STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. Building B. Wing	10/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookside Rehab & Nursing Center	614 Hastings Lane Warrenton, VA 20186

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (continued on next page)

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, facility staff failed to notify the physician of a need to alter treatment for one of 14 residents in the survey sample, Resident #8 (R8). The findings include:For R8, facility staff failed to notify the physician of X-ray results in a timely manner. R8 was admitted with diagnosis that included but not limited to dementia (1). On the most recent comprehensive MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 09/21/2025, R8 scored 0 (zero) out of 15 on the BIMS (brief interview for mental status), indicating R8 was severely impaired for making daily decisions. The facility's incident report dated 11/19/2024 documented in part, Incident date: 11/18/2024. Resident involved: (Name of R8). Incident type: Injury of unknown injury. Resident noticed w/ (with) bruise on left leg. Resident was in her bed. The facility's nursing notes for R8 dated 11/18/2024 at 6:42 a.m. documented Note Text: Staff reported bruise on resident left front leg, pain to touch, MD (medical doctor) notified, MD stated, called (Name of After-Hours Provider Organization). (Name of After-Hours Provider Organization) was contacted via (by) iPad, response is pending. POA (power of attorney) was notified. Morning will follow up. The facility's nursing notes for R8 dated 11/18/2024 at 6:50 a.m. documented Note Text: Received a call from (Name of After-Hours Provider Organization) (Name of Representative) to use ice for pain as needed. The facility's nursing notes for R8 dated 11/18/2024 at 2:45 p.m. documented Note Text: Writer was informed this morning about a bruise on the left leg. The resident was monitored for any signs of pain. The resident reported 0 (zero) pain, and no discomfort was noted during morning shift. The facility's nursing notes for R8 dated 11/18/2024 at 11:05 p.m. documented Note Text: New orders given X-ray for left hip and left lower leg 2 (two) views. The physician's order for R8 dated 11/18/2024 documented in part, Left lower leg xray (X-ray) 2 (two) view. For bruise. The report from (Name of X-ray Company) for R8 documented in part, Exam date: 11/19/2024. Impression: Comminuted, angulated, intertrochanteric (2) fracture of the left femur (thigh bone). The facility's nursing notes for R8 dated 11/20/2024 at 9:41 a.m. documented Note Text: X-ray of left hip received at 0845 (8:45 a.m.). (Name of Nurse Practitioner) notified of results immediately. No new orders received at this time. Plan of [sic]is ongoing. The facility's nursing notes for R8 dated 11/20/2024 at 10:56 a.m. documented Note Text: Order recvd (sic)(received) from (Name of Nurse Practitioner) to send resident to (Name of Hospital) for evaluation and treatment Fracture of left femur. R/P (responsible party) (Name of Responsible Party) notified of xray (X-ray) results and transfer to (Name of Hospital) via (by) EMS (emergency medical services). The (Name of Hospital) Emergency Department Visit Note for R8 dated 11/20/2024 documented in part, The patient is a [AGE] year-old female who is seen in the Emergency Department for hip fracture. General Appearance: no apparent distress, normally reactive to environment 'Baseline according to nursing. On 10/21/2025 at approximately 10:27 a.m. a telephone interview was conducted with OSM (other staff member) #2, workflow coordinator for (Name of X-ray Company). When asked to describe the procedure for contacting a nursing home for X-ray results he stated that if the results have a positive finding (fracture) they call the facility the same day with the results. When asked about notifying the facility with the findings of the X-ray taken on 11/19/2024 OSM #2 stated that (Name of X-ray Company) records indicated that the facility was notified of R8's fracture on 11/19/2024 and that they spoke to (Name of Registered Nurse #5). Review of R8's clinical record failed to evidence documentation on 11/19/2024 that the physician was notified of the X-ray results. On 10/21/2025 at approximately 12:47 p.m. an interview was conducted with LPN (licensed practical nurse) #1. When asked about receiving the results of a resident's X-ray she stated that the X-ray company calls the facility if the results indicate a broken bone or fracture. When asked what a nurse should do if a phone call has not been received from the X-ray company by the end of the day that the X-ray was obtained she stated that the nurse should call the X-ray company for the results. She further stated that after receiving the X-ray results the nurse should immediately notify the physician of the results. After reviewing the nurse's notes and X-ray report for R8 LPN #1 stated that there was no evidence of the physician being notified on 11/19/2024 of R8's X-ray results. On 10/21/2025 at approximately 1:25 p.m. an interview was conducted with RN (registered nurse) #5. When asked if she recalled receiving a telephone call from (Name of X-ray Company) on 11/19/2024 with the results of R8's X-ray, RN #5 stated she did not recall receiving a call. After reviewing the nurse's notes and X-ray report for R8, RN #5 stated that there was no evidence of the physician being notified on 11/19/2024 of R8's X-ray results. On 10/21/2025 at approximately 3:05 p.m. ASM (administrative

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on staff interview and clinical record review, it was determined that the facility staff failed to review or revise the comprehensive care plan for one of 14 residents, Residents in the survey sample, Resident #2 (R2). The findings include:For R2, the facility staff failed to review or revise comprehensive care plan to address behaviors of play with and ingesting fecal material. R2 was admitted to the facility with diagnosis that included but was not limited to bipolar disorder (1) and dementia (2). On the most recent comprehensive MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 09/13/2025, R2 scored 0 (zero) out of 15 on the BIMS (brief interview for mental status), indicating R2 was severely impaired of cognition for making daily decisions. The Psychiatric Note for R2 dated 09/27/2025 documented in part, Relevant Interval History (Symptoms) Staff reported observing concerning behavior where the patient had a bowel movement and was subsequently playing with and eating her own feces, though the timing of when this behavior started is uncertain. The patient does not exhibit any anxiety, depression, delusional thoughts, or hallucinations at this time .Review of R2's comprehensive care plan dated 11/12/2024 failed to evidence documentation to address behaviors of play with and ingesting fecal material. On 10/20/2025 at approximately 3:50 p.m. an interview was conducted with CNA (certified nursing assistant) #1 regarding R2. CNA #1 stated she worked on the North Wing and was usually assigned and provided care to R2. When asked if she recalled an incident of R2 ingesting feces CNA #1 stated yes. She further stated that R2 frequently puts her hands in her pants and removes feces and having it on her hands and lips. CNA #1 also stated that even after being toileted R2 would engage in the behavior of removing fecal material with her hands. When asked if she was aware of a plan to prevent R2 from removing and ingesting feces she stated no. On 10/20/2025 at approximately 4:00 p.m. an interview was conducted with CNA (certified nursing assistant) #2 regarding R2. CNA #2 stated she worked on the North Wing and was usually assigned and provided care to R2. When asked if she recalled an incident of R2 ingesting feces CNA #2 stated yes. She further stated that R2 frequently puts her hands in her pants and removes feces and ingests it . CNA #2 also stated that even after being toileted R2 would engage in the behavior of removing fecal material with her hands. When asked if she was aware of a plan to prevent R2 from removing and ingesting feces she stated that when she sees R2 reaching into her pant CNA #2 stated she intervenes and either redirects R2 or takes her to the bathroom. When asked if she was aware of a plan to prevent R2 from removing and ingesting feces she stated no. On 10/21/2025 at approximately 12:39 p.m. an interview was conducted with LPN (licensed practical nurse) #1 regarding R2 playing with and ingesting feces. LPN #1 stated she worked on the North Wing and was aware of two incidences of R2 playing with her feces with her hands and one of the incidences LPN #1 witnessed. After reviewing R2's comprehensive care plan dated 11/12/2024 LPN #1 stated that the care plan failed to document or address R2's behavior involving feces. When asked to describe the purpose of a resident's care plan she stated the purpose of the care plan is for all disciplines to have a picture of the resident. On 10/21/2025 at approximately 3:05 p.m. ASM (administrative staff member) #1, administrator, ASM #2, director of nursing, ASM #3, regional director of clinical operations and ASM #4 risk nurse, were made aware of the above findings. No further information was provided prior to exit. Reference:(1) A brain disorder that causes unusual shifts in mood, energy, activity levels, and the ability to carry out day-to-day tasks. This information was obtained from the website: https://www.nimh.nih.gov/health/topics/bipolar-disorder/index.shtml. (2) A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, facility staff failed to provide care and services in a timely manner for one of 14 residents in the survey sample, Resident #8 (R8). The findings include:For R8, facility staff failed to act on the results of an x-ray in a timely manner. R8 was admitted with diagnosis that included but not limited to dementia (1). On the most recent comprehensive MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 09/21/2025, R8 scored 0 (zero) out of 15 on the BIMS (brief interview for mental status), indicating R8 was severely impaired of cognition for making daily decisions. The facility's incident report dated 11/19/2024 documented in part, Incident date: 11/18/2024. Resident involved: (Name of R8). Incident type: Injury of unknown injury. Resident noticed w/ (with) bruise on left leg. Resident was in her bed. The facility's nursing notes for R8 dated 11/18/2024 at 6:42 a.m. documented Note Text: Staff reported bruise on resident left front leg, pain to touch, MD (medical doctor) notified, MD stated, called (Name of After-Hours Provider Organization). (Name of After-Hours Provider Organization) was contacted via (by) iPad, response is pending. POA (power of attorney) was notified. Morning will follow up. The facility's nursing notes for R8 dated 11/18/2024 at 6:50 a.m. documented Note Text: Received a call from (Name of After-Hours Provider Organization) (Name of Representative) to use ice for pain as needed. The facility's nursing notes for R8 dated 11/18/2024 at 2:45 p.m. documented Note Text: Writer was informed this morning about a bruise on the left leg. The resident was monitored for any signs of pain. The resident reported 0 (zero) pain, and no discomfort was noted during morning shift. The facility's nursing notes for R8 dated 11/18/2024 at 11:05 p.m. documented Note Text: New orders given X-ray for left hip and left lower leg 2 (two) views. The physician's order for R8 dated 11/18/2024 documented in part, Left lower leg xray (X-ray) 2 (two) view. For bruise. The report from (Name of X-ray Company) for R8 documented in part, Exam date: 11/19/2024. Impression: Comminuted, angulated, intertrochanteric (2) fracture of the left femur (thigh bone). The facility's nursing notes for R8 dated 11/20/2024 at 9:41 a.m. documented Note Text: X-ray of left hip received at 0845 (8:45 a.m.). (Name of Nurse Practitioner) notified of results immediately. No new orders received at this time. Plan of [sic]is ongoing. The facility's nursing notes for R8 dated 11/20/2024 AT 10:56 a.m. documented Note Text: Order recvd (received) from (Name of Nurse Practitioner) to send resident to (Name of Hospital) for evaluation and treatment Fracture of left femur. R/P (responsible party) (Name of Responsible Party) notified of xray (X-ray) results and transfer to (Name of Hospital) via (by) EMS (emergency medical services). The (Name of Hospital) Emergency Department Visit Note for R8 dated 11/20/2024 documented in part, The patient is a [AGE] year old female who is seen in the Emergency Department for hip fracture. General Appearance: no apparent distress, normally reactive to environment (Baseline according to nursing. On 10/21/2025 at approximately 10:27 a.m. a telephone interview was conducted with OSM (other staff member) #2, workflow coordinator for (Name of X-ray Company). When asked to describe the procedure for contacting a nursing home for X-ray results he stated that if the results have a positive finding (fracture) they call the facility the same day with the results. When asked about notifying the facility with the findings of the X-ray taken on 11/19/2024 OSM #2 stated that (Name of X-ray Company) records indicated that the facility was notified of R8's fracture on 11/19/2024 and that they spoke to (Name of Registered Nurse #5). OSM #2 was asked if he would provide a copy of the record documenting the (Name of X-ray Company's) contact with RN #5. He stated that the request for the document would be sent to his supervisor and have the supervisor contact the surveyor. At the time of exit no further information or telephone call was received from (Name of X-ray Company). On 10/21/2025 at approximately 12:47 p.m. an interview was conducted with LPN (licensed practical nurse) #1. When asked to describe the procedure for a resident with a bruise that is identified as an injury of unknown origin she stated that the director of nursing, nurse practitioner and responsible party are notified of the injury, assess for pain level and conduct a head-to-to-toe assessment. She also stated that if the physician or nurse practitioner orders an X-ray it is scheduled and obtain as soon as possible with the X-ray company. When asked about receiving the results of a resident's X-ray she stated that the X-ray company calls the facility if the results indicate a broken bone or fracture. When asked what a nurse should do if a phone call has not been received from the X-ray company by the end of the day that the X-ray was obtained she stated that the nurse should call the X-ray company for the results. After reviewing the nurse's notes and X-ray report for R8 LPN #1 stated that the nurse should have called the X-ray company for the result. LPN #1 agreed that there was

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on staff interview, facility document review, and clinical record review, the facility staff failed to provide adequate supervision for three of 14 residents in the survey sample, Residents #2, #11, and #6.The findings include:1. For R2, facility staff failed to provide supervision to prevent playing with and ingesting fecal material. R2 was admitted to the facility with diagnosis that included but was not limited to bipolar disorder (1) and dementia (2). On the most recent comprehensive MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 09/13/2025, R2 scored 0 (zero) out of 15 on the BIMS (brief interview for mental status), indicating R2 was severely impaired of cognition for making daily decisions. The Psychiatric Note for R2 dated 09/27/2025 documented in part, Relevant Interval History (Symptoms) Staff reported observing concerning behavior where the patient had a bowel movement and was subsequently playing with and eating her own feces, though the timing of when this behavior started is uncertain. The patient does not exhibit any anxiety, depression, delusional thoughts, or hallucinations at this time . Review of R2's comprehensive care plan dated 11/12/2024 failed to evidence documentation to address behaviors of play with and ingesting fecal material. Review of R2's clinical record failed to evidence documentation of R2 playing with or ingesting fecal material and failed to evidence a plan for supervision to prevent R2 from engaging in playing with or ingesting fecal material. On 10/20/2025 at approximately 3:50 p.m. an interview was conducted with CNA (certified nursing assistant) #1 regarding R2. CNA #1 stated she was usually assigned and provided care to R2. When asked if she recalled an incident of R2 ingesting feces CNA #1 stated yes. She further stated that R2 frequently puts her hands in her pants and removes feces and having it on her hands and lips. CNA #1 also stated that even after being toileted R2 would engage in the behavior of removing fecal material with her hands. When asked if she was aware of a plan or supervision to prevent R2 from removing and ingesting feces she stated no. On 10/20/2025 at approximately 4:00 p.m. an interview was conducted with CNA (certified nursing assistant) #2 regarding R2. CNA #2 stated she was usually assigned and provided care to R2. When asked if she recalled an incident of R2 ingesting feces CNA #2 stated yes. She further stated that R2 frequently puts her hands in her pants and removes feces and ingests it . CNA #2 also stated that even after being toileted R2 would engage in the behavior of removing fecal material with her hands. When asked if she was aware of a plan to prevent R2 from removing and ingesting feces she stated that when she sees R2 reaching into her pant CNA #2 stated she intervenes and either redirects R2 or takes her to the bathroom. When asked if she was aware of a plan or supervision to prevent R2 from removing and ingesting feces she stated no. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/21/2025 at approximately 12:39 p.m. an interview was conducted with LPN (licensed practical nurse) #1 regarding R2 playing with and ingesting feces. LPN #1 stated she was aware of two incidences of R2 playing with her feces with her hands and one of the incidences LPN #1 witnessed. When asked if she was aware of a plan or supervision to prevent R2 from removing and ingesting feces she stated no. The facility's policy Safety and Supervision of Residents documented in part, Individualized, Resident-Centered Approach to Safety. 1. Our individualized, resident-centered approach to safety addresses safety and accident hazards for individual residents. 2. The interdisciplinary care team will analyze information obtained from assessments and observations to identify any specific accident hazards or risks for individual residents. 3. The care team will target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices. 4. Implementing interventions to reduce accident risks and hazards shall include the following: a. Communicating specific interventions to all relevant staff; b. Assigning responsibility for carrying out interventions; c. Providing training, as necessary; d. Ensuring that interventions are implemented; and e. Documenting interventions. On 10/21/2025 at approximately 3:05 p.m. ASM (administrative staff member) #1, administrator, ASM #2, director of nursing, ASM #3, regional director of clinical operations and ASM #4 risk nurse, were made aware of the above findings. No further information was provided prior to exit. Reference: (1) A brain disorder that causes unusual shifts in mood, energy, activity levels, and the ability to carry out day-to-day tasks. This information was obtained from the website: https://www.nimh.nih.gov/health/topics/bipolar-disorder/index.shtml. (2) A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm. 2. For Resident #11 (R11), the facility failed to provide adequate supervision. On 5/27/25, R11 grabbed the collar of Resident #10's (R10's) shirt. A final facility synopsis of events dated 6/3/25 documented actions taken were a room change and one on one supervision, but these interventions were not implemented until 6/3/25, after R11 was involved in a physical altercation with Resident #12 (R12). R11's comprehensive care plan initiated on 2/27/25 documented, BEHAVIORS: (R11) has behaviors of anxiety, related to dementia, bipolar disorder, depression. (R11) noted to have periods of agitation AND aggression. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of R11's clinical record revealed a nurse's note dated 5/27/25 that documented, Please describe the behavior demonstrated: Resident grabbed resident (R10) by her shirt. Resident was redirected by multiple staff to release (R10) shirt. Describe any Interventions attempted: Resident redirected to his room. N/P (Nurse Practitioner) (name) notified, R/P (Responsible Party) (name) notified. Per Unit Manager Psych (Psychiatric) NP (Nurse Practitioner) notified via Email [sic]. An initial facility synopsis dated 5/27/25 documented, It is alleged that resident (R11) grabbed the collar of resident (R10's) shirt and would not let go. Residents immediately separated by staff and assessed for injury. No injuries were noted. Admin (Administrator) and DON (Director of Nursing) notified. Further review of R11's clinical record revealed the below nurses' notes regarding R11's behaviors after the 5/27/25 incident: 5/28/25- Resident was trying to communicate that he wanted to shower, while a CNA (Certified Nursing Assistant) and the UM (Unit Manager) were talking. Resident became irritated because he thought he was being ignored and kicked the half door at the nursing station. 5/29/25- Please describe the behavior demonstrated: Took assignment book from desk .Describe any Interventions attempted: I asked him for the book back. He cursed at me and went into his room and shut the door. He later was sitting in the dining (room) with the book. A CNA asked him for the book and he refused to give it to her and cursed at her. Night supervisor made aware. 5/29/25- Spent the majority of the night walking the halls. Denies having the assignment book. Night supervisor aware. 5/29/25- Please describe the behavior demonstrated: Asked for water and then threw the cup of water over the desk onto the floor. 5/29/25- Please describe the behavior demonstrated: Resident is opening other residents [sic] doors and entering rooms .Describe any Interventions attempted: Redirected to his room but refused to enter, cursing, threatening, what he would do if we kept bothering him! 5/31/25- Please describe the behavior demonstrated: Resident stated to resident (number) daughter 'don't [sic] look at me or I'll put your head through the f***ing window .' Describe any Interventions attempted: Resident redirected to his room with a snack/juice Ativan (anti-anxiety medication) 0.5 mg (milligrams) po (by mouth). 6/1/25- Please describe the behavior demonstrated: Resident approached resident (number) family member in her personal space. Family member was standing up talking to resident (number) in dining room when (R11) approached her .Describe any Interventions attempted: Resident redirected to a chair in the dining room, snack provided. 6/1/25- Please describe the behavior demonstrated: Resident took resident (number) by her elbow and attempted to assist her to stand from her wheelchair .Describe any Interventions attempted: Residents separated. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6/2/25- Please describe the behavior demonstrated: Resident attempted to slap resident (number) hand. Verbally threatened resident (number) with physical harm .Describe any Interventions attempted: offered snacks in room. 6/3/25- Please describe the behavior demonstrated: Resident standing at nurses [sic] station and noted to come into contact with resident (number) .Describe any Interventions attempted: Residents immediately separated to different areas of unit. Resident pacing unit, unable to redirect resident to his room for rest/snacks. Lorazepam (anti-anxiety medication) 0.5 mg PO administered NP (Nurse Practitioner) (name) notified. Notification for psych (psychiatry) in notebook. R/P (Responsible Party) (name) notified. 6/3/25- Spoke with resident's guardian, (name). Offered room change to south unit with wander guard placement. Staff notes that resident seems to be triggered by other resident's behaviors and is acting as a 'protector' by his perceptions of interactions. South (unit) may be a more suitable environment. Guardian agreeable to trialing room change with initial 1:1 (one on one) supervision to decrease behaviors. A final facility synopsis of events regarding the 5/27/25 incident and dated 6/3/25 documented, On May 27, 2025, staff witnessed resident (R11), grab onto another resident's shirt collar and would not let go. The other resident was identified as (R10). Staff was able to separate the residents and redirect. No injuries were noted. No other residents were affected. Actions Taken .Room change to south unit for less stimulating environment with 1:1 (one on one) supervision pending follow-up with psych. Further review of R11's clinical record revealed the resident was not moved to the South Unit or provided one on one supervision until after another incident on 6/3/25. An initial facility synopsis of events dated 6/3/25 documented, It is alleged that (R12) grabbed (R13's) hair. (R11) and (R12) exchanged physical contact with their hands. Residents immediately separated and assessed for injury. DON (Director of Nursing) and admin (Administrator) notified. A witness statement signed by CNA (Certified Nursing Assistant) #3 on 6/3/25 documented, I was inside the nurse station area when (R12) was drinking water out of a plastic cup. Then suddenly, (R13) approached (R12) and snatched his water from his hands. In response, (R12) shouted at her and grabbed her by the hair. At that point (R11) trying [sic] to intervene and attepting [sic] to restrain (R12) grabbed him by the neck, hoping to protect (R13). A witness statement signed by RN (Registered Nurse) #4 on 6/3/25 documented, This writer noticed another resident (R12) come up to (R13) and grabbed her hair. This writer attempted to dissolve situation. (R12) would not let go of (R13's) hair. When another resident (R11) stepped in and attacked (R12) in attempts to defend (R13) . A final facility synopsis of events regarding the 6/3/25 incident and dated 6/10/25 documented, (R12) was drinking a cup of water on the memory care unit, when a female resident, (R13) approached him and took the cup of water from his hands. In response, (R12) yelled at her and grabbed her by the hair. (R11) attempted to intervene to protect (R13), he grabbed (R12) trying to stop him from hurting (R13). No injuries noted. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. Building B. Wing	10/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookside Rehab & Nursing Center	614 Hastings Lane Warrenton, VA 20186

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/20/2025 at 3:58 p.m., an interview was conducted with CNA #1. CNA #1 stated R11 was very aggressive, and staff were afraid of the resident. CNA #1 stated there were not enough staff to supervise R11 and incidents happened. On 10/21/25 at 8:55 a.m., an interview was conducted with ASM (Administrative Staff Member) #1 (the Administrator). ASM #1 stated R11 there was no evidence that R11 was placed on one-on-one supervision until the resident was trialed a room change on 6/3/25. ASM #1 stated that sometimes R11 was agreeable to one-on-one supervision but sometimes the supervision triggered the resident and made his behaviors worse. ASM #1 stated one on one supervision was implemented based on the situations but there was no documentation regarding the decision making for this. On 10/21/25 at 12:26 p.m., an interview was conducted with LPN (Licensed Practical Nurse) #1. LPN #1 stated R11 was a strong, large, tall, big built man, and multiple staff had to assist her with removing the resident from R10 on 5/27/25. LPN #1 stated a lot of activity occurs in the dining room on the North (memory care) Unit and the stimulation upset R11. LPN #1 stated R11 was only provided one on one supervision at times, and she did not recall the supervision triggering any behaviors. On 10/21/25 at 1:12 p.m., an interview was conducted with LPN #2. LPN #2 stated R11 could be really nice then would turn aggressive, on a dime. LPN #2 stated R11 was big, strong, fast, and scary. LPN #2 stated she occasionally provided one on one supervision for R11, and this did not trigger the resident's aggression as long as she didn't stay on top of the resident. LPN #2 stated it was important for R11 to receive adequate supervision because the resident was dangerous, but residents wandered on the North Unit and staff were not always able to keep their eyes on the residents all the time. On 10/21/25 at 3:11 p.m., ASM #1, and ASM #2 (the Director of Nursing) were made aware of the above concerns. ASM #1 stated R11's room change to another unit was not made until 6/3/25 because the interdisciplinary team came together to brainstorm and review the resident's care. ASM #1 stated the team was hesitant to change R11's environment. ASM #1 stated one-on-one supervision agitated R11 so the decision to implement one on one supervision was made on a case-by-case basis. No further information was presented prior to exit. 3. For Resident #6 (R6), the facility staff failed to provide adequate supervision to prevent multiple resident to resident incidents. On 1/24/25, R6 was found in another resident room, slapping Resident #7 (R7). On 1/26/25, R6 was found lying in Resident #4's (R4's) bed with R4. On 2/26/25, R6 was found in another resident bathroom slapping Resident #1 (R1), and on 3/20/25, R6 was found in another resident room hitting Resident #14 (R14). R6's comprehensive care plan revised on 2/28/24 documented, (R6) was involved in a resident-to-resident altercation .Monitor resident closely and anticipate needs. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of R6's clinical record revealed a nurse's note dated 1/24/25 that documented, Resident found across the hall in another residents [sic] room. Witnessed by staff, both were slapping at each other, pushing each other, pulling hair. Immediately separated and assessed for injuries, none found. RPs (Responsible Parties), Geri-pysch [psychiatry], DON (Director of Nursing), and unit manager notified/aware. A review of R7's clinical record revealed a nurse's note dated 1/24/25 that documented, Resident (R6) entered residents [sic] room and residents began slapping each other. Residents were immediately separated. Resident assessed for injury no injury noted. Geri psych NP (Nurse Practitioner), NP (name) notified Unit Manager, R/P (name) notified. Further review of R6's clinical record revealed a nurse's note dated 1/26/25 that documented, Please describe the behavior demonstrated: At 2000 (8:00 p.m.) this writer observed resident fully clothed lying in bed, with another male resident who was also fully clothed, in his room .Describe any Interventions attempted: Resident taken out of male resident's room . A review of R4's clinical record revealed a nurse's note dated 1/26/25 documented, Please describe the behavior demonstrated: Resident observed fully clothed with female resident, also fully clothed, laying down on top of his sheet on his bed .Describe any Interventions attempted: Separated residents immediately . Further review of R6's clinical record revealed a nurse's note dated 2/26/25 that documented, Resident was in anothers [sic] bathroom with another resident and they were slapping at each other. Residents immediately separated and assessed for injuries, none found. RP, NP and unit manager notified. A review of R1's clinical record revealed a nurse's note dated 2/26/25 that documented, Resident exhibiting aggressive behaviors toward other residents, by biting, hitting and slapping. Immediately separated and all involved assessed for injuries, none found. RP (name) notified. NP notified, arrived to unit and prescribed ativan (anti-anxiety medication) 0.5 mg (milligrams) PO (by mouth) stat. Resident was medicated and placed on 1;1 (one on one supervision) observation for safety. Further review of R6's clinical record revealed a nurse's note dated 3/20/25 that documented, This nurse was informed by a staff member that the resident had hit another resident (R14) on her back when she had told her to get out of her room .This nurse did not witness the incident. This nurse approached resident (R6) and redirected her back into her room. Resident (R6) has no recollection of what had happened. Skin assessment completed and no injuries at this time .UM (Unit Manager), DON, NP, RP and the Administrator all informed on all parties involved. Police notified. Labs were drawn for residents [sic] agitation and aggressive behavior. Will continue to monitor. A review of R14's clinical record revealed a nurse's note dated 3/20/25 that documented, (R14) was noted to be in an altercation with another resident .dayshift nurse caring for resident noted to have informed RP of incident and per Dayshift nurse assigned to resident no new injuries at this time. On 10/20/25 at 3:58 p.m., an interview was conducted with CNA (Certified Nursing Assistant) #1. CNA #1 stated it's hard to monitor every resident going into every resident's room. CNA #1 stated when there is less staff, each CNA has a bigger assignment and has less time to supervise residents because the CNAs are providing care in resident rooms and can't be in the dining room or halls to supervise residents going in and out of other resident rooms. On 10/21/25 at 12:26 p.m., an interview was conducted with LPN (Licensed Practical Nurse) #1. LPN #1 stated R6 wandered into other resident rooms multiple times a week and could be combative. LPN #1 stated if the unit census was full (60 residents), staff wasn't always able to keep R6 out of other resident rooms. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/21/25 at 1:12 p.m., an interview was conducted with LPN #2. LPN #2 stated R6 was always protective of her space, even if it wasn't her space. LPN #2 stated R6 was always easily agitated and very confrontational. LPN #2 stated residents wander on the North Unit and staff are not always able to keep their eyes on the residents all the time. LPN #2 stated it was important to provide adequate supervision for R6 and to keep all residents safe. On 10/21/25 at 3:11 p.m., ASM (Administrative Staff Member) #1, (the Administrator) and ASM #2 (the Director of Nursing) were made aware of the above concerns. No further information was presented prior to exit.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on staff interview, facility document review, and clinical record review, the facility staff failed to provide sufficient nursing staff for three of 14 residents in the survey sample, Residents #2, #11, and #6.The findings include:1. For R2, facility staff failed to provide sufficient nursing staff to prevent playing with and ingesting fecal material. R2 was admitted to the facility with diagnosis that included but was not limited to bipolar disorder (1) and dementia (2). On the most recent comprehensive MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 09/13/2025, R2 scored 0 (zero) out of 15 on the BIMS (brief interview for mental status), indicating R2 was severely impaired of cognition for making daily decisions. The Psychiatric Note for R2 dated 09/27/2025 documented in part, Relevant Interval History (Symptoms) Staff reported observing concerning behavior where the patient had a bowel movement and was subsequently playing with and eating her own feces, though the timing of when this behavior started is uncertain. The patient does not exhibit any anxiety, depression, delusional thoughts, or hallucinations at this time . Review of R2's comprehensive care plan dated 11/12/2024 failed to evidence documentation to address behaviors of play with and ingesting fecal material. Review of R2's clinical record failed to evidence documentation of R2 playing with or ingesting fecal material and failed to evidence a plan for supervision to prevent R2 from engaging in playing with or ingesting fecal material. On 10/20/2025 at approximately 3:50 p.m. an interview was conducted with CNA (certified nursing assistant) #1 regarding R2. CNA #1 stated she worked on the North Wing and was usually assigned and provided care to R2. When asked if she recalled an incident of R2 ingesting feces CNA #1 stated yes. She further stated that R2 frequently puts her hands in her pants and removes feces and having it on her hands and lips. CNA #1 also stated that even after being toileted R2 would engage in the behavior of removing fecal material with her hands. 1. CNA #1 stated staff sufficiency depended on the day, weekends were the worst, and more incidents occurred on the weekends. CNA #1 stated that when there is less staff, each CNA has a bigger assignment and has less time to supervise residents. CNA #1 stated it is impossible to supervise residents unless there is an adequate number of staff. When asked if there were enough staff to monitor R2 from engaging in removal and ingesting feces CNA #1 stated no. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/20/2025 at approximately 4:00 p.m. an interview was conducted with CNA (certified nursing assistant) #2 regarding R2. CNA #2 stated she worked on the North Wing and was usually assigned and provided care to R2. When asked if she recalled an incident of R2 ingesting feces CNA #2 stated yes. She further stated that R2 frequently puts her hands in her pants and removes feces and ingests it . CNA #2 also stated that even after being toileted R2 would engage in the behavior of removing fecal material with her hands. When asked if she was aware of a plan to prevent R2 from removing and ingesting feces she stated that when she sees R2 reaching into her pant CNA #2 stated she intervenes and either redirects R2 or takes her to the bathroom. When asked if there were enough staff to monitor R2 from engaging in removal and ingesting feces CNA #2 stated no. On 10/21/2025 at approximately 12:39 p.m. an interview was conducted with LPN (licensed practical nurse) #1 regarding R2 playing with and ingesting feces. LPN #1 stated she worked on the North Wing and was aware of two incidences of R2 playing with her feces with her hands and one of the incidences LPN #1 witnessed. LPN #1 stated there have been times that there was not sufficient staff and staff were not able to provide adequate supervision. On 10/21/25 at 1:12 p.m., an interview was conducted with LPN #2. LPN #2 stated that in the past, staffing was awful and there were not enough staff to monitor residents and supervise each area of the unit. The facility's policy Staffing documented in part, Our facility provides sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents in accordance with resident care plans and the facility assessment. On 10/21/2025 at approximately 3:05 p.m. ASM (administrative staff member) #1, administrator, ASM #2, director of nursing, ASM #3, regional director of clinical operations and ASM #4 risk nurse, were made aware of the above findings. No further information was provided prior to exit. Reference: (1) A brain disorder that causes unusual shifts in mood, energy, activity levels, and the ability to carry out day-to-day tasks. This information was obtained from the website: https://www.nimh.nih.gov/health/topics/bipolar-disorder/index.shtml. (2) A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm. 2. For Resident #11 (R11), the facility failed to provide sufficient nursing staff for adequate supervision of the resident. On 5/27/25, R11 grabbed the collar of Resident #10's (R10's) shirt. A final facility synopsis of events dated 6/3/25 documented actions taken were a room change and one on one supervision, but these interventions were not implemented until 6/3/25, after R11 was involved in a physical altercation with Resident #12 (R12). (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of R11's clinical record revealed a nurse's note dated 5/27/25 that documented, Please describe the behavior demonstrated: Resident grabbed resident (R10) by her shirt. Resident was redirected by multiple staff to release (R10) shirt. Describe any Interventions attempted: Resident redirected to his room. N/P (Nurse Practitioner) (name) notified, R/P (Responsible Party) (name) notified. Per Unit Manager Psych (Psychiatric) NP (Nurse Practitioner) notified via Email [sic]. An initial facility synopsis dated 5/27/25 documented, It is alleged that resident (R11) grabbed the collar of resident (R10's) shirt and would not let go. Residents immediately separated by staff and assessed for injury. No injuries were noted. Admin (Administrator) and DON (Director of Nursing) notified. Further review of R11's clinical record revealed the below nurses' notes regarding R11's behaviors after the 5/27/25 incident: 5/28/25- Resident was trying to communicate that he wanted to shower, while a CNA (Certified Nursing Assistant) and the UM (Unit Manager) were talking. Resident became irritated because he thought he was being ignored and kicked the half door at the nursing station. 5/29/25- Please describe the behavior demonstrated: Took assignment book from desk .Describe any Interventions attempted: I asked him for the book back. He cursed at me and went into his room and shut the door. He later was sitting in the dining (room) with the book. A CNA asked him for the book and he refused to give it to her and cursed at her. Night supervisor made aware. 5/29/25- Spent the majority of the night walking the halls. Denies having the assignment book. Night supervisor aware. 5/29/25- Please describe the behavior demonstrated: Asked for water and then threw the cup of water over the desk onto the floor. 5/29/25- Please describe the behavior demonstrated: Resident is opening other residents [sic] doors and entering rooms .Describe any Interventions attempted: Redirected to his room but refused to enter, cursing, threatening, what he would do if we kept bothering him! 5/31/25- Please describe the behavior demonstrated: Resident stated to resident (number) daughter 'don't [sic] look at me or I'll put your head through the f***ing window .' Describe any Interventions attempted: Resident redirected to his room with a snack/juice Ativan (anti-anxiety medication) 0.5 mg (milligrams) po (by mouth). 6/1/25- Please describe the behavior demonstrated: Resident approached resident (number) family member in her personal space. Family member was standing up talking to resident (number) in dining room when (R11) approached her .Describe any Interventions attempted: Resident redirected to a chair in the dining room, snack provided. 6/1/25- Please describe the behavior demonstrated: Resident took resident (number) by her elbow and attempted to assist her to stand from her wheelchair .Describe any Interventions attempted: Residents separated. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6/2/25- Please describe the behavior demonstrated: Resident attempted to slap resident (number) hand. Verbally threatened resident (number) with physical harm .Describe any Interventions attempted: offered snacks in room. 6/3/25- Please describe the behavior demonstrated: Resident standing at nurses [sic] station and noted to come into contact with resident (number) .Describe any Interventions attempted: Residents immediately separated to different areas of unit. Resident pacing unit, unable to redirect resident to his room for rest/snacks. Lorazepam (anti-anxiety medication) 0.5 mg PO administered NP (Nurse Practitioner) (name) notified. Notification for psych (psychiatry) in notebook. R/P (Responsible Party) (name) notified. 6/3/25- Spoke with resident's guardian, (name). Offered room change to south unit with wander guard placement. Staff notes that resident seems to be triggered by other resident's behaviors and is acting as a 'protector' by his perceptions of interactions. South (unit) may be a more suitable environment. Guardian agreeable to trialing room change with initial 1:1 (one on one) supervision to decrease behaviors. A final facility synopsis of events regarding the 5/27/25 incident and dated 6/3/25 documented, On May 27, 2025, staff witnessed resident (R11), grab onto another resident's shirt collar and would not let go. The other resident was identified as (R10). Staff was able to separate the residents and redirect. No injuries were noted. No other residents were affected. Actions Taken .Room change to south unit for less stimulating environment with 1:1 (one on one) supervision pending follow-up with psych. Further review of R11's clinical record revealed the resident was not moved to the South Unit or provided one on one supervision until after another incident on 6/3/25. An initial facility synopsis of events dated 6/3/25 documented, It is alleged that (R12) grabbed (R13's) hair. (R11) and (R12) exchanged physical contact with their hands. Residents immediately separated and assessed for injury. DON (Director of Nursing) and admin (Administrator) notified. A witness statement signed by CNA (Certified Nursing Assistant) #3 on 6/3/25 documented, I was inside the nurse station area when (R12) was drinking water out of a plastic cup. Then suddenly, (R13) approached (R12) and snatched his water from his hands. In response, (R12) shouted at her and grabbed her by the hair. At that point (R11) trying [sic] to intervene and attepting [sic] to restrain (R12) grabbed him by the neck, hoping to protect (R13). A witness statement signed by RN (Registered Nurse) #4 on 6/3/25 documented, This writer noticed another resident (R12) come up to (R13) and grabbed her hair. This writer attempted to dissolve situation. (R12) would not let go of (R13's) hair. When another resident (R11) stepped in and attacked (R12) in attempts to defend (R13) . A final facility synopsis of events regarding the 6/3/25 incident and dated 6/10/25 documented, (R12) was drinking a cup of water on the memory care unit, when a female resident, (R13) approached him and took the cup of water from his hands. In response, (R12) yelled at her and grabbed her by the hair. (R11) attempted to intervene to protect (R13), he grabbed (R12) trying to stop him from hurting (R13). No injuries noted. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/20/2025 at 3:58 p.m., an interview was conducted with CNA #1. CNA #1 stated R11 was very aggressive, and staff were afraid of the resident. CNA #1 stated there were not enough staff to supervise R11 and incidents happened. CNA #1 stated staff sufficiency depended on the day, weekends were the worst, and more incidents occurred on the weekends. CNA #1 stated it's hard to monitor every resident going into every resident's room. CNA #1 stated that when there is less staff, each CNA has a bigger assignment and has less time to supervise residents. CNA #1 stated it is impossible to supervise residents unless there is an adequate number of staff. On 10/21/25 at 8:55 a.m., an interview was conducted with ASM (Administrative Staff Member) #1 (the Administrator). ASM #1 stated R11 there was no evidence that R11 was placed on one-on-one supervision until the resident was trialed a room change on 6/3/25. ASM #1 stated one-on-one supervision triggered R11's behaviors and was implemented based on the situations but there was no documentation regarding the decision making for this. On 10/21/25 at 12:26 p.m., an interview was conducted with LPN (Licensed Practical Nurse) #1. LPN #1 stated there have been times that there was not sufficient staffing and staff were not able to provide adequate supervision. LPN #1 stated R11 was a strong, large, tall, big built man, and multiple staff had to assist her with removing the resident from R10 on 5/27/25. LPN #1 stated a lot of activity occurs in the dining room on the North (memory care) Unit and the stimulation upset R11. LPN #1 stated R11 was only provided one on one supervision at times, and she did not recall the supervision triggering any behaviors. On 10/21/25 at 1:12 p.m., an interview was conducted with LPN #2. On 10/21/25 at 1:12 p.m., an interview was conducted with LPN #2. LPN #2 stated residents wander on the North Unit and staff are not always able to keep their eyes on the residents all the time. LPN #2 stated that in the past, staffing was awful and there were not enough staff to monitor residents and supervise each area of the unit. LPN #2 stated R11 could be really nice then would turn aggressive, on a dime. LPN #2 stated R11 was big, strong, fast, and scary. LPN #2 stated she occasionally provided one on one supervision for R11, and this did not trigger the resident's aggression as long as she didn't stay on top of the resident. LPN #2 stated it was important for R11 to receive adequate supervision because the resident was dangerous, but residents wandered on the North Unit and staff were not always able to keep their eyes on the residents all the time. On 10/21/25 at 3:11 p.m., ASM #1, and ASM #2 (the Director of Nursing) were made aware of the above concerns. ASM #1 stated R11's room change to another unit was not made until 6/3/25 because the interdisciplinary team came together to brainstorm and review the resident's care. ASM #1 stated the team was hesitant to change R11's environment. ASM #1 stated one-on-one supervision agitated R11 so the decision to implement one on one supervision was made on a case-by-case basis. No further information was presented prior to exit. 3. For Resident #6 (R6), the facility staff failed to provide sufficient staffing to prevent multiple resident to resident incidents. On 1/24/25, R6 was found in another resident room, slapping Resident #7 (R7). On 1/26/25, R6 was found lying in Resident #4's (R4's) bed with R4. On 2/26/25, R6 was found in another resident bathroom slapping Resident #1 (R1), and on 3/20/25, R6 was found in another resident room hitting Resident #14 (R14). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. Building B. Wing	10/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookside Rehab & Nursing Center	614 Hastings Lane Warrenton, VA 20186

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of R6's clinical record revealed a nurse's note dated 1/24/25 that documented, Resident found across the hall in another residents [sic] room. Witnessed by staff, both were slapping at each other, pushing each other, pulling hair. Immediately separated and assessed for injuries, none found. RPs (Responsible Parties), Geri-pysch [psychiatry], DON (Director of Nursing), and unit manager notified/aware. A review of R7's clinical record revealed a nurse's note dated 1/24/25 that documented, Resident (R6) entered residents [sic] room and residents began slapping each other. Residents were immediately separated. Resident assessed for injury no injury noted. Geri psych NP (Nurse Practitioner), NP (name) notified Unit Manager, R/P (name) notified. Further review of R6's clinical record revealed a nurse's note dated 1/26/25 that documented, Please describe the behavior demonstrated: At 2000 (8:00 p.m.) this writer observed resident fully clothed lying in bed, with another male resident who was also fully clothed, in his room .Describe any Interventions attempted: Resident taken out of male resident's room . A review of R4's clinical record revealed a nurse's note dated 1/26/25 documented, Please describe the behavior demonstrated: Resident observed fully clothed with female resident, also fully clothed, laying down on top of his sheet on his bed .Describe any Interventions attempted: Separated residents immediately . Further review of R6's clinical record revealed a nurse's note dated 2/26/25 that documented, Resident was in anothers [sic] bathroom with another resident and they were slapping at each other. Residents immediately separated and assessed for injuries, none found. RP, NP and unit manager notified. A review of R1's clinical record revealed a nurse's note dated 2/26/25 that documented, Resident exhibiting aggressive behaviors toward other residents, by biting, hitting and slapping. Immediately separated and all involved assessed for injuries, none found. RP (name) notified. NP notified, arrived to unit and prescribed ativan (anti-anxiety medication) 0. 5 mg (milligrams) PO (by mouth) stat. Resident was medicated and placed on 1;1 (one on one supervision) observation for safety. Further review of R6's clinical record revealed a nurse's note dated 3/20/25 that documented, This nurse was informed by a staff member that the resident had hit another resident (R14) on her back when she had told her to get out of her room .This nurse did not witness the incident. This nurse approached resident (R6) and redirected her back into her room. Resident (R6) has no recollection of what had happened. Skin assessment completed and no injuries at this time .UM (Unit Manager), DON, NP, RP and the Administrator all informed on all parties involved. Police notified. Labs were drawn for residents [sic] agitation and aggressive behavior. Will continue to monitor. A review of R14's clinical record revealed a nurse's note dated 3/20/25 that documented, (R14) was noted to be in an altercation with another resident .dayshift nurse caring for resident noted to have informed RP of incident and per Dayshift nurse assigned to resident no new injuries at this time. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. Building B. Wing	10/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/20/25 at 3:58 p.m., an interview was conducted with CNA (certified nursing assistant) #1. CNA #1 stated staff sufficiency depended on the day, weekends were the worst, and more incidents occurred on the weekends. CNA #1 stated it's hard to monitor every resident going into every resident's room. CNA #1 stated when there is less staff, each CNA has a bigger assignment and has less time to supervise residents because the CNAs are providing care in resident rooms and can't be in the dining room or halls to supervise residents going in and out of other resident rooms. CNA #1 stated it is impossible to supervise residents unless there is an adequate number of staff. On 10/21/25 at 12:26 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated R6 wandered into other resident rooms multiple times a week and could be combative. LPN #1 stated if the unit census was full (60 residents), staff wasn't always able to keep R6 out of other resident rooms. LPN #1 stated there have been times that there was not sufficient staffing and staff were not able to provide adequate supervision. On 10/21/25 at 1:12 p.m., an interview was conducted with LPN #2. LPN #2 stated R6 was always protective of her space, even if it wasn't her space. LPN #2 stated R6 was always easily agitated and very confrontational. LPN #2 stated residents wander on the North Unit and staff are not always able to keep their eyes on the residents all the time. LPN #2 stated it was important to provide adequate supervision for R6 and to keep all residents safe but in the past, staffing was awful and there were not enough staff to monitor residents and supervise each area of the unit. On 10/21/25 at 3:11 p.m., ASM (Administrative Staff Member) #1, (the Administrator) and ASM #2 (the Director of Nursing) were made aware of the above concerns. No further information was presented prior to exit.