falls should be redical record and a post fall the documented the resident fied the physician and the fied the physician and the fall after they got the resident the fall in the progress notes fing in condition assessment  1 p.m., ASM (administrative administrator, ASM #2, the sing and ASM #3, the tant were made aware of  1 was provided prior to exit. 1 occoccal Immunizations (2)	F 8				

STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I` ′		CONSTRUCTION	(X3) DATE COMP	LETED
		495267	B. WING _			09/0	01/2023
	ROVIDER OR SUPPLIER  DE REHAB & NURSING	CENTER		61	TREET ADDRESS, CITY, STATE, ZIP CODE 14 HASTINGS LANE //ARRENTON, VA 20186		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 883	policies and procedur (i) Before offering the each resident or the receives education repotential side effects (ii) Each resident is o immunization Octobe annually, unless the icontraindicated or the immunized during this (iii) The resident or the has the opportunity to (iv)The resident's me documentation that ir following:  (A) That the resident was provided education and potential side efficimmunization; and  (B) That the resident immunization or did refusal.  §483.80(d)(2) Pneummust develop policies that-  (i) Before offering the immunization, each representative receives benefits and potential immunization;  (ii) Each resident is o immunization, unless	za. The facility must develop res to ensure that- influenza immunization, resident's representative regarding the benefits and of the immunization; ffered an influenza r 1 through March 31 mmunization is medically resident has already been stime period; re resident's representative refuse immunization; and dical record includes redical received the influenza redicter received the influenza redical contraindications or redical contraindications or redical contraindications or record incluence receive the influenza redical contraindications or record disease. The facility read and procedures to ensure resident or the resident's	F	883	<ol> <li>The deficient practice could no retroactively corrected.</li> <li>All current residents have the potential to be affected by the alled deficient practice. An audit was performed of current residents when have received the Influenza and/of Pneumococcal vaccination at the in the past 30 days to ensure educate in the past 30 days to ensure educate in the past 30 days to ensure educate in the past 30 days to ensure education when offering a vaccina All current residents and/or responsition will be educated and inforregarding the Influenza and Pneumococcal vaccine will be proto the resident and/or Responsible representative.</li> <li>DON/designee will perform an of current residents offered the Influenza and Pneumococcal vaccine education was provided wateveeks. These results will be reand discussed by the Interdiscipli Team through the Quality Assurated process and corrective action plated into place as indicated based on along with determinations related ongoing monitoring.</li> <li>Date of Compliance 10/16/202</li> </ol>	eged no or facility cation ensed ation. nsible mation ovided e audit cine to reekly viewed nary nce ns put review, to	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED
		495267	B. WING _			C <b>09/01/2023</b>
	ROVIDER OR SUPPLIER  DE REHAB & NURSING	CENTER	1	STREET ADDRESS, CITY, STATE, ZIP COI 614 HASTINGS LANE WARRENTON, VA 20186	DE	00.0 112020
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CO ( (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIA	
F 883	has the opportunity to (iv)The resident's me documentation that in following:  (A) That the resident was provided educati and potential side efficimmunization; and (B) That the resident pneumococcal immunithe pneumococcal immunitation or residents of the influence providents and influence providents and influence pneumococcal immunithe pneumococcal immunitation or residents of the influence providents and influence providents and influence pneumococcal immunitation or residents of the influence pneumococc	e resident's representative orefuse immunization; and dical record includes indicates, at a minimum, the cor resident's representative on regarding the benefits ects of pneumococcal either received the nization or did not receive munization due to medical fusal.  The is not met as evidenced iiew, clinical record review, review, it was determined ailed to evidence that ation regarding risks vsuza and/or pneumonia ed to the resident and/or ve, prior to the vaccines or refused, for four of five or immunizations; Residents and vaccination was or documented, "The ritinent information about the penefits of vaccines to staff	F8			

• · · ·		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495267	<b>495267</b> B. WING			C <b>09/01/2023</b>		
NAME OF PROVIDER OR SUPPLIER  BROOKSIDE REHAB & NURSING CENTER			,	STREET ADDRESS, CITY, STATE, ZIP COD 614 HASTINGS LANE WARRENTON, VA 20186	Æ			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIA		(X5) COMPLETION DATE	
F 883	Consent for the admin vaccination will be ob and/or resident's reprosent to administration of the consent form will be relinical record6.a. I representative refuse vaccine administered be notified, and documphysician notification nursing notes" An facility's "Influenza Vacconsent/Declination" effects of the vaccine has an allergy to egging resident had received vaccine, and whether accepted or declined. The facility policy, "Proviewed. This policy offering pneumococcaresident or the resident consent for the admin pneumococcal vaccination of the consent form will be record8. If a reside representative refuse vaccine administered be notified, and the dand physician notificat the nursing notes" the facility's "Pneumococcant in the resident of the consent form will be record8. If a reside representative refuse vaccine administered be notified, and the dand physician notificat the nursing notes"	of the immunization4. Inistration of the influenza tained from the resident esentative or employee prior the vaccine. A copy of the maintained in the resident's fa resident or resident's so to have the influenza, the attending physician will mentation of the refusal and will be documented in the eview of a blank copy of the accination - Informed form documented side, whether or not the resident so, a statement that the deducation about the for not the resident the vaccine.  Incumococcal Vaccine" was a documented, "3. Before al immunization, each not's legal representative will parding the benefits and of the immunization6. Inistration of the eaction will be obtained from the vaccine. A copy of the maintained in the clinical	F8	83				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIF	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		495267	B. WING		, ا	C 09/01/2023	
NAME OF PROVIDER OR SUPPLIER  BROOKSIDE REHAB & NURSING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 883	received education a	e 145 ement that the resident had bout the vaccine, and sident accepted or declined	F 88	3			
	evidence that educati regarding the influence were provided to the representative prior to administered and the being refused  A review of the clinical influenza vaccine admander and the provided to Resident evidence that the education on the state of	za and pneumonia vaccines resident and/or resident to the influenza vaccine being pneumococcal vaccine  al record revealed an ministration dated 11/16/22. Ited that consent was given er, the box for "Education /Family" was not marked to ucation was provided. There entation either that would ducation was provided prior					
	a pneumococcal vaccinesident's representathe box for "Educatio Resident/Family" was that the education was other documentation	s not marked to evidence as provided. There was no either that would have ion was provided prior to the					
	Member) the Assistar Infection Preventionis	M, an interview was #4 (Administrative Staff nt Director of Nursing and st. She stated that if the box t checked, she did not have					

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495267	B. WING		C 09/01/2023		
NAME OF PROVIDER OR SUPPLIER  BROOKSIDE REHAB & NURSING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE WARRENTON, VA 20186	1 09/01/2023		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	D BE COMPLETION		
F 883	any other evidence written consent form that education was progoing forward, the far forms.  On 8/31/23 at 4:30 ff Administrator, ASM and ASM #3 the Remade aware of the finformation was progoing to the composition of the finformation of the finformation was no other documnate evidence that the education was given on 1/10/2 "Education Provided marked to evidence provided. There was going forward to the finformation of the finformatio	as the facility did not utilize as, which contained evidence brovided. She stated that acility would be using such  PM, ASM #1 the #2 the Director of Nursing, gional Nurse Consultant were indings. No further vided.  , the facility staff failed to ation and information and pneumonia vaccines be resident and/or resident to the vaccines being  cal record revealed an dministration dated 1/10/23. anted that consent was given ber, the box for "Education at/Family" was not marked to ducation was provided. There are that the that would beducation was provided prior	F 883	3			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
		495267	B. WING			C	
NAME OF B	201/1252 02 01/221/52	493207	D. WIIVO			09/	01/2023
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 614 HASTINGS LANE		
BROOKSI	DE REHAB & NURSING	CENTER		,	WARRENTON, VA 20186		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 883	Continued From page vaccine.  On 8/31/23 at 1:38 Pt		f :	883			
	conducted with ASM: Member) the Assistar Infection Preventionis for education was not any other evidence as written consent forms that education was pr	#4 (Administrative Staff at Director of Nursing and at. She stated that if the box a checked, she did not have as the facility did not utilize a, which contained evidence avoided. She stated that acility would be using such					
		2 the Director of Nursing, onal Nurse Consultant were idings. No further					
	evidence that educati regarding the influenz	ca vaccine was provided to sident representative prior					
	This record document on 9/14/22. However Provided to Resident/ evidence that the edu was no other docume have evidence that ed to the administration of On 8/31/23 at 1:38 Pt	ninistration dated 10/12/22. ted that consent was given to the box for "Education" (Family" was not marked to finite the cation was provided. There entation either that would ducation was provided prior of the vaccine.  M, an interview was					
		#4 (Administrative Staff nt Director of Nursing and					

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		495267	B. WING			C	
NAME OF DDO	VIDER OR SUPPLIER	433201	J		OTDEET ADDRESS SITV STATE 7/D SODE	09/	01/2023
NAME OF PRO	WIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
BROOKSIDE	E REHAB & NURSING	CENTER			MARRENTON VA 20486		
				'	WARRENTON, VA 20186		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
In for an with grant for an in in the control of th	or education was not any other evidence as written consent forms hat education was proping forward, the factorms.  On 8/31/23 at 4:30 PM Administrator, ASM #3 the Regionade aware of the finance and the resident and/or resorted to the vaccine being at A review of the clinical influenza vaccine administrator document on 10/10/22. However the resident and the education and the resident and the record document on 10/10/22. However the vaccine that the education are evidence that the education of the administration of the admin	t. She stated that if the box checked, she did not have at the facility did not utilize, which contained evidence ovided. She stated that sility would be using such  M, ASM #1 the 2 the Director of Nursing, onal Nurse Consultant were dings. No further ded.  the facility staff failed to on and information as vaccine was provided to sident representative prior administered.  If record revealed an inistration dated 10/11/22, ted that consent was given er, the box for "Education Family" was not marked to cation was provided. There intation either that would ducation was provided prior of the vaccine.	F	883			

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		495267	B. WING		09/0	) 01/2023	
NAME OF PROVIDER OR SUPPLIER  BROOKSIDE REHAB & NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  614 HASTINGS LANE  WARRENTON, VA 20186				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 883 F 887 SS=D	forms.  On 8/31/23 at 4:30 PM Administrator, ASM # and ASM #3 the Regi made aware of the fin information was provi COVID-19 Immunizat CFR(s): 483.80(d)(3)(s) §483.80(d) (3) COVID LTC facility must deve and procedures to en (i) When COVID-19 v facility, each resident is offered the COVID-immunization is media resident or staff members are provide regarding the benefits effects associated wit (iii) Before offering CO resident or the resider receives education rerisks and potential sid the COVID-19 vaccine.	M, ASM #1 the 2 the Director of Nursing, onal Nurse Consultant were dings. No further ded. ion ii)-(vii)  D-19 immunizations. The elop and implement policies sure all the following: accine is available to the and staff member 19 vaccine unless the cally contraindicated or the ber has already been  DVID-19 vaccine, all staff d with education and risks and potential side the the vaccine; DVID-19 vaccine, each int representative garding the benefits and the effects associated with the; e; e COVID-19 vaccination tes, the resident,	F 88	33	leged no tion st 30 een censed nation. ated OVID esident		
	additional doses, included benefits or risks and passociated with the C	information regarding those uding any changes in the potential side effects OVID-19 vaccine, before r administration of any					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
	495267 B. WING			C 09/01/2023			
NAME OF P	ROVIDER OR SUPPLIER		<del></del>	STREET ADDRESS, CITY, STATE, ZIP COD	<b>I</b>	09/01/2023	
TO THE OT T	NAME OF FROMBER OR SOFF EIER			614 HASTINGS LANE			
BROOKSI	DE REHAB & NURSING	CENTER		WARRENTON, VA 20186			
	I						
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 887	(v) The resident, resmember has the opp COVID-19 vaccine, a (vi) The resident's m documentation that i the following:  (A) That the resident was provided education and inform COVID-19 vaccine; a (B) Each dose of CO to the resident; or (C) If the resident did vaccine due to medic contraindications or (vii) The facility main to staff COVID-19 vaccine and potential to staff ware offered information on obtain (C) The COVID-19 vaccine ward facility document that the facility staff if education and inform COVID-19 vaccine wand/or resident representation to the potential to the facility staff if education and inform COVID-19 vaccine wand/or resident representation that the facility staff if education and inform COVID-19 vaccine wand/or resident representation that the potential transport in the potential transpo	ident representative, or staff contunity to accept or refuse a cand change their decision; edical record includes indicates, at a minimum, at or resident representative tion regarding the cal risks associated with and covID-19 vaccine administered and not receive the COVID-19 cal refusal; and catains documentation related accination that im, the following: rovided education regarding cential risks and resident education regarding cential risks are covided education regarding cential risks and receive the COVID-19 vaccine; and receive the COVID-19 vaccine or ning COVID-19 vaccine; and receive the CovID-19 vaccine the center of the vaccine that resident the resident resident resident reviewed resident #82.	F 8	4. DON/designee will per audit of current residents COVID vaccine to ensure was provided weekly x4w These results will be revied discussed by the Interdist Team through the Quality process and corrective ac put into place as indicated review, along with determ related to ongoing monito 5. Date of Compliance 10	offered the education reeks. ewed and ciplinary Assurance ction plans d based on inations oring.		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	IPLE CONSTRUCTION  NG	` '	(X3) DATE SURVEY COMPLETED		
		495267	B. WING _			C <b>09/01/2023</b>	
NAME OF PROVIDER OR SUPPLIER  BROOKSIDE REHAB & NURSING CENTER				STREET ADDRESS, CITY, STATE, ZIP COD 614 HASTINGS LANE WARRENTON, VA 20186	E	03/01/2023	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 887	Residents" was revied documented, "2. Residential in the provided in the variable in the value of the valu	OVID-19 Vaccination for wed. This policy esident / resident e educated on: a) risks / O vaccination. The education on the being and; b) current CDC ation or residents for emptoms, risks and benefits COVID-19 virus5. Prior to COVID-19 vaccine, consent the resident / resident ill be documented in the cord"  The facility staff failed to ion and information esident representative prior refused.  The record revealed that a as refused by the resident's 1/1/22. However, the box for to Resident/Family" was not that the education was a no other documentation e evidence that education the refusal of the vaccine.  M, an interview was	F8	,			
	Member) the Assista Infection Preventionis for education was no any other evidence a written consent forms	#4 (Administrative Staff nt Director of Nursing and st. She stated that if the box t checked, she did not have s the facility did not utilize s, which contained evidence rovided. She stated that					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			IPLE CONSTRUCTION  NG		COMPLETED		
		495267	B. WING _			C 09/01/2023	
NAME OF PROVIDER OR SUPPLIER  BROOKSIDE REHAB & NURSING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE  614 HASTINGS LANE  WARRENTON, VA 20186			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 887	going forward, the factorms.  On 8/31/23 at 4:30 P Administrator, ASM #	M, ASM #1 the the Director of Nursing, tional Nurse Consultant were andings. No further	F	387			