DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 03/14/20 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVI OMB NO. 0938-03 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING COMPLETED C 495401 B. WING NAME OF PROVIDER OR SUPPLIER 03/02/2017 STREET ADDRESS, CITY, STATE, ZIP CODE TYLER'S RETREAT AT IRON BRIDGE 12001 IRON BRIDGE RD CHESTER, VA 23831 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5)**PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG COMPLETION TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 000 INITIAL COMMENTS F 000 An unannounced Medicare/Medicaid standard survey was conducted 2/28/17 through 3/2/17. A complaint was investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care RECEIVED requirements. The Life Safety Code survey/report will follow. MAR 29 2017 The census in this 90 certified bed facility was 87 at the time of the survey. The survey sample VDH/OLC consisted of 16 current Resident reviews (Residents #1 through #15 and #22) and six closed record reviews (Residents #16 through #21). F 157 483.10(g)(14) NOTIFY OF CHANGES F 157 SS=D F 157 SS=D ((INJURY/DECLINE/ROOM, ETC) The facility will ensure that the physician is notified of changes in resident's condition. (g)(14) Notification of Changes. 1. Address how corrective action will be (i) A facility must immediately inform the resident; accomplished for those residents found to consult with the resident's physician; and notify, have been affected by the deficient consistent with his or her authority, the resident practice. representative(s) when there isa. Resident #7's physician was notified of blood pressure outside of parameters on (A) An accident involving the resident which 3/1/17. MD did not give any new orders. 3/31/17 results in injury and has the potential for requiring b. Resident #7's physician was notified of her physician intervention; weight and gave a new order for weights x 3 days. (B) A significant change in the resident's physical, 3/31/17 mental, or psychosocial status (that is, a 2. Address how the facility will identify deterioration in health, mental, or psychosocial other residents having the potential to be status in either life-threatening conditions or affected by the same deficient practice. clinical complications); a. Residents with Blood Pressure parameters will have their charts reviewed by the RN (C) A need to alter treatment significantly (that is, Unit Manager / designee to ensure MD order a need to discontinue an existing form of parameters are being followed and MD is treatment due to adverse consequences, or to notified.

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

TITLE

(X6) DATE

3/31/17

6. Kran

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

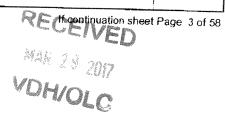
PRINTED: 03/14/201 FORM APPROVE

STATEMENT OF DEF CIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(Y2) MU	TIPLE CONSTRUCTION	<u> </u>
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:		(X3) DATE SURVEY COMPLETED	
			ING	С
k. F. & B. T. A. F.	495401	B. WING	A	03/02/2017
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 03/02/2017
TYLER'S RETREAT AT IRON!	BRIDGE	1	12001 IRON BRIDGE RD	
			CHESTER, VA 23831	
PREFIX (EACH DEFICIENCY	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)	DRE COMPLETE
F 157 Continued From pa	ne 1		h Residents found in the	oc out
commence a new fe	orm of treatment); or	F 15	of Parameters will have their MD notifi	ied hy
			a morning mini tollow fib as	led by
(D) A decision to tra	nsfer or discharge the		appropriate.	3/31/17
resident from the fac	cility as specified in		c. All residents with orders for weights have their weights reviewed by the RN	will
§483.15(c)(1)(ii).	;		wianager and any variation of 5lbs plue	or
′ (ii) When making no	tification under paragraph (g)		minus will have a reweight and interven	tions
(14)(I) of this section	the facility must ensure that		put into place per the registered dieticial Physician.	n/
all pertinent informat	ion specified in \$483 15(c)(2)		i nysician.	3/31/17
physician.	ided upon request to the		3. Address what measures will be put	into
,			place of systemic changes made to one	
(iii) The facility must	also promptly notify the		that the deficient practice will not rect a. Licensed Nurses will be in-serviced or	
when there is-	dent representative, if any,		Change in Resident condition, notification	n of
			physician policy and reweight policy by	ł
(A) A change in room	or roommate assignment		Director of Nursing / Designee by 4-1-17	4/1/17
as specified in §483.1	ru(e)(b); or		4. Indicate how the facility plans to	
(B) A change in reside	ent rights under Federal or		monitor its performance to make sure	that
State law or regulation	ns as specified in paragraph		solutions are sustained.	
. (e)(10) of this section.			a. RN Unit Manager / designee will audit MAR's with parameters and/or weights for the MR.	5
(iv) The facility must re	ecord and periodically		MD notification per week for 4 weeks and	or
update the address (n	nailing and email) and		then monthly for 2 months	4/14/10
Phone number of the I	resident representative(s).	!	b. Unit Managers will report the results of	the
by:	is not met as evidenced		audits to the QAPI committee monthly for months.	1
Based on staff intervie	ew, facility document review	1	c. Audit results / trends will be reviewed a	4/14/17
and clinical record revi	ew, it was determined that		QAPI meeting to ensure that Action Plane	are
facility staff failed to no change in a resident's	Condition for any of 22		effective. Additional action plans will be done as needed.	
residents in the survey	sample, Resident #7.		- Avoided.	4/14/17
a. The Facility staff faile	ed to notify the physician			
higher than 150 as orde	stolic blood pressure was ered by the physician.			:
b. The Facility staff faile	ed to notify the physician of			
MS-2567(02-99) Previous Versions Obso	lete Event ID: J9DN11	Facili	ly ID: VA0402 If continue allow	



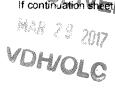
PRINTED: 03/14/20 FORM APPROVE

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	OF CONNECTION	IDENTIFICATION NUMBER:		A. BUILDING		
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	PROVIDER OR SUPPLIER RETREAT AT IRON I	BRIDGE	1	STREET ADDRESS, CITY, STATE, ZIP C 12001 IRON BRIDGE RD CHESTER, VA 23831	ODE 1 03	/02/2017
(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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 157	Continued From pa a 15 pound weight of for Resident #7.	ge 2 gain over a three day period	F 157		1	
Red	3/5/14 and readmitted that included but were fractured leg, demendelevated cholesterol. The most recent MD day assessment, with reference date) of 2/8 naving scored an 11 enterview for mental sizes moderately imparts and the resident was predicted in the resident was predicted in the physicial occurrented, "B/P (blocall MD (medical cood pressure) > (gredicted in the care place) in the care place with a size of the care place of the care of the care place of the care of the ca	admitted to the facility on ed on 1/25/17 with diagnoses re not limited to: arthritis, atia, high blood pressure and S (minimum data set), a 14 n an ARD (assessment 8/17 coded the resident as out of 15 on the brief tatus indicating the resident ired cognitively. The s requiring assistance from aily living except for eating s coded as able to do after pared. an's orders dated 2/8/17 pod pressure) Q (every) doctor) if SBP (systolic ater than) 150 and if DBP re is > 90."				
nc pro Re ad	ot evidence document essures. eview of the February ministration record) o	tation related to the blood 2017 TAR (treatment				
. Re	view of the TAR docu	and if DBP > 90. 2/8/17." umented the following to 3:00 p.m.) 190/80"	; ;			



PRINTED: 03/14/2011 **FORM APPROVE** OMB NO. 0938-0391

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIEF AND PLAN OF CORRECTION IDENTIFICATION NUM		(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495401	B. WING			C 3/03/2047
	PROVIDER OR SUPPLIEF RETREAT AT IRON	BRIDGE		STREET ADDRESS, CITY, STATE, Z 12001 IRON BRIDGE RD CHESTER, VA 23831	IP CODE	<u>3/02/2017</u>
(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 T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETIC DATE
th as photo in the control of the co	2/11/17"11-7 155 2/14/17 "11-7 156 2/17/17 "11-7 166 2/19/17 "7-3 155/ 2/25/17 "7-3 171/ 2/27/17,"7-3 166/ 2/28/17 "11-7 156 Review of the Febru Resident #7 did not the physician had be blood pressures. An interview was cop.m. with RN (registmanager. RN #6 rev February 2017 TAR When asked if it woo he physician was note. RN #6 reviewed notes. RN #6 stated, doctor." On 3/1/17 at 4:45 p.m. member) #1, the admirector of nursing we notings. In interview was com.m. with RN #7. regardings. In interview was com. with RN #7. regardings.	00 p.m. to 7:00 a.m.) 170/68" /63" - 4/74" 0/80" /74" /62"	F 1	57		
10440 0===	***************************************				Par Colombia	1



DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 03/14/2013 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING C 495401 B. WING 03/02/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE ZIP CODE 12001 IRON BRIDGE RD TYLER'S RETREAT AT IRON BRIDGE CHESTER, VA 23831 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 157 Continued From page 4 F 157 February 2017 TAR's for the blood pressures, RN #7 stated, "Yes I would call and let them (physician) know." When asked if that notification to the physician would be documented, RN #7 stated, "Absolutely. You're supposed to document everything." When asked why, RN #7 stated, "It's important because that's continuity of care. Anyone following you gets a clear picture of what's going on.' An interview was conducted on 3/2/17 at 11:30 a.m. with ASM (administrative staff member) #4, the nurse practitioner. When asked why she would order blood pressure parameters on a resident, ASM #4 stated, "Typically, I personally, would order those if I'd changed a medication. Also if they've come out of the hospital their medications are usually changed. As they recover things are going to normalize and they may need the medication back." An interview was conducted on 3/2/17 at 12:35 p.m. with LPN (licensed practical nurse) #6, regarding when staff would notify the physician, LPN #6 stated, "High blood pressure, low pressure. Any change in condition." When asked if staff would document that the physician was notified, LPN #6 stated, "I document it in the nurse's notes and on the 24 hour report." When asked why she documented the notification, LPN #6 stated, "Because they have parameters for a reason. The doctor may need to increase the dosage (of a medication). Something could be going on with them, they could have an infection."

Review of the facility's policy titled, "Change in Resident Condition" documented, "The Charge Nurse will recognize and appropriately intervene in the event of a change in resident condition.

DEPARTMENT OF HEALT	H AND HUMAN SERVICES RE & MEDICAID SERVICES			PRINTED: 03/14/2017 FORM APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD	LTIPLE CONSTRUCTION DING	CMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIEF TYLER'S RETREAT AT IRON			STREET ADDRESS, CITY, STATE, ZIP COD 12001 IRON BRIDGE RD CHESTER, VA 23831	03/02/2017 PE
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notified as soon as change in condition stablePROCEDUTE record in the reside relative to changes medical/mental con No further information. The physical responsible for displaying a patient. 1. b. Review of the physical responsible for displaying a patient. 1. b. Review of the physical responsible for displaying a patient. 1. b. Review of the physical responsible for displaying a patient. 1. b. Review of the physical responsible for displaying a patient. Review of the care physical responsible for displaying a patient of the physical responsible for displaying a patient. Review of the care physical responsible for the physical responsible for the physical responsible for displaying a patient. Review of the January (Wt. QD (everyday)) weight of 126 pounds 1/27/17 no weight was weight of 141 pounds pound weight gain. Review of the nurse's 1/30/17 did not evider	mily/Responsible party will be the nurse has identified the nurse has identified the n and the resident is URE: 7. The clinical nurse will ent's clinical chart information in the resident's addition or status." Ion was provided prior to exit. Issential for Practice, 6th Perry, 2007, pages 56-59), urce for physician's orders and visician or health care provider recting the medical treatment. Individual treatment with the provider of the pro	F 1		ZEIVED 2.9 2017 VOLC

An interview was conducted on 2/28/17 with RN

PRINTED: 03/14/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVEC** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING C 495401 B. WING 03/02/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 12001 IRON BRIDGE RD TYLER'S RETREAT AT IRON BRIDGE CHESTER, VA 23831 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENT: FYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) F 157 Continued From page 6 F 157 #6, the unit manager. RN #6 was asked to review the above weights. After reviewing the weights, RN #6 stated, "She should have did (sic) a re-weight. Then they should have notified the doctor and the family and they probably should have told me." An interview was conducted on 3/1/17 at 10:55 a.m. with RN #7. When asked why residents were weighed, RN #7 stated, "We do it for nutrition to monitor for weight loss." When asked to review Resident #7's January 2017 TAR, RN #7 stated, "It's a big flag (the weight gain). We should have re-weighed (the resident). If they gain more than three pounds in a day or five pounds in a week we would notify the doctor. Maybe it's addressed in the notes." RN #7 reviewed the nurse's notes, and RN #7 stated, "I don't see anything." An interview was conducted on 3/1/17 at 11:00 a.m. with LPN #5, the resident's nurse. When asked to review the TAR, LPN #5 stated, "I would notify the doctor because not all of the weights were done and that's a big jump from 126 to 141." On 3/1/17 at 4:45 p.m. ASM #1, the administrator and ASM #2, the director of nursing were made

SS=E LIGHTING LEVELS

all areas:

by:

aware of the findings.

No further information was provided prior to exit.

(i)(5) Adequate and comfortable lighting levels in

This REQUIREMENT is not met as evidenced

F 256; 483.10(i)(5) ADEQUATE & COMFORTABLE

F 256

DH/OLC

PRINTED: 03/14/2017 **FORM APPROVED** OMB NO. 0938-0391

### AB5401 ### AB	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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STREET ADDRESS, CITY, STATE, ZIP CODE 1200 RON BRIDGE SUMMARY STATEMENT OF DEFICENCES PRESS RETREAT AT IRON BRIDGE SUMMARY STATEMENT OF DEFICENCES PRESS RETREAT AT IRON OR LSC IDENTIFYING INFORMATION) FEGULATORY OR LSC IDENTIFYING INFORMATION) FESTOR Based on observation, resident interview, and staff interview, it was determined that the facility staff falled to provide adequate lighting to meet the resident's motivation or neet the resident's Motivation and the survey sample, Resident #2, #12, #13, and #22. Festor H12, #13, and #22. 1. Resident #25 lamp in the room was observed with the lamp shades off, to give more light. Resident #2 stated she was unable to read in her room due to the lighting. 2. Resident #12 was observed in her room attempting to read her mail and on interview stated there was not enough light in the room attempting to read her mail and on interview Resident #12 stated we took them (the lamp shade) off to add light but then they (the lights) get too hot so we have to turn them off. 3. For Resident #13, the facility staff did not provide adequate lighting in the Resident's room. The findings include. 1. Resident #2 was admixted to the facility on 3/15/16 with a recent readmission on 12/30/16 with diagnoses that included but were not limited to muscle weakness, spinal stenosis (an abnormal narrowing of the spine) (1), sociloiss (abnormal lateral or sideward curve to the spino) (2), oslocarthritis (degenerative changes in the points) (3) paraplegia (paralysis of the lower limits)		495401	B. WING		ı	1/0047
12001 RON RRIDGE RO CHESTER VA 23831 12001 RON RIDGE RO RECEDED FITH LEAD CORNECTION RECEDED TO RECED TO RECEDE T	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 03/02	2/201/
CHESTER, VA 23831 SUMMARY STATEMENT OF DEFICIENCIES FROM PRICE FACTOR PRODUCTION SHOULD BE FACTOR PRODUCTION SHOULD	TYLER'S RETREAT AT IRON E	RPINGE				
F256 Continued From page 7 Based on observation, resident interview, and staff interview, it was determined that the facility staff failed to provice adequate lighting to meet the resident's individual needs for four of 22 residents in the survey sample, Residents #2, #12, #13 and #22. 1. Resident #2's lamp in the room was observed with the lamp shade removed and on interview Resident #2's tated there was not enough light in the room that's why we have the lamp shades off, to give more light. Resident #2 stated lamp shades off, to give more light. Resident #2 stated lamp shades off, to give more light. Resident #2 stated she was unable to read in her room dattempting to read her mail and on interview stated there was not enough light in the room. Resident #12 stanp in the room was observed with the lamp shade removed and on interview stated there was not enough light in the room. Resident #12 stanp in the room was observed with the lamp shade removed and on interview Resident #12 stanp in the room was observed with the lamp shade removed and on interview Resident #12 stanp in the room was observed with the lamp shade removed and on interview Resident #12 stand we took turn them off. 3. For Resident #12 was observed in her room. The findings include: 4. For Resident #22, the facility staff did not provide adequate lighting in the Resident's room. 5. For Resident #22, was admitted to the facility on 3/15/16 with a recent readmission on 12/30/16 with diagnoses that included but were not limited to: muscle weakness, spinal stenosis (an abnormal lateral or sideward curve to the spine) (2), osteoarthritis (degenerative changes in the joints) (3) paraplegia (paralysis of the lower limbs)		SKIDGE		CHESTER, VA 23831		
F 256 Continued From page 7 Based on observation, resident interview, and staff interview, it was determined that the facility staff failed to provice adequate lighting to meet the resident's individual needs for four of 22 residents in the survey sample, Residents #2, #12, #13 and #22. 1. Resident #2's lamp in the room was observed with the lamp shade removed and on interview Resident #2 stated there was not enough light in the room that's why we have the lamp shades off, to give more light. Resident #2 stated she was unable to read in her room due to the lighting. 2. Resident #12 was observed in her room attempting to read her mail and on interview stated there was not enough light in the room. Resident #12 stated we took them (the lamp shade removed and on interview stated there was not enough light in the room. Resident #12 stated we took them (the lamp shade) off to add light but then they (the lights) get too hot so we have to turn them off. 3. For Resident #13, the facility staff did not provide adequate lighting in the Resident's room. 4. For Resident #2 2, the facility staff did not provide adequate lighting in the Resident's room. The findings include: 1. Resident #13 the facility staff did not provide adequate lighting in the Resident's room. The findings include: 1. Resident #10 was observed in her room attempting to read her mail and on interview stated there was not enough light in the room. 3. For Resident #12 was observed in her room attempting to read her mail and on interview Resident #12 was adequate lighting in the Resident's room. 4. For Resident #22, the facility staff did not provide adequate lighting in the Resident's room. The findings include: 1. Resident #12 was admitted to the facility on 3/15/16 with a recent readmission on 12/30/16 with diagnoses that included but were not limited to: muscle weakness, spinal stenosis (an abnormal harrowing of the spine) (11), scoliosis (abnormal lateral or sideward curve to the spine) (2), osteoarthintis (degenerative changes in the	(X4) ID SUMMARY STA	TEMENT OF DEFICIENCIES	JD	PROVIDER'S PLAN OF CORRECT	TION	/VE:
Based on observation, resident interview, and staff interview, it was determined that the facility staff failed to provide adequate lighting to meet the resident's individual needs for four of 22 residents in the survey sample, Residents #2, #12, #13 and #22. 1. Resident #2's lamp in the room was observed with the lamp shade removed and on interview Resident's #2 stated there was not enough light in the room that's why we have the lamp shades off, to give more light. Resident #2 stated she was unable to read in her room due to the lighting. 2. Resident #12 was observed in her room due to the lighting. 2. Resident #12 was observed in her room was observed with the lamp shade removed and on interview stated there was not enough light in the room. Resident #12's lamp in the room was observed with the lamp shade removed and on interview Resident #12's lamp in the room was observed with the lamp shade removed and on interview Resident #12's taked we look them (the lamp shade) off to add light but then they (the lights) get too hot so we have to turn them off. 3. For Resident # 13, the facility staff did not provide adequate lighting in the Resident's room. 4. For Resident #2 taked we took them (the lamp shade) off to add light but then they (the lights) get too hot so we have to turn them off. 3. For Resident #2 taked we took them (the lamp shade) off to add light but then they (the lights) get too hot so we have to turn them off. 3. For Resident #2 2, the facility staff did not provide adequate lighting in the Resident's room. 4. For Resident #2 was admilted to the facility on 3/15/16 with a recent readmission on 12/30/16 with diagnoses that included but were not limited to muscle weakness, spinal stenosis (an abnormal lateral or sideward curve to the spine) (2), osteoarthritis (degenerative changes in the joints) (3) paraplegia (paralysis of the lower limbs)	FREFIX (EACH DEFICIENCY FAG REGULATORY OR LS	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	1	(EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE LC	OMPLETIO
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The findings include: 1. Resident #2 was admitted to the facility on 3/15/16 with a recent readmission on 12/30/16 with diagnoses that included but were not limited to: muscle weakness, spinal stenosis (an abnormal narrowing of the spine) (1), scoliosis (abnormal lateral or sideward curve to the spine) (2), osteoarthritis (degenerative changes in the joints) (3) paraplegia (paralysis of the lower limbs) place or systemic changes made to ensure that the deficient practice will not recur. a. Maintenance Director will replace current light bulbs of residents who request the LED daytime bulbs at use the LED daytime bulbs as they burn out. b. Residents will be asked during Resident Council by the Activity Director / designee whether they feel the lighting is adequate in their rooms monthly for 3 months and at least quarterly for a year. 4/14/17	4. FOI Resident # 22,	the facility staff did not		2		
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(2), osteoarthritis (degenerative changes in the joints) (3) paraplegia (paralysis of the lower limbs) whether they feel the lighting is adequate in their rooms monthly for 3 months and at least quarterly for a year. 4/14/17	abnormal narrowing of	the spine) (1), scoliosis	1	Council by the Activity Director / decid	mee	
joints) (3) paraplegia (paralysis of the lower limbs) their rooms monthly for 3 months and at least quarterly for a year. 4/14/17	(abnormal lateral or sid	deward curve to the spine)	, '	whether they feel the lighting is adequa	ite in	- 1
quarterly for a year. 4/14/17	(2), osteoarthritis (dege	enerative changes in the	1	their rooms monthly for 3 months and a	it least	
	juirits) (3) parapiegia (p	paralysis of the lower limbs)	(quarterly for a year.	3	/17

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	,	LTIPLE CONSTRUCTION DING	(X3) E	OATE SURVEY OMPLETED
		495401	B. WING		_ 0	C 03/02/2017
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to Fw	assessment, a quarassessment referent resident as being condecisions. The resident upon the staff for all and toileting. She refor personal hygiener Resident #2 was condecision B1200 - Conwas coded as wearing completing B1000. Staround the facility in Resident #2's compression. Observation was made 2/28/17 at 3:25 p.m. It wo overhead lights, and observed on the resided in the bed close peared poorly lit. The two night stands and observed on the Resident Interview was here was enough lighted the stands of the resident interview was here was enough lighted the stands of the resident interview was here was enough lighted the stands off, to give mourn them off because on." When asked if she resident #2 stated, "Nouldn't be able to resident the resident	gh blood pressure. OS (minimum data set) terly assessment, with an ce date of 2/3/17, coded the ignitively intact to make daily ent was totally dependent transfers, moving in the bed, equired extensive assistance ded in Section B1000 - Vision to see in adequate light. In rective lenses, the resident and glasses used to the was independent to move a motorized wheelchair. The room was noted to have one at the entrance and one the two beds. Resident #2 the sest to the door. The room there was a lamp on each of the lampshades were off top of the closets. The as initiated. When asked if a inting in the room, Resident why we have the lamp ore light. Then we have to it gets too hot with them the had enough light to read, lo, if I didn't have a Kindle, I	F 2	monitor its performal solutions are sustained a. The Activity Coordin report the responses of QAPI committee month b. Audit results / trends QAPI meeting to ensure effective. Additional actions as needed.	nater to make sure that d. nator / designee will the residents to the nature of a months. will be reviewed at that Action Plans are	4/14/17
#	2 on 3/2/17 at 9:50 a	m. When asked how she			i	

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		H AND HUMAN SERVICES			f): 03/14/2017 APPROVED
	RS FUR MEDICAN T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X3/ MI)	TIDLE	CONCEDUCTION	MB NC). <mark>0938-</mark> 0391
	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
entrenomen (1000 A.Papa Leving & Fargo, parameter annique		495401	B. WING			0.3	C /02/2017
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F 256	Continued From pa	age 9	 F2	56			
	reads her mail, Re	sident #2 stated, "I have to		-			The state of the s
	take it to the alcove	e outside the activity room to					Total for the
1	read it, there's not	enough light in here (The		ž .			
	and our eyes need	read it. We are getting older					
:	and our cycs need	more light.		:		ľ	
	On 3/2/17 at 9:55 a	ı.m. other staff member (OSM)					Grill To Const.
	#4, the director of n	naintenance, was asked if		1			e-labora
i	anyone had compla	ained of there not being					
	stated "I've always	resident rooms, OSM #4 felt that there wasn't enough		1			No.
	light in these rooms	but yes, some residents				A CONTRACTOR OF THE CONTRACTOR	Restrumentogy
i	complained and I pr	ut the newer spiral light bulbs		-			50000E4-
	that are equivalent t	to a 60 watt bulb in the		i			
i	bedside lamps." OS	M #4 was taken to Resident				į	Remondon
, t	iahtina OSM #4 sta	sked if there was enough ated, "Yes, it's not bright in				* 1900	
	nere." When shown	the lamps on the bedside					TO THE STATE OF TH
t	ables, OSM #4 stat	ed, "We have to put those					northe and a second
1	amp shades back o	n, that's a fire hazard."		1			Street, or other street
: 7	The shows seemen	was shared with the				i	ľ
		/17 at 10:15 a.m. A policy		:			
		sident room lighting and the		:			
a	dministrator stated	there was not a policy.		1		i	
٨	lo further informatio	n was provided prior to exit.				- my 2000 à 111 mg 2000 ;	
		The state of the s		ı			
N	. Barron's Dictionar Ion-Medical Reader hapman; page 544.	y of Medical Terms for the , 5th edition, Rothenberg and				Man	
		y of Medical Terms for the				Ì	
N	on-Medical Reader	5th edition, Rothenberg and				:	Bernander
C	hapman; page 523.			ř			
		y of Medical Terms for the		1			
	on-Medical Reader, hapman; page 420.	5th edition, Rothenberg and					

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

4. Barron's Dictionary of Medical Terms for the

Event ID: J9DN11

Facility ID: VA0402

If continuation sheet Page 10 of 58



PRINTED: 03/14/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495401	B. WING		0	C 3/02/2017
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	Chapman; page 4 2. Resident #12 referoom and there was her needs. Resident #12 was 10/6/16 with diagn limited to: muscle pressure, anxiety, random contraction causing irregular bresulting in decreadiot formation) (1), obstructive pulmor nonreversible lung. The most recent Maignificant change assessment referencesident as being codecisions, scoring a interview for mental Vision, the resident ability to see in ade	der, 5th edition, Rothenberg and 35. esided on the window side of the as not adequate lighting to meet admitted to the facility on oses that included but were not weakness, high blood atrial fibrillation (rapid and nof the atria of the heart eats of the ventricles and sed heart output and frequently and COPD (chronic tary disease - chronic	F 2	<u> </u>		
	contacts to complet	e care plan dated 10/10/16 did		RECEIV	*	
t t	observed in her room he bed with the win eaning across her t	m. Resident #12 was m. She resided on the side of dow. She was observed bed with a piece of paper in t. When asked if there was		**************************************	017 C	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER TYLER'S RETREAT AT IRON E	BRIDGE		STREET ADDRESS, CI 12001 IRON BRIDGE CHESTER, VA 238	RD	00,,		
PREFIX (EACH DEFICIENCY	JEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	X (EACH CORF	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD RENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
Resident #12 stated leaning toward the visuancy day outside). Iampshades were of Resident #12 stated light but then they get them off." When ask (Resident #2) had to about the lighting, Resident #2) had to about the lighting, Resident #2 had to about the nurses, can'ther roommate) told. The administrator, Resident #4, the administrator would make a differency she had worked for a she had complained enough light in the resistated, "I've always for light in these rooms be complained and I put that are equivalent to be did lamps." OSM #2's room. When ask lighting, OSM #4 states here. "When shown the tables, OSM #4 states lamp shades back on The above concern we administrator on 3/2/1 was requested on residential administrator stated the sumministrator st	room for her to read her mail, if, "No, I can barely read it window." (It was a bright When asked why the if of her night stand lamp, if, "We took them off to add too hot so we have to turn red if she and her roommate old anyone of the concern resident #12 stated, "We had to remember who we (her and when we will will will will will because we didn't think it rence." Resident #12 stated an electrical contractor and he light in the room. In other staff member (OSM) aintenance, was asked if ned of there not being resident rooms, OSM #4 relet that there wasn't enough out yes, some residents the newer spiral light bulbs a 60 watt bulb in the if was taken to Resident ked if there was enough red, "Yes, it's not bright in the lamps on the bedside d, "We have to put those, that's a fire hazard." The shared with the if a 10:15 a.m. A policy ident room lighting and the intended it was a shared with the intended it is a	F 2	256				
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If continuation sheet Page 12 of 58

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 12001 IRON BRIDGE RD CHESTER, VA 23831	, ZIP CODE	3/02/2011
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F 256	Continued From p	age 12	F 2	256		
	Non-Medical Read Chapman; page 56 2. Barron's Diction Non-Medical Read Chapman; page 12 3. For Resident # 1 provide adequate li Resident # 13 was 11/22/10 with diagn limited to: hyperten gastroesophageal reference date) of 1 coded as scoring a BIMS (brief interview that she was cognitional was coded under Vincer vision was impacorrective lenses.	arry of Medical Terms for the er, 5th edition, Rothenberg and 24. 3 the facility staff did not ghting in the Resident's room. admitted to the facility on a loses that included but are not sion, hyperlipidemia, reflex disease, diabetes, and diabetic retinopathy (2). On the lose of mental status, a lost of a possible 15 on the lost of mental status) indicating vely intact. Resident # 13 sion as a "1" indicating that irred and as wearing				
F (0	Resident # 13) has i	an for a "Focus: (name of mpaired vision, dx retinopathy Date initiated:				
te o - cl - ne	Adapt environment e ensure resident is bjects/own environr Keep environment i lutter Obtain eye exam co	nent free of small objects and onsultation as needed erials with resident when		· · · · · · · · · · · · · · · · · · ·	The street stree	

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Event ID J9DN11

Facility ID: VA0402

If continuation sheet Page 13 of 58

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TYLER'S	RETREAT AT IRON	BRIDGE	occumentary.	12001 IRON BRIDGE RD CHESTER, VA 23831			
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	During the Group in 10:30 a.m., Reside the group was ask in their rooms Reside in their rooms Reside in their rooms Reside in their rooms Reside in the policy and one near the term one table lamp. Resident noted their one table lamp. Resident in the lack of light mobecause you cannot one 3/2/17 at 9:55 at 44, the director of ranyone had complained and I per that are equivalent bedside lamps." Os #13's room, a private light was positioned. It was outside	er MD (medical doctor) orders." Interview Task on 3/1/17 at ent # 13 was present and when ed if there was adequate light ident # 13 responded that the	F 2				
	was no light within t curtain. When aske provide care, OSM	he perimeter of the privacy d how the staff could see to #4 stated, "I guess we can d to the other side of the bed."					

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

Event ID: J9DN11

Facility ID: VA0402

If continuation sheet Page 14 of 58



PRINTED: 03/14/2017 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	495401	B. WING			C 3/02/2017	
NAME OF PROVIDER OR SUPPLIER TYLER'S RETREAT AT IRON I			STREET ADDRESS, CITY, STATE, ZIP CODE 12001 IRON BRIDGE RD CHESTER, VA 23831		3/02/2017	
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
is acceptable. During an interview	to first ask the resident if that on 3/2/17 at 10:00 a.m. with	F 25	66			
administrator, and C the director of main discussed.	e staff member) # 1, the DSM (other staff member) # 4, enance, this concern was					
swelling. It happens body's soft tissues. I white blood cells tha https://search.nih.go	he name of a type of when lymph builds up in your lymph is a fluid that contains t defend against germs.					
the blood vessels of common diabetic eye cause of blindness in https://www.nei.nih.g	ov/faqs/diabetic-retinopathy					
provide adequate ligi	the facility staff did not nating in the Resident's room. Imitted to the facility on		!			
5/4/10 and most rece with diagnoses that in to: Atrial fibrillation, he gastroesophageal ref arthr/tis, depression, most recent MDS (mi assessment with ARI date) of 2/20/17, Res	ntly readmitted on 4/14/14 ncluded but are not limited		RECEIVE MAR 29 2017	:		

PRINTED: 03/14/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	495401	95401 B. WING		03/0		
NAME OF PROVIDER OR SUPPLIER TYLER'S RETREAT AT IRON			STREET ADDRESS, CITY, STATE, ZI 12001 IRON BRIDGE RD CHESTER, VA 23831			
PREFIX (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 DEFICIENCY	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 256 Continued From pa	age 15	F2	56		9 7 7 7 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8	
(brief interview of mass cognitively into under Vision as a "was adequate and corrective lenses. Review of Resident documented care primpaired vision and initiated: 12/6/2016 "Interventions: - Adapt environment to ensure resident in objects/own environs. - Instill/apply eye moorders - Keep environment clutter - Obtain eye exam of the ambulating. - Use large print manneeded." During the Group In 10:30 a.m., Resident the group was asked in their rooms Resident with the light her two lamps and manneeded."	nental status) indicating that he act. Resident # 22 was coded 10" indicating that her vision she was coded as wearing 11 # 22's care plan revealed a plan for a "Focus: Potential for a lor complications Date " 12 to resident's individual needs a sable to recognize ment redication as per physician at free of small objects and consultation as needed dent turns head side to side afterials with resident when 12 was present and when 13 difference was adequate light lent # 22 stated she had a noting but her friend brought now it was fine.					
have two additional to have two additional to have as have and the table lamp to facility. Resident # 2	floor lamps that Resident # ng been brought in by a friend nat had been provided by the 22 commented that the two e room much brighter.					

PRINTED: 03/14/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING C 495401 B. WING 03/02/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 12001 IRON BRIDGE RD TYLER'S RETREAT AT IRON BRIDGE CHESTER, VA 23831 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 256 | Continued From page 16 F 256 On 3/2/17 at 9:55 a.m. other staff member (OSM) #4, the director of maintenance, was asked if anyone had complained of there not being enough light in the resident rooms, OSM #4 stated, "I've always felt that there wasn't enough light in these rooms but yes, some residents complained and I put the newer spiral light bulbs that are equivalent to a 60 watt bulb in the bedside lamps." OSM #4 was taken to Resident #22's room. When shown the room, the resident had two pole lamps in the room in addition to the lamp on the night stand and the overhead lamp. OSM #4 was informed that the resident had a friend bring her the pole lamps because it was dark in her room. OSM #4 shook his head in agreement and stated, "I can see that." During an interview on 3/2/17 at 10:00 a.m. with ASM (administrative staff member) # 1, the administrator, and OSM (other staff member) # 4, the director of maintenance, this concern was discussed. Nothing further provided prior to exit. F 278 483.20(g)-(j) ASSESSMENT F 278 F 278 SS=D ACCURACY/COORDINATION/CERTIFIED SS=D The facility will maintain an accurate MDS (g) Accuracy of Assessments. The assessment (minimum data set) assessment for each must accurately reflect the resident's status. resident. (h) Coordination A registered nurse must conduct or coordinate 1. Address how corrective action will be accomplished for those residents found to each assessment with the appropriate participation of health professionals. have been affected by the deficient practice. (i) Certification a. Resident #3's and #9's MDS was reviewed

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the assessment is completed.

(1) A registered nurse must sign and certify that

Event ID: J9DN11

Facility ID: VA0402

by the MDS coordinator and accurately reflects resident status as of 3/15/2017.

If continuation sheet Page 17 of 58

3/15/2017



MAR 29 2017



PRINTED: 03/14/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONS A. BUILDING	COMP	(X3) DATE SURVEY COMPLETED		
	495401	B. WING		C	03/02/2017	
NAME OF PROVIDER OR SUPPLIE TYLER'S RETREAT AT IRON	BRIDGE	12001 IR	NDDRESS, CITY, STATE, ZIP CODE ON BRIDGE RD ER, VA 23831	03/0/	<u> </u>	
PREFIX (EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX (FAG CF	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL ROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE 0	(X5) COMPLETIC DATE	
assessment must that portion of the (j) Penalty for Fals (1) Under Medicard who willfully and kr (i) Certifies a mater resident assessme penalty of not more assessment; or (ii) Causes another and false statemen subject to a civil most, 5,000 for each assessment and false statemen subject to a civil most, 5,000 for each assessment; and false statemen subject to a civil most, 5,000 for each assessment; and false statemen subject to a civil most, 5,000 for each assessment; and false statemen subject to a civil most, 5,000 for each assessment; and false statemen subject to a civil most, 5,000 for each assessment; and false statemen subject to a civil most, 5,000 for each assessment; and false statemen subject to a civil most, 5,000 for each assessment; and false statemen subject to a civil most, 5,000 for each assessment; and false statemen subject to a civil most, 5,000 for each assessment; and false statemen subject to a civil most, 5,000 for each assessment; and false statemen subject to a civil most, 5,000 for each assessment; and false statemen subject to a civil most, 5,000 for each assessment; and false statemen subject to a civil most, 5,000 for each assessment; and false statemen subject to a civil most, 5,000 for each assessment; and false statemen subject to a civil most, 5,000 for each assessment; and false statemen subject to a civil most, 5,000 for each assessment; and false statemen subject to a civil most, 5,000 for each assessment; and false statemen subject to a civil most, 5,000 for each assessment; and false statemen subject to a civil most, 5,000 for each assessment; and false statemen subject to a civil most, 5,000 for each assessment; and false statemen subject to a civil most, 5,000 for each assessment; and false statemen subject to a civil most, 5,000 for each assessment; and false statemen subject to a civil most, 5,000 for each assessment; and false statemen subject to a civil most, 5,000 for each assessment; and false statemen subject to a civil most, 5,000 for each assessment; and fa	I who completes a portion of the sign and certify the accuracy of assessment. Ification and Medicaid, an individual nowingly- rial and false statement in a certify a material to a subject to a civil money than \$1,000 for each Individual to certify a material to in a resident assessment is oney penalty or not more than sessment. If is not met as evidenced eview, facility document review eview, it was determined that do maintain an accurate a set) assessment for two of survey sample, Resident's #3 It and documented Resident loss when there had been no multiple MDS assessments. It is not constitute a tand documented Resident loss when there had been no multiple MDS assessments.	affecte a. An a assessm weight, by an R active a 3. Addi place o that the a. The I be in-se designed answer current and sect b. The II meet we significa interven Medical 4. Indie monitor solutions a. The R the Dieta audit 4 M the accur b. RN M the result monthly c. Audit r the QAPI Plans are	dress how the facility will idented by the same deficient practiculation of current resident's MDS ments to ensure accuracy of height, and weight losses will be completed by the same deficient practiculation of the massessment by 4/14/17. The systemic changes made to ensure the deficient practice will not restricted by the RN MDS coordinated by the RN MDS when there information available for that resident of the MDS by 4/1/17, interdisciplinary Care Plan Team teckly to review any residents with the weight change and documentations related to that Change in the sum of the MDS related to that Change in the second of the MDS and documentations related to that Change in the sum of the same that the second of the MDS and documentations related to that Change in the second of the MDS and documentations related to that Change in the second of the MDS and the second of t	to be ice. ght, pleted current 4 tinto issure cur. in will hator / to exis no exident at the he 4// e that with e will sure 4/I report tee 4/I by on ans	/14/17 14/17 4/17 4/17	
the resident's height	on the quarterly assessment reference date (ARD) of	will be do	one as needed.	4/14	4/17	

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

Event ID: J9DN11

Facility ID: VA0402

If continuation sneet Page 18 of 58



PRINTED: 03/14/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY -COMPLETED	
		495401	B. WING			0.5	C
	PROVIDER OR SUPPLIER			ST/	REET ADDRESS, CITY, STATE, ZIP CODE 001 IRON BRIDGE RD IESTER, VA 23831	<u> </u>	3/02/2017
(X4) IÜ PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 278	an ARD of 4/19/17. The findings include 1. The facility staff of the resident's weight #3 had had a weight weights obtained or Resident #3 was ad 4/22/10 with diagno limited to: dementia (Age-related macula disease that blurs the need for "straight-ahreading, sewing, and macula, the part of the detail) (1), a his	cant change assessment with for Resident #9. e: failed to accurately document and documented Resident to the facility on sess that included but were not a macular degeneration (AMD) is a ne sharp, central vision you need" activities such as didriving. AMD affects the he eye that allows you to see tory of colon and breast	F2	78			
	was currently under The most recent MD assessment, a quart ARD of 2/10/17, cod severely impaired to decisions. The residitotally dependent on activities of daily living Review of the clinical obtained weight was weight was 149.4 po The significant chang ARD 5/20/16 in Section of the resignificant changes are significant changes.	record documented the last on 5/9/16. The resident's		manders of the commonweal of t			

PRINTED: 03/14/2017 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED C		
		495401	B. WING			03/02/2017		
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2 12001 IRON BRIDGE RD CHESTER, VA 23831	IP CODE			
(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 X (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE		
enskriverske enskriver het de forstelle de forstelle de forstelle de forstelle de forstelle de forstelle de fo	Continued From parmore in last 6 monor not on a physician-regimen. The quarterly MDS 8/19/16, coded the Swallowing/Nutrition of "000." A "2" was "Loss of 5% or more in last resident was not or weight- loss regime. The quarterly MDS 11/14/16, coded the Swallowing/Nutrition of "000." A "2" was "Loss of 5% or more 10% or more in last resident was not or weight- loss regime. The quarterly MDS 2/10/17, coded the Swallowing/Nutrition of "000." A "2" was "Loss of 5% or more 10% or more in last "Loss of 5% or more 10% or more in last "Loss of 5% or more 10% or more in last "Loss of 5% or more 10% or more in last "Loss of 5% or more 10% or more in last "Loss of 5% or more 10% or more in last "Loss of 5% or more 10% or more in last "Loss of 5% or more in	age 19 assessment, with an ARD of a resident in Section K - and Status, as having a weight of a physician-prescribed en. assessment, with an ARD of a resident in Section K - and Status, as having a weight of a physician-prescribed en. assessment, with an ARD of a resident in Section K - and Status, as having a weight of a courant of a courant or loss of the formal status, as having a weight of a physician-prescribed en. assessment, with an ARD of a physician-prescribed en. assessment, with an ARD of a physician-prescribed en. assessment, with an ARD of a physician-prescribed en. assessment of the column for the in the last month or loss of the months, indicating the in the last month or loss of the months, indicating the in a physician-prescribed	F 2		(Y)			
i	An interview was conurse) #3, the MDS 11:52 a.m. When as K, RN #3 stated, "It' dietary manager." Von the MDS, if the robtained, RN #3 sta	enducted with RN (registered coordinator, on 3/1/17 at sked who completes Section is either the dietician or the When asked how that is coded esident has not had a weight lated, "I believe it should be "RN #3 was asked which				t Page 20 of 59		

FORM CM\$-2567(02-99) Previous Versions Obsolete

Event ID: J9DN11

Facility ID: VA0402

If continuation sheet Page 20 of 58

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MAR 29 2017

PRINTED: 03/14/2017 **FORM APPROVED** OMB NO. 0938-0391

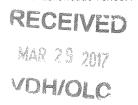
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	495401	B. WING		03/02/2017	
NAME OF PROVIDER OR SUPPLIER TYLER'S RETREAT AT IRON	BRIDGE	120	REET ADDRESS, CITY, STATE, ZIP COD 001 IRON BRIDGE RD IESTER, VA 23831		3/0 <u>2</u> /2017
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	HOULD BE	COMPLETION CATE
assessments, RN # (resident assessments) #3 was asked to brit Section K regarding On 3/1/17 at 12:10 from the RAI manual part, "If a resident context period because or risk of pathological in no-information code the resident's medical further documented. Assessments: 37. Frompare the resider observation period to observation period 30 weight is less than the period 30 days ago, weight loss. 39. From compare the resident observation period 10 current weight is less observation period 10 percentage of weight	uses to complete the MDS it a stated, "We use the RAI ent instrument) manual." RN ing a copy of completing weight documentation. p.m. RN #3 presented a copy al. The paper documented in annot be weighed, for fextreme pain, immobility, or fractures, use the standard in all record." The RAI manual "For Subsequent rom the medical record, it's weight in the current in the weight in the current in the medical record, it's weight in the observation calculate the percentage of in the medical record, it's weight in the current in the medical record, it's weight in the current in the medical record, it's weight in the current in the medical record, it's weight in the current in the medical record, it's weight in the current in the sthan the weight in the stone in th	F 278			
member (OSM) #1, t 3/1/17 at 1:05 p.m. We the resident on the Me zeros, OSM #1 stated dashes. I didn't know asked how you can coloss when there has re	ducted with other staff he dietary manager, on /hen asked why she coded IDS assessments, with triple d, "The zeros should be y that until today." When ode a resident with a weight not been any weights taken SM #1 stated, "I guess				

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

Event ID: J9DN11

Facility ID: VA0402

If continuation sheet Page 21 of 58



PRINTED: 03/14/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
	495401	B. WING			C 3/02/2017
NAME OF PROVIDER OR SUPPLIER TYLER'S RETREAT AT IRON			STREET ADDRESS, CITY, STATE, ZI 12001 IRON BRIDGE RD CHESTER, VA 23831		
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 278 Continued From pa		F 27	8		
	director of nursing and the made aware of the above at 4:37 p.m.				
No further informat	ion was provided prior to exit.				
following website:	was obtained from the ealth/maculardegen/				
the resident's heigh with an assessmen	ailed to accurately document ton the quarterly assessment treference date (ARD) of cant change assessment with for Resident #9.				
12/6/10 with a recer diagnoses that inclu diabetes, high blood	noma (cancer of the lymph				
assessment, a quar assessment referen resident as being se decisions. The resid	OS (minimum data set) terly assessment, with an ce date of 12/9/16 coded the everely impaired to make daily dent was coded as being on the staff for all of her				
4/1/16, coded the re Swallowing/Nutrition tall. The MDS docui inches). Record mos	assessment with an ARD of sident in Section K - al Status, as being 50 inches mented, "A. Height (in st recent height measure at admission/entry or reentry."		·		

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

Event ID: J9DN11

Facility ID: VA0402

If continuation sheet Page 22 of 58



PRINTED: 03/14/2017 FORM APPROVED OMB NO. 0938-0391

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		105104				С
		495401	B. WING_			03/02/2017
NAME OF	PROVIDER OR SUPPLIE	R		STREET ADDRESS, CITY, STATE	E, ZIP CODE	
TYLER'S	RETREAT AT IRON	BRIDGE		12001 IRON BRIDGE RD CHESTER, VA 23831		
egalamidi kelenga kita kilalaman kemasa asa asa asa asa asa asa asa asa asa	OLD BLACK OF	TATELON TOP DEPLOYED		PROVIDER'S PLAN	OF CORRECTION	***
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F 278	Continued From p	page 22	F 27	78		
	and ARD of 4/19/1	ange MDS assessment with 6 coded the resident in Section tritional Status, as being 50				
2.00	ARD of 5/9/16 cod	day MDS assessment with an led the resident in Section K - onal Status, as being 60 inches				
	ARD of 5/16/16, co	day MDS assessment with an oded the resident in Section K - onal Status, as being 60 inches				
:	a.m. with RN (regis coordinator. Wher height on the MDS "The dietary mana- was informed of the	onducted on 3/1/17 at 11:42 stered nurse) #2, the MDS nasked who documents the assessments, RN #2 stated, ger or the dietician." RN #2 e height difference on the sments. She stated she'd look with this surveyor.				
	p.m. with other staf dietary manager. V height into the com assessments, OSM the heights." When different heights on assessments, OSM was taken with the transferred to (nam	#1 stated, "Nursing enters asked to explain the two				
		.m. OSM #1 stated, "I spoke she said she changed the				
		Obsolete Event ID: IODNI11		mility ID: VA0402	If continuation shee	D 00 (FO

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



PRINTED: 03/14/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495401	B. WING		1	C (02/2017	
	PROVIDER OR SUPPLIER	BRIDGE		STREET ADDRESS, CITY, STATE, ZIP CODE 12001 IRON BRIDGE RD CHESTER, VA 23831		02/201/	
(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 APPROPRIES DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 279 SS=D	correct. The resider inches." The administrator, (administrative staff nurse, were made a 3/1/17 at 4:37 p.m. No further information of the companition of the comp	as she knew 50 inches wasn't ent is five foot tall or 60 director of nursing and ASM f member) #3, the corporate aware of the above findings on ion was provided prior to exit. ary of Medical Terms for the er, 5th edition; Rothenberg and 6. (1) DEVELOP E CARE PLANS nust maintain all resident leted within the previous 15 ent's active record and use the sments to develop, review tent's comprehensive care	F 2	778	I be nd to d by care cd by a lify o be	3/31/17	
	to meet a resident's and psychosocial ne	medical, nursing, and mental eeds that are identified in the essment. The comprehensive		a. All residents with comprehensive assessments in past 30 days will be revible by members of the Inter Disciplinary Caplan (IDCP) team to ensure triggered Cawere addressed with coordinating care p	are AAs	3/31/17	

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

Event ID: J9DN11

Facility ID: VA0402

If continuation sheet Page 24 of 58



PRINTED: 03/14/2017 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY MPLETED
		495401	B. WING			l	C /02/201 7
	PROVIDER OR SUPPLIER			1:	TREET ADDRESS, CITY, STATE, ZIP CODE 2001 IRON BRIDGE RD CHESTER, VA 23831	1 00.	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 279	the RN MDS coordinators for review and correction by the Care Plan Team. or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and the RN MDS coordinators for review and correction by the Care Plan Team. 3. Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not recurrent.		nd t into isure	4/7/17			
	under §483.24, §4 provided due to the	at would otherwise be required 83.25 or §483.40 but are not e resident's exercise of rights sluding the right to refuse 483.10(c)(6).		and the control of th	a. The IDCP team will be in-serviced o updating /creating care plans related to CAA triggers by RN MDS coordinator designee. 4. Indicate how the facility plans to	n MDS	4/1/17
	(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes.			ensure	4/14/17		
;					results of audits to the QAPI committee monthly for 3 months. c. Audit results / trends will be reviewe QAPI meeting to ensure that Action Pla effective. Additional action plans will done as needed.	d at ans are	4/14/17
,	(B) The resident's future discharge. F whether the reside community was as	preference and potential for facilities must document nt's desire to return to the sessed and any referrals to cies and/or other appropriate rpose.			done as necucu.		7/17/17
	plan, as appropriat requirements set for section. This REQUIREME by:	is in the comprehensive care te, in accordance with the borth in paragraph (c) of this NT is not met as evidenced erview, facility document					

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

Event ID: J9DN11

Facility ID: VA0402

If continuation sheet Page 25 of 58



PRINTED: 03/14/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' ' '	TIPLE CONST		(X3) DATE SURVEY COMPLETED		
		495401	B. WING	B. WING		C 03/02/2017	
	PROVIDER OR SUPPLIER			12001 IRO	ODRESS, CITY, STATE, ZIP CON BRIDGE RD R, VA 23831		
(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 COR EACH CORRECTIVE ACTION OSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	IX5) COMPLETION CATE
F 279	determined that factomprehensive can in the survey samp 1. The facility staff for the CAA (care a areas of delirium at Resident #1's significate aset) assessment for the CAA (care a area of pressure ulicity staff for the CAA (care a area of pressure ulicity staff for the CAA (care a area of pressure ulicity staff for the CAA (care a area of pressure ulicity staff for the CAA (care a area of pressure ulicity staff for the care and	record review, it was cility staff failed to develop a re plan for two of 22 residents le, Resident # 1, and # 10. failed to develop a care plan area assessment) triggered and cognition in Section V of ficant change MDS (minimum ent with an ARD (assessment)	F2	279			
;	02/07/13 with a readiagnoses that inclustenosis (1), hyperto (3), joint pain, musc	e: s admitted to the facility on dmission on 11/23/16 with uded but not limited to: spinal ension (2), rheumatoid arthritis ele weakness, depression, and gastroesophageal reflux		The same section of the sa			
	data set), a significa an ARD (assessme coded the resident a brief interview for m of 0 - 15, seven bein cognition. Resident extensive assistanc activities of daily livi Area Assessment (0	mprehensive MDS (minimum ant change assessment with nt reference date) of 11/30/16 as scoring a seven on the ental status (BIMS) of a score ng severely impaired of # 1 was coded as requiring e of one staff member for ng. Review of Section V Care CAA) Summary revealed, "01. Cognition" was coded as		:			

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

Event ID: J9DN11

Facility ID: VA0402

If continuation sheet Page 26 of 58



PRINTED: 03/14/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED C 495401 B. WING 03/02/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 12001 IRON BRIDGE RD TYLER'S RETREAT AT IRON BRIDGE CHESTER, VA 23831 (X4) (C) SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 279 : Continued From page 26 F 279 "Addressed in Care Plan." Review of Resident # 1's comprehensive care plan with dated of 01/16/2016 failed to evidence a care plan to address Resident # 1's delirium and cognition. On 02/28/17 at 3:35 p.m., an interview was conducted with OSM (other staff member) #3. the social worker. When asked about the assessment for delirium and cognition on Resident # 1's significant change assessment with the ARD of 11/30/16, OSM # 3 stated. "I did the assessment for delirium and cognition." After reviewing the care plan dated 01/16/2016 for Resident # 1, OSM # 3 was asked if a care plan was developed for delirium and cognition. OSM # 3 stated, "I determined that the delirium and cognition was more depression and there was already a care plan for depression. Looking back there should have been care plans developed for delirium and cognition." On 02/28/17 at 3:40 p.m., an interview was conducted with RN (registered nurse) # 2, MDS coordinator regarding the CAA area of delirium and cognition being identified for a care plan. When asked about the process of developing a care plan from the triggered areas on the CAA of an MDS assessment, RN # 2 stated, "If the area triggered on the CAA a care plan should be developed according to the RAI (resident assessment instrument)." After reviewing the significant change MDS assessment with the ARD of 11/30/16 for Resident # 1 and the comprehensive care plan dated of 01/16/2016.

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RN #2 stated, "It's not on the care plan. A care

plan should have been developed."

Event ID: J9DN11

Facility ID: VA0402

If continuation sheet Page 27 of 58



PRINTED: 03/14/2017 **FORM APPROVED** OMB NO. 0938-0391

AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
	495401	5401 B. WING		C 03/02/2		
NAME OF PROVIDER OR SUPPLIER TYLER'S RETREAT AT IRON BE			STREET ADDRESS, CITY, S 12001 IRON BRIDGE RD CHESTER, VA 23831		00/02/2017	
PREFIX (EACH DEFICIENCY N	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENCE)	PLAN OF CORRECTION TIVE ACTION SHOULD CED TO THE APPROPR EFICIENCY)	BE COMPLETION	
F 279 Continued From pag	e 27	F 2	79			
Williams and Wilkins documented, "A writte communication tool a members that helps e careThe nursing ca information about the and goals. It contains achieving the goals e and is used to direct or revise and update the there are changes in with new orders" (1 Lippincott Williams & Company Philadelphic On 03/01/17 at approx (administrative staff madministrator, ASM # and ASM # 3, corpora aware of the findings.	en care plan serves as a among health care team ensure continuity of re plan is a vital source of patient's problems, needs, a detailed instructions for stablished for the patient careexpect to review, a care plan regularly, when condition, treatments, and Fundamentals of Nursing Wilkins 2007 Lippincott a pages 65-77. Eximately 4:40 p.m. the ASM nember) # 1, the 2, the director of nursing te consultant, were made					
No further information References:	was provided prior to exit.					
(1) A narrowing of the pressure on the spina openings (called neuronerves leave the spina was obtained from the https://medlineplus.go	v/ency/article/000441.htm. e. This information was		acility ID: VA0402	Managhan Man	n sheet Page 28 of 58	



MAR 23 2017



PRINTED: 03/14/2017 FORM APPROVED OMB NO. 0938-0391

	TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LTIPLE CONSTRUCTION DING		CO	TE SURVEY MPLETED
		495401	B. WING		and the second s	03/02/2017	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S 12001 IRON BRIDGE RD CHESTER, VA 23831	TATE, ZIP CODE		
(X4) ID PREFIX TAG	(EAGH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECT CROSS-REFERENC	LAN OF CORRECTIOI IVE ACTION SHOULD ED TO THE APPROPI FICIENCY)	BE	(X5) COMPLETION DATE
F 279	obtained from the https://www.nlm.ni essure.html. (3) A long-term dis of the joints and su affect other organs obtained from the https://medlineplus (4) Makes your bobreak. This informwebsite: https://www.nlm.ni s.html. (5) Stomach conte the esophagus and was obtained from	website: ih.gov/medlineplus/highbloodpr sease. It leads to inflammation urrounding tissues. It can also s. This information was website: s.gov/ency/article/000431.htm. nes weak and more likely to nation was obtained from the h.gov/medlineplus/osteoporosi ints to leak back, or reflux, into d irritate it. This information	F 2	279	FILIENCT)		
	04/04/13 with a readiagnoses that includiabetes mellitus (7(2), bilateral (right a thrombosis (3), hypgastroesophageal (anxiety (7), edema (10), and pain. The most recent codata set), an annual (assessment reference the resident as scofor mental status (Ebeing cognitively in the diagnoses that its control of the company that it is the control of the company that it is the control of the company that is the control of the company that is the control of	was admitted to the facility on admission on 03/30/15 with uded but not limited to: 1), cerebral vascular accident and left sides) deep vein pertension (4), reflux disease (5), epilepsy (6), (8), neuropathy (9), glaucoma of the percentage of 04/04/16 coded ring a 15 on the brief interview BIMS) of a score of 0 - 15, 15 tact for daily decision making.				**************************************	

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

Event ID: J9DN11

Facility ID: VA0402

If continuation sheet Page 29 of 58



MAR 29 2017



PRINTED: 03/14/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495401	B. WING			0	C 3/02/2017
	PROVIDER OR SUPPLIER			12	REET ADDRESS, CITY, STATE, ZIP CODE 001 IRON BRIDGE RD HESTER, VA 23831		
(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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
	daily living. Review Assessment (CAA) Pressure Ulcer" wa Care Plan."	staff member for activities of v of Section V Care Area Summary revealed, "16. Is coded as "Addressed in the state of the section of the sect	F2	279			
	On 02/28/17 at 3:40 conducted with RN coordinator regarding pressure ulcer being When asked about care plan from the tan MDS assessment inggered on the CA developed according assessment instrumannual MDS assess 04/04/16 for Reside comprehensive care RN # 2 stated, "Only ulcer care plan was care plan for pressurated care plan was still should be a care	p.m., an interview was (registered nurse) # 2, MDS and the triggered CAA area of g identified for a care plan. The process of developing a riggered areas on the CAA of at, RN # 2 stated, "If the area A a care plan should be g to the RAI (resident lent)." After reviewing the ment with the ARD of		· description of the second se			
: (8 8	administrative staff administrator, ASM #	member) # 1, the # 2, the director of nursing ate consultant, were made		:		,	
ŀ	No further informatio	n was provided prior to exit.					
, F	References:	!					

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

Event ID: J9DN11

Facility ID: VA0402

If continuation sheet Page 30 of 58



PRINTED: 03/14/2017 FORM APPROVED OMB NO. 0938-0391

	E & MEDICAID SERVICES			OMB NO	D. 093 8-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I .	TIPLE CONSTRUCTION NG	(X3) DA	ATE SURVEY OMPLETED
	495401	B. WING		0.3	C 3/02/2017
NAME OF PROVIDER OR SUPPLIEF	3	<u> </u>	STREET ADDRESS, CITY, STATE,	ZIP CODE	10212011
TYLER'S RETREAT AT IRON	PDIDOE	J	12001 IRON BRIDGE RD		
THE THE THE TANK IN THE	BRIDGE		CHESTER, VA 23831		
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 279 Continued From pa	age 30	F 27	'9		
	se in which the body cannot				
regulate the amour	nt of sugar in the blood. This				
information was ob	tained from the website:				
https://www.nlm.ni/	n.gov/medlineplus/ency/article/		1 0004)		
001214.htm.	,				· ·
(2) A stroke When	blood flow to a part of the				
brain stops. A strol	ke is sometimes called a "brain		:		
attack." If blood flo	w is cut off for longer than a				
few seconds, the br	ain cannot get nutrients and				
oxygen. Brain cells	can die, causing lasting				
damage. This inforr website:	mation was obtained from the				
	gov/ency/article/000726.htm.				O CONTROL ACCURATION OF THE PROPERTY OF THE PR
(3) A condition that (occurs when a blood clot				West of the second
forms in a vein deep	inside a part of the body. It		1	** *** *** *** *** *** *** *** *** ***	-
mainly affects the la	rge veins in the lower leg and		!	·	***************************************
thigh, but can occur	in other deep veins such as			ļ	and the state of t
in the arms and pelv	is. This information was			:	Militaria
obtained from the we	ebsite: jov/ency/article/000156.htm.		i	:	
mpo.mnoamtepias.g	jovrency/article/000 (56.fitm).			1	
(4) High blood press	ure. This information was		ŧ .	20	
obtained from the we	ebsite:			1	
	gov/medlineplus/highbloodpr			į	
essure.html.					
(5) Stomach contents	s to leak back, or reflux, into	:		-	WESTER
the esophagus and in	ritate it. This information	!			CONTRACTOR OF THE CONTRACTOR O
was obtained from th	e website:			:	ı
https://www.nlm.nih.g	ov/medlineplus/gerd.html.				
(B) A brain dinand-14		i			
recurring seizurge. The	nat causes people to have ne seizures happen when	1		ļ	
clusters of nerve cells	s, or neurons, in the brain			;	
send out the wrong si	gnals. People may have	:			
strange sensations ar	nd emotions or behave				
	nave violent muscle spasms			1 8	

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

Event ID: J9DN11

Facility ID: VA0402

If continuation sheet Page 31 of 58



PRINTED: 03/14/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	RIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
	495401	B. WING		C 03/02/2017	
NAME OF PROVIDER OR SUPPLIER TYLER'S RETREAT AT IRON B	RIDGE		STREET ADDRESS. CITY, STATE, ZIP CODE 12001 IRON BRIDGE RD CHESTER, VA 23831	00/02/2012	
PREFIX (EACH DEFICIENCY	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE COMPLETION	
obtained from the whttps://medlineplus.g (7) Fear. This inform website: https://www.nlm.nih. #summary. (8) A swelling cause tissues. This inform website: https://www.nlm.nih. (9) Peripheral neurol don't work properly. occur because of dargroup of nerves. It medlineplus.g (10) A group of disease eye's optic nerve. The from the website: https://www.nlm.nih.gml. F 280 483.10(c)(2)(i-ii,iv,v)(ss. This information was ebsite:	F 28	F280 SS=D The facility will review and revise the resident comprehensive care plans. 1. Address how corrective action will accomplished for those residents found.	id to	
and implementation of plan of care, including	rticipate in the development of his or her person-centered g but not limited to: pate in the planning process,		by Occupational Therapist on 3/2/17. To occupational Therapist determined that splints were no longer warranted as they originally prescribed due to the resident fingers tingling and that she no longer warranted.	The the / were Ts vas	
including the right to	identify individuals or roles to inning process, the right to		experiencing the tingling. The resident' plan was updated by the IDCP Team to these changes.		

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

Event ID:J9DN11

Facility ID: VA0402

If continuation sheet Page 32 of 58



PRINTED: 03/14/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495401	B. WING		C 03/02/2017	
	PROVIDER OR SUPPLIER RETREAT AT IRON		1	STREET ADDRESS, CITY, STATE, ZIP CODE 12001 IRON BRIDGE RD CHESTER, VA 23831	, COLOCI, EUTI	
X4HD PREF X PAF	(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 APPROPI DEFICIENCY)	BE COMPLETION	
F 280	(ii) The right to part expected goals and amount, frequency, other factors related plan of care. (iv) The right to recincluded in the plan (v) The right to see right to sign after sign of care. (c)(3) The facility shright to participate in shall support the replanning process m (i) Facilitate the inclinesident representa (ii) Include an assess strengths and needs (iii) Incorporate the coultural preferences 483.21 (b) Comprehensive (2) A comprehensive	and the right to request son-centered plan of care. icipate in establishing the doutcomes of care, the type, and duration of care, and any dout the effectiveness of the eive the services and/or items of care. The care plan, including the gnificant changes to the plan half inform the resident of the half in this right. The just—just—just of the resident and/or tive. Sesment of the resident and/or tive. Sesment of the resident and in developing goals of care. Care Plans The care plan must be- 7 days after completion of	F 280	2. Address how the facility will ident other residents having the potential taffected by the same deficient practice. a. Residents with a splint(s) have the pot to be affected by this deficient practice. b. Current residents with splint orders whave their care plan reviewed for accurand completeness by the IDCP team. 3. Address what measures will be put place or systemic changes made to enthat the deficient practice will not reca. The IDCP team will be in-serviced or developing and updating care plans with MD Orders and changes in condition by RN MDS coordinator / designee. b. Residents with significant changes were viewed weekly by the IDCP team and care plans updated to reflect changes, grand interventions. 4. Indicate how the facility plans to monitor its performance to make sure solutions are sustained. a. The IDCP team will audit 4 Care Plan week weekly for 3 months for accuracy completeness. b. Social Services / designee will report results of audits to the QAPI committee monthly for 3 months. c. Audit results / trends will be reviewed QAPI meeting to ensure that Action Plae effective. Additional action plans will be done as needed.	o be se. otential vill acy 3/31/17 into sure cur. a h new / the 4/1/17 ill be their oals 4/14/17 e that as per and 4/14/17 the 4/14/17	

20035/0060

(XS) COMPLETION DATE

(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE

DEFICIENCY)

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 03/14/20 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROV STATEMENT OF DEFICIENCIES AND PLANEOF CORRECTION OMB NO. 0938-03 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING_ COMPLETED C B. WING 03/02/2017 STREET ADDRESS, CITY, STATE, ZIP CODE 12001 IRON BRIDGE RD CHESTER, VA 23831 PROVIDER'S PLAN OF CORRECTION

Market and an arrange of	- Control of the Cont		IDENTIFICATION NUMBER:				
Charles of the Control of the Contro			49540 1				
	NAME OF PRO	VIDER OR SUPPLIER					
	PREFIX	FRAUH DEFICIENCY	MUST DE DOCOPORDED DATE	-			
	F 280 Co	ntinued From pag	e 32	-			
	req	uest meetings and islicions to the perso	d the right to request on-centered plan of care.				
	amo othe	ected goals and o bunt, frequency, a er factors related to	utcomes of care, the type,	,			
	(iv) inclu	(iv) The right to receive the services and/or items					
	of care.						
	shall	support the reside	s or her treatment and				
	; (i) Fac reside	cilitate the inclusion trepresentative.	n of the resident and/or				
	(ii) Inc. streng	lude an assessme ths and needs.	ent of the resident's				
	(iii) Inc cultura	orporate the resid I preferences in de	ent's personal and eveloping goals of care.				
	483.21 (b) Con	nprehensive Care	Plans				
	(2) A co	mprehensive care	e plan must be-				
	(i) Deve	loped within 7 day	/s after completion of				

F 280

PREFIX

TAG

(i) Developed within 7 days after completion of the comprehensive assessment.

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

Event ID: J9DN11

Facility ID: VA0402

If continuation sheet Page 33 of 58

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MAR 29 2017

VDH/OLC

PRINTED: 03/14/2017 **FORM APPROVED** OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	495401	B. WING_		03	C 3/02/2017	
NAME OF PROVIDER OR SUPPLIE TYLER'S RETREAT AT IROI			STREET ADDRESS, CITY, STATE, ZIP 12001 IRON BRIDGE RD CHESTER, VA 23831		71 (Sac) and (B)	
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
(A) The attending (B) A registered in resident. (C) A nurse aide versident. (D) A member of the extent pathe resident and the resident and the resident and their resident in the pathe resident resident in the pathe resident resident in the pathe resident in the pathe resident in the pathe resident in the pathe resident in the survey samp. The facility staff faile comprehensive caling the pathe resident in the survey samp.	n interdisciplinary team, that t limited to physician. urse with responsibility for the vith responsibility for the vith responsibility for the lood and nutrition services staff. practicable, the participation of the resident's representative(s). Let be included in a resident's the participation of the resident representative is determined the development of the number of the look of the resident. The professionals in remined by the resident's needs of the resident. The professionals in remined by the interdisciplinary is essment, including both the display of the quarterly review. The professionals in revised by the interdisciplinary is essment, including both the display of the quarterly review. The professionals in revised by the interdisciplinary is essment, including both the display of the professional state of the professio	F 280				
054 CNS, 2567(82, 80) Province Vargions		ř	liby ID VADAD2	antinuation sheet F	3000 24 of 50	

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

Event ID: J9DN11

Facility ID. VA0402

If continuation sheet Page 34 of 58



PRINTED: 03/14/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION		TE SURVEY MPLETED
	495401	B. WING		03	C 8 /02/2017
NAME OF PROVIDER OR SUPPLIER TYLER'S RETREAT AT IRON E	BRIDGE		STREET ADDRESS, CITY, STATE, ZIP CODE 12001 IRON BRIDGE RD CHESTER, VA 23831		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
04/04/13 with a read diagnoses that includiabetes mellitus (1) (2), bilateral (right at thrombosis (3), hyper gastroesophageal reparately (7), edema (10), and pain. The most recent MD quarterly assessment reference date) of 11	et hand. admitted to the facility on dmission on 03/30/15 with ided but not limited to:), cerebral vascular accident ind left sides) deep vein ertension (4), eflux disease (5), epilepsy (6), 8), neuropathy (9), glaucoma OS (minimum data set), a int with an ARD (assessment 1/16/16 coded the resident as	F 280			
status (BIMS) of a so cognitively intact for Resident # 10 was c assistance of one sta daily living. Residen impairment of range	brief interview for mental core of 0 - 15, 15 being daily decision making. oded as requiring extensive aff member for activities of t # 10 was coded as having of motion of the upper elbow, wrist, hand) on one				
10 dated 11/28/16 do	ephone Order" for Resident # locumented, "Pt (patient) to er extremity] splint X6 (six e day."	;		;	
The POS (physician's 03/01/17 through 03/ "11/28/16: Wear left U 6 hours daily during the	31/17 documented, JE (upper extremity) splint X	;		and a separate separa	
	administration records) 1/31/2017, 02/01/2017 -	e Landa di Maria de Landa de La		The second secon	

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

If continuation sheet Page 35 of 58



PRINTED: 03/14/2017 **FORM APPROVED** OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495401	B. WING		_	03/0) 2/2017
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STAT 12001 IRON BRIDGE RD CHESTER, VA 23831	TE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCED		BE	(X5) COMPLETION DATE
	documented, ""11. extremity) splint X Review of Resider plan dated 04/04/2 documentation for extremity splint. On 03/02/17 at 9:3 conducted with RI manager and ASM # 2, the director of were asked to revious of a left hand and ASM # 2 state have been revised hand splint." The facility policy "facility must develor each resident to objectives to meet and mental and psidentified in the conduction of the communication to members that help careThe nursing information about the and goals. It contains achieving the goals.	page 35 3/01/2017 - 03/30/2017 /28/16: Wear left UE (upper 6 hours daily during the day." Int # 10's comprehensive care 2016 failed to evidence the use of a left upper 80 a.m. an interview was N (registered nurse) # 6, the unit M (administrative staff member) in ursing. RN # 6 and ASM # 2 lew the physician's orders dated 03/31/17 and the care plan for Resident # 10. When solan was revised to reflect the splint for Resident # 10, RN # 6 d, "It's not there. It should to indicate the use of the left (Care plans" documented, "The pa a comprehensive Care Plan that includes measurable the resident's medical, nursing ychosocial needs that are imprehensive assessment." Amentals of Nursing Lippincott ins 2007 pages 65-77 inten care plan serves as a sol among health care team is ensure continuity of care plan is a vital source of the patient's problems, needs, ains detailed instructions for sestablished for the patient of care expect to review,	F 2	80			
		Charlette Superior IO: IOONI11		Facility ID: VA0402	If continuation	- sheet Oo	2C -4 F.O

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

Event ID: J9DN11

Facility ID: VA0402



PRINTED: 03/14/2017 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495401	B. WING			03	C 3/ 02/2017
	PROVIDER OR SUPPLIED S RETREAT AT IRON			120	REET ADDRESS, CITY, STATE, ZIP CODE 101 IRON BRIDGE RD IESTER, VA 23831		
(X4) ID PREFIX TAG	(EACH DEFICIENT	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	κ .	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 280	there are changes with new orders' Lippincott Williams Company Philadel On 03/01/17 at ap (administrative state administrator, ASM and ASM # 3, corp aware of the findin	the care plan regularly, when in condition, treatments, and "(1)Fundamentals of Nursing & Wilkins 2007 Lippincott lphia pages 65-77. proximately 4:40 p.m. the ASM off member) # 1, the M # 2, the director of nursing porate consultant, were made	F 2	80			
	regulate the amour information was ob	se in which the body cannot nt of sugar in the blood. This stained from the website: n.gov/medlineplus/ency/article/		Marrian		!	
	brain stops. A strol attack." If blood flo few seconds, the br oxygen. Brain cells damage. This inforr website:	h blood flow to a part of the ke is sometimes called a "brain w is cut off for longer than a rain cannot get nutrients and can die, causing lasting mation was obtained from the gov/ency/article/000726.htm.				, , , , , , , , , , , , , , , , , , , ,	
. † !	forms in a vein deep mainly affects the la thigh, but can occur in the arms and pelv obtained from the w	occurs when a blood clot p inside a part of the body. It arge veins in the lower leg and in other deep veins such as vis. This information was vebsite: gov/ency/article/000156.htm.					

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Event ID: J9DN11

Facility ID: VA0402

If continuation sheet Page 37 of 58



PRINTED: 03/14/2017 FORM APPROVED OMB NO. 0938-0391

S"AFEMENT OF CEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495401	B. WING		_	C 03/02/2017	
	PROVIDER OR SUPPLIE RETREAT AT IRON			STREET ADDRESS, CITY, STA 12001 IRON BRIDGE RD CHESTER, VA 23831			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE) TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE	
	obtained from the https://www.nlm.n essure.html. (5) Stomach contethe esophagus anwas obtained from https://www.nlm.ni (6) A brain disorde recurring seizures.	ssure. This information was website: ih.gov/medlineplus/highbloodprents to leak back, or reflux, into d irritate it. This information	F2	80			
	send out the wrong strange sensations strangely. They may or lose conscious nobtained from the whittps://medlineplus (7) Fear. This inforwebsite:	g signals. People may have and emotions or behave by have violent muscle spasms ess. This information was website:					
, () i t	(8) A swelling cause tissues. This informatissues. This informatissues. This informatissues. This informatis website: 9) Peripheral neurodon't work properly. Deccur because of degroup of nerves. It revhole body. This in the website: https://medlineplus.	ed by fluid in your body's nation was obtained from the gov/medlineplus/edema.html. pathy means these nerves Peripheral neuropathy may amage to a single nerve or a nay also affect nerves in the formation was obtained from gov/ency/article/000593.htm.					
······································	(02-99) Previous Varsions (acility ID: VANAN2	If continuation choot	<u> </u>	



MAR 29 2017



PRINTED: 03/14/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495401	B. WING		C 03/02/2017		
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 12001 IRON BRIDGE RD CHESTER, VA 23831		702/2017	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 281 SS=D	from the website: https://www.nlm.nil ml. (11) Paralysis is the part of your body. If from the website: https://medlineplus 483.21(b)(3)(i) SEF PROFESSIONAL S (b)(3) Comprehens The services provious outlined by the comust- (i) Meet professional This REQUIREMEN by: Based on observat policy review, it was failed to follow profes for one of two medicunit's medication room. Facility staff failed to multidose vial when the findings include An observation was of the medication room a rebottle of lidocaine was bottle of lidocaine was part of the medication room a rebottle of lidocaine was part of the medication room a rebottle of lidocaine was part of the medication room a rebottle of lidocaine was part of the medication room a rebottle of lidocaine was part of the medication room a rebottle of lidocaine was part of the medication room a rebottle of lidocaine was part of the medication room a rebottle of lidocaine was part of the medication room a rebottle of lidocaine was part of the medication room a rebottle of lidocaine was part of the medication room a rebottle of lidocaine was part of the medication room a rebottle of lidocaine was part of the medication room a rebottle of lidocaine was part of the medication room a rebottle of lidocaine was part of the medication room a rebottle of lidocaine was part of the medication room and	This information was obtained in gov/medlineplus/glaucoma.ht eloss of muscle function in this information was obtained gov/paralysis.html. RVICES PROVIDED MEET STANDARDS live Care Plans led or arranged by the facility, omprehensive care plan, at standards of quality. It is not met as evidenced lion, staff interview and facility determined that facility staff essional standards of practice cation rooms, the 300/400 om.	F 28	F 281 SS=D The facility will ensure staff follows professional standards of practice. 1. Address how corrective action will be accomplished for those residents found have been affected by the deficient practice. No residents were found to be affected by deficient practice. 2. Address how the facility will identify other residents having the potential to affected by the same deficient practice. a. All residents receiving a lidocaine inject have the potential to be affected. 3. Address what measures will be put in place or systemic changes made to ensuthat the deficient practice will not recula. Staff will be in-serviced on storage of medications policy / procedure by DON/designee by 4/1/17.	y be ction nto	4/14/17	

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

Event ID: J9DN11

Facility ID: VA0402

If continuation sheet Page 39 of 58



PRINTED: 03/14/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495401	B. WING		0.	03/02/2017	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z		3/02/2017	
TYLER'	S RETREAT AT IRON I	BRIDGE		12001 IRON BRIDGE RD CHESTER, VA 23831			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
	An interview was cop.m. with RN #7. With multidose vial of lide labeled with the ope staff would know white director of nursing followed when they comedication. ASM #2 was asked when the observed in the medication. ASM #2 was asked when the observed in the medication. ASM #2 was asked when the observed in the medication. ASM #2 was asked when the observed in the medication. ASM #2 was a vial of lidocaine shoustated, "It depends to asked what nursing signal was made at this time aware of the findings. Review of the lidocaim anufacturer's literate after a vial was open. A telephone interview 10:35 a.m. with OSM pharmacist. OSM #5 multidose vial of lidocomed in the lidocaim was asked what his time aware of the findings. Review of the lidocaim anufacturer's literate after a vial was open. A telephone interview 10:35 a.m. with OSM pharmacist. OSM #5 multidose vial of lidocomed in the lidocaim was a with OSM pharmacist. OSM #5 multidose vial of lidocomed in the lidocaim was a with OSM pharmacist. OSM #5 multidose vial of lidocomed in the lidocaim was a with OSM pharmacist. When asked pharmacist. When asked pened." When asked pharmacist. When asked pharmacist. OSM #5 multidose vial of lidocomed in the lidocaim was a with OSM pharmacist. OSM #5 multidose vial of lidocomed in the lidocaim was a with OSM pharmacist. OSM #5 multidose vial of lidocomed in the lidocaim was a with OSM pharmacist. OSM #5 multidose vial of lidocomed in the lidocaim was a with OSM pharmacist. OSM #5 multidose vial of lidocomed in the lidocaim was a with OSM pharmacist. OSM #5 multidose vial of lidocomed in the lidocaim was a with OSM pharmacist.	documented on the label. The tely one-half full. Inducted on 3/1/17 at 2:56 hen asked to look at the ocaine, RN #7 stated, "It's not en date." When asked how nen the multidose vial of N #7 stated, "I don't know." Inducted on 3/1/17 at 4:45 inistrative staff member) #2, no regarding the process staff opened a multidose vial of stated, "We date it." ASM #2 multidose vial of lidocaine lication room on the 300/400 SM #2 stated she didn't asked when the multi-dose wild be discarded. ASM #2 in when it expires." When standard the staff used, ASM inpincott and our policies." A mane manufacturer's literature is and ASM #2 was made. The multidose vial fure did not specify how long and before it was expired. The was conducted on 3/2/17 at (other staff member) #5, the	F 28	4. Indicate how the facility monitor its performance to solutions are sustained. a. RN Unit Manager/ design Medication rooms weekly for monthly for 2 months to ensivials are dated when opened b. RN Unit Manager/designeresults of audits to the QAPI monthly for 3 months. c. Audit results / trends will I QAPI meeting to ensure that effective. Additional action done as needed.	ce will audit or I month, ure multi-dose . ee will report the committee be reviewed at Action Plans are	4/14/17 4/14/17	

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

Event ID: J9DN11

Facility ID: VA0402

If continuation sheet Page 40 of 58



MAN 23 2017 VOH/OLC

PRINTED: 03/14/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1`'	IPLE CONSTRUCTION IG		COMPLETED	
		495401	B. WING_		- 0	3/02/2017	
	PROVIDER OR SUPPLIEF						
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE O TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE	
	"Recommended M (based on manufadocumented, "Mul Date when opened after 28 days or in manufacturer's recfacility's policy title and Medication Ad "Procedure: 3.11 Edate opened on the shortened expiration irrigation solutions." No further informa In addition, the Unicumentary (USP) General Chrollowing for multipharmaceuticals: If opened or accessed vial should be date unless the manufal (shorter or longer) information was obtained the duration of action in BUPIVACAINE or longer or was obtained from	rmacy's document titled, linimum Storage Parameters cturer's guidelines)." tiple-Dose Vials for Injection. If and discard unused portion accordance with commendations." Review of the d, "General Dose Preparation iministration" documented, facility staff should enter the e label of medications with an dates (e.g., insulins, etc.)." tion was provided prior to exit. Ited States Pharmacopeia apter 797 [16] recommends the dose vials of sterile if a multi-dose has been ed (e.g., needle-punctured) the ed and discarded within 28 days cturer specifies a different date for that opened vial. This obtained from the website: v/injectionsafety/providers/provi	F 28				
		Ct. 1.1 Event ID: IODM11		acility ID: VA0402	If continuation shee	t Page 41 of 58	

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



MAR 23 2017



PRINTED: 03/14/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	80-71-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1	A. BUILDING	J		С	
	495401	B. WING		0.3	3/02/2017	
NAME OF PROVIDER OR SUPPLIER TYLER'S RETREAT AT IRON			STREET ADDRESS, CITY, STATE, ZIP CODE 12001 IRON BRIDGE RD CHESTER, VA 23831	1 00	<i>3102/2</i> 017	
PREFIX (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	(X5) COMPLETIC DATE	
483.24 Quality of life applies to all care a residents. Each refacility must provide services to attain or practicable physical well-being, consiste comprehensive ass 483.25 (k) Pain Manageme The facility must emprovided to resident consistent with profestine comprehensive and the residents' good (i) Dialysis. The facility must engresidents who requires ervices, consistent of practice, the comprehensive and the residents who requires ervices, consistent of practice, the comprehensive and the residents who requires ervices. This REQUIREMENT by: Based on observation interview, facility docured review, it was failed to maintain the for one of 22 resident Resident #10.	indamental principle that and services provided to facility sident must receive and the extension the highest and psychosocial maintain the highest and psychosocial int with the resident's essment and plan of care. Int. Int. Int. Int. Is use that pain management is swho require such services, essional standards of practice, person-centered care plan, pals and preferences. It is must ensure that e dialysis receive such with professional standards prehensive person-centered esidents' goals and In is not met as evidenced on, resident interview, staff ument review and clinical determined that facility staff highest level of well-being its in the survey sample,	t t t 3	The facility will ensure that each reside received the necessary care and services attain or maintain the highest practicable physical, mental and psychosocial well-in accordance with the comprehensive assessment and plan of care. 1. Address how corrective action will accomplished for those residents four have been affected by the deficient practice. a. Resident #10 order for splint was eval by Occupational Therapist on 3/2/17. Toccupational Therapist determined that the splints were no longer warranted as they originally prescribed due to the resident's fingers tingling and that she no longer wexperiencing the tingling. MD informed findings and wrote an order for splints to discontinued. 2. Address how the facility will identify the residents having the potential to affected by the same deficient practice. A splint audit will be conducted for residents identified with orders for splints he RN Unit Managers. b. Resident's found with a splint order the not being followed or is confusing as to the interapy for evaluation and / or clarification and in the splint is to be worn will be referrance or systemic changes made to ensure the place or systemic changes made to ensur	be d to uate he were s as of be be be be d to uate he were s as of be be ty be to be d to on.	3/2/17 3/31/17	
The facility staff failed right hand splint acco	to apply Resident # 10's rding the physician's orders.	ti ; a fo	hat the deficient practice will not recur . Licensed Nurses will be in-serviced on ollowing physician orders by Director of lursing / designee by 4/1/17.	r.	1/1/17	

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

Event ID: J9DN11

Facility ID: VA0402

If continuation sheet Page 42 of 58



	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		495401	B. WING		0:	C 3 /02/2017
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 12001 IRON BRIDGE RD CHESTER, VA 23831		102/2011
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	iX5) COMPLETION DATE
	The findings includ The facility staff fail right hand splint actors of the facility staff fail right hand splint actors of the facility of t	ed to apply Resident # 10's cording the physician's orders. admitted to the facility on dmission on 03/30/15 with uded but not limited to:), cerebral vascular accident nd left sides) deep vein extension (4), effux disease (5), epilepsy (6), (8), neuropathy (9), glaucoma OS (minimum data set), a nt with an ARD (assessment 1/16/16 coded the resident as	F 309	4. Indicate how the facility plans monitor its performance to make solutions are sustained. a. RN Unit Manager / designee wil residents with splints weekly for 3 ensure splints are on as ordered by b. RN Unit Manager / designee wil results of audits to the QAPI commonthly for 3 months. c. Audit results / trends will be revi QAPI meeting to ensure that Action effective. Additional action plans of done as needed.	Il audit months to physician. Il report the nittee iewed at n Plans are	4/14/17 4/14/17 4/14/17
	status (BIMS) of a sicognitively intact for Resident # 10 was dassistance of one stable to the state of the s	brief interview for mental core of 0 - 15, 15 being daily decision making. oded as requiring extensive aff member for activities of t # 10 was coded as having of motion of the upper elbow, wrist, hand) on one p.m. Resident # 10 was bed watching television. of Resident # 10 failed to her right hand. p.m. Resident # 10 was between the was been watching television. of Resident # 10 was been wheelchair outside her Further observations of to evidence a splint on her				

PRINTED: 03/14/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DA	(X3) DATE SURVEY COMPLETED	
		495401	B. WING	i		0:	C 3/02/2017	
	PROVIDER OR SUPPLIER RETREAT AT IRON	BRIDGE		120	REET ADDRESS, CITY, STATE, ZIP COD 101 IRON BRIDGE RD ESTER, VA 23831		70212011	
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 309	Continued From pa	ge 43	F3	809				
	observed sitting up Further observation evidence a splint or On 03/01/17 at 3:00 observed in the dini wheelchair participa	05 a.m. Resident # 10 was in her bed watching television. Its of Resident # 10 failed to her right hand. 10 p.m. Resident # 10 was ng room sitting up in her riting in BINGO with numerous of Resident # 10 was ng robservations of Resident						
	On 03/02/17 at 8:45 observed sitting up and eating breakfas	a.m. Resident # 10 was in her bed watching television tindependently. Further ident # 10 failed to evidence hand.		A COMMANDA OF THE PROPERTY OF				
	03/01/15 through 03	's order sheet) dated /31/15 documented, "Apply the morning and remove at		V TOTAL STREET, AND ADDRESS OF THE PARTY OF				
3 4 1 1 1 1	plan dated 04/04/20° Self-care deficit r/t [ri [cerebral vascular ac hemiparesis (11)." U	# 10's comprehensive care 16 documented, "Focus: elated to] (L) [left] CVA ccident] with ® [right] sided Inder "Interventions" it nd splint as ordered."		The second section of the sect				
0 0 0 a p F -	dated 01/01/2017 - 0 02/28/2017 and 03/0 documented, "Splint and remove at bedtin 0.m.) On. 3-11(3:00 Further review of the 01/31/2017, 02/01/20	to right hand in the morning ne. 7-3 (7:00 a.m. to 3:00 p.m. to 11:00 p.m.) Off." TARs dated 01/01/2017 -						

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

Event ID: J9DN11

Facility ID: VA0402

If continuation sheet Page 44 of 58



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED C	
	495401	B. WING		0:	3/02/2017	
NAME OF PROVIDER OR SUPPLIER TYLER'S RETREAT AT IRON E	BRIDGE		STREET ADDRESS, CITY, STATE, 12001 IRON BRIDGE RD CHESTER, VA 23831	ZIP CODE		
DREELY (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	ARAGA DEFENDENCED TO	CTION SHOULD BE THE APPROPRIATE	COMPLETION DATE	
was being applied of bed time. On 03/01/17 at 3:30 conducted with Resishe has the splint for 10 stated, "Yes, It's immediate observate table revealed a harright hand. Resider splint for her right has stated, "They put the night and take it off who puts the splint stated, "The CNAs Con 03/02/17 at 11:3 conducted with CNAs schedule of Resider When asked if she 10, CNA # 7 stated, asked if Resident # hand and when it we "It's supposed to be taken off at bedtimes."	ge 44 to Resident # 10's right hand each morning and removed at a p.m. an interview was ident # 10. When asked if or her right hand Resident # on the table by my bed." An iden of Resident # 10 bedside and splint for Resident # 10's at #10 was asked when the and is applied. Resident # 10 e splint on my right hand at in the morning." When asked on her hand, Resident # 10 (certified nursing assistants)." 10 a.m. an interview was a # 7 regarding the wearing at # 10's right hand splint. The had taken care of Resident # "I'm assigned to her." When 10 wore a splint on her right as applied, CNA # 7 stated, put on in the morning and the 10's right hand CNA # 7.	F3				
conducted with LPN 8. When asked if R her right hand and v stated, "It's put on ir bedtime." When as	out it on." 10 p.m. an interview was i (licensed practical nurse) # lesident # 10 wore a splint on when it was applied, LPN # 8 in the morning and taken off at ked who put the splint on thand, LPN # 8 stated, "The					
On 03/02/17 at 12:1	0 p.m. an interview was		ì	If continuation shee	t Dago As of Se	



		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		N	(X3) DATE SURVEY COMPLETED	
		495401		B. WING		C 03/02/2017	
	PROVIDER OR SUPPLIER	Autoritation and the autoritation described and the second and the		STREET ADDRESS 12001 IRON BRID CHESTER, VA			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	X (EACH C	IDER'S PLAN OF CORRECT ORRECTIVE ACTION SHOU FERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
	manager, regarding Resident # 10's righ Resident # 10 wore when it was applied supposed to be put off at bedtime." When Resident # 10's "The nurse should because they are of When asked if she being put on Reside stated, "No." On 03/02/17 at 12:1 conducted with ASM member) # 2, the diasked who should a 10's right hand, ASM and CNA but the nurse that the splint 10 at night, ASM #2 In "Fundamentals of Patricia A. Potter and Inc; Page 419. "The	(registered nurse) # 6, the unit of the wearing schedule of a splint on her right hand and I, RN # 6 stated, "It's on in the morning and taken nen asked who put the splint right hand, RN # 6 stated, be putting on the splint right have to document it." was aware that the splint was ent # 10 at night, RN # 6 O p.m. an interview was I (administrative staff rector of nursing. When apply the splint on Resident # III I I I I I I I I I I I I I I I I		309			
	obligated to follow pl	atment. Nurses are hysician's orders unless they re in error or would harm					
, 1	ASM (administrative administrator, and Al were made aware of			;			
go yayaan a amada dhahiga Migaa gagana	No further informatio	n was provided prior to exit. Dissolete Event ID: J9DN11		Facility ID: VA0402	If continua	ition sheet Pa	age 46 of 58

PRINTED: 03/14/2017 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		495401	B. WING_		0	C 03/02/2017		
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP CODE 12001 IRON BRIDGE RD CHESTER, VA 23831					
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
F 309	Continued From p	page 46	F 30	19				
	regulate the amou information was o	ase in which the body cannot ant of sugar in the blood. This btained from the website: ih.gov/medlineplus/ency/article/						
ļ	brain stops. A stro attack." If blood fi few seconds, the b oxygen. Brain cells damage. This info website:	n blood flow to a part of the oke is sometimes called a "brain ow is cut off for longer than a brain cannot get nutrients and s can die, causing lasting rmation was obtained from the agov/ency/article/000726.htm.						
in the second se	forms in a vein dee mainly affects the l thigh, but can occu in the arms and pe obtained from the v	occurs when a blood clot op inside a part of the body. It arge veins in the lower leg and or in other deep veins such as lvis. This information was website: .gov/ency/article/000156.htm.						
. !	obtained from the v	sure. This information was vebsite: n.gov/medlineplus/highbloodpr		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1				
1	he esophagus and was obtained from	nts to leak back, or reflux, into irritate it. This information the website:gov/medlineplus/gerd.html.						
r • (ecurring seizues. clusters of nerve ce	that causes people to have The seizures happen when Is, or neurons, in the brain signals. People may have	;	:				

FORM CMS-25£7(02-99) Previous Versions Obsolete

Event ID: J9DN11

Facility ID: VA0402

If continuation sheet Page 47 of 58



PRINTED: 03/14/2017 FORM APPROVED OMB NO 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495401	B. WING	·		0:	C 3/02/2017	
	PROVIDER OR SUPPLIER S RETREAT AT IRON E	BRIDGE		1	TREET ADDRESS, CITY, STATE, ZIP CODE 2001 IRON BRIDGE RD CHESTER, VA 23831		***************************************	
(X4) ID PREFIX TAG	, (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 309	Continued From pa	ge 47 and emotions or behave	F3	809				
	strangely. They may	have violent muscle spasms ess. This information was ebsite:						
	website:	mation was obtained from the gov/medlineplus/anxiety.html						
	tissues. This inform website:	d by fluid in your body's ation was obtained from the gov/medlineplus/edema.html.		describe some or easily regal to produce				
	(9) Peripheral neuron don't work properly. I occur because of dai group of nerves. It m whole body. This infi the website:	pathy means these nerves Peripheral neuropathy may mage to a single nerve or a ay also affect nerves in the ormation was obtained from ov/ency/article/000593.htm.		The second secon				
	eye's optic nerve. The from the website:	ses that can damage the is information was obtained ov/medlineplus/glaucoma.ht						
F 371		PROCURE,	F 37		F 371 SS=D	The second secon		
		om sources approved or		7	The facility will store food in a safe and anitary manner.			

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

Event ID: J9DN11

Facility ID: VA0402

If continuation sheet Page 48 of 58



NAME OF PROVIDER OR SUPPLIER TYLER'S RETREAT AT IRON BRID	495401	B. WING	G	С
	***************************************			03/02/2017
TYLER'S RETREAT AT IRON BRID		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	03/02/2017
TYLER'S RETREAT AT IRON BRID			12001 IRON BRIDGE RD	
	OGE	1	CHESTER, VA 23831	
(X4) ID SUMMARY STATEM	ENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	i sees
PRÉFIX (EACH DEFICIENCY MUS	ST BE PRECEDED BY FULL DENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
E 371 Continued From page 4	40	F 034	1. Address how corrective action will b	e
F 371 Continued From page 4		F 3/1	accomplished for those residents found	to
	by federal, state or local		have been affected by the deficient	
authorities.			practice.	
And the state of t			No residents were found to have been	
(i) This may include foo	d items obtained directly		affected.	
from local producers, su	ubject to applicable State		1_	
and local laws or regula	ations.		2. Address how the facility will identify	<i>y</i>
(ZM This manifetime does	1.4.4		other residents having the potential to	be
(ii) This provision does r			affected by the same deficient practice.	
facilities from using proc			Residents on pureed diets have the potent to be affected.	i
gardens, subject to com safe growing and food-h			to be affected.	4/14/17
sale growing and lood-i	lanuling practices.		3 Address what many and the	
(iii) This provision does	not preclude residents		3. Address what measures will be put in	ito
from consuming foods r	not precide residents		place or systemic changes made to ensu that the deficient practice will not recur	re
in our borious ming roods in	lot procured by the racinty.		a. Thicken Powder will be stored in a	•
(i)(2) - Store, prepare, di	istribute and serve food in		container with a lid which will seal tightly	
accordance with profess			when closed. A label will be placed on the	
service safety.			container with the product name and date t	the
·	1		product was put into the container.	3/15/17
(i)(3) Have a policy regar	rding use and storage of		b. Dietary staff will be in-serviced by the	3/13/17
foods brought to residen			Dietary Services Manager on the policy an	d
visitors to ensure safe ar		!	procedure of storing food products.	3/31/17
handling, and consumpti		J.	c. The cook will check the store room daily	,
This REQUIREMENT is	not met as evidenced		and document on a store room check sheet	
by:		:	that all containers are closed appropriately.	3/31/17
Based on observation, s			-	
document review, it was		i	4. Indicate how the facility plans to	
facility staff failed to store	e tood in a sanitary	1	monitor its performance to make sure th	at
manner.			solutions are sustained.	
A twenty-five pound box of	of poudor thickopor was		a. The Dietary Services Manager will spot	
found stored open to the			check the store room and check sheet at lea	
iouna otorea open to the	QIII.		weekly and will report the results of the aud	,
The findings include:		*	to the QAPI committee for 3 months.	4/14/17
			b. Audit results / trends will be reviewed at	
Observation of the kitcher	n was conducted on	,	the QAPI meeting to ensure that Action Pla	ns
02/28/17 at approximately		,	are effective. Additional action plans will be done as needed.	1 4
following was observed:		•	чоль аз песиси.	4/14/17

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495401	B. WING		C 03/02/2017
	PROVIDER OR SUPPLIER	BRIDGE		STREET ADDRESS, CITY, STATE, ZIP CODE 12001 IRON BRIDGE RD CHESTER, VA 23831	, , , , , , , , , , , , , , , , , , , ,
(X4: ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRING DEFICIENCY)	BE COMPLETION
SS=D	with approximately was observed open storage shelf in the On 02/28/17 at approximately above concerns we member) #1, a dieta that the powdered #1 sealed and closed. The facility policy "S in part, "Storage of #1 (i.e. bulk cereal) mu sealed tightly to avo On 03/01/17 at approximately (administrative staff administrator, ASM and ASM #3, corporaware of the findings No further informatic 483.70(i)(1)(5) RES RECORDS-COMPL LE (i) Medical records. (1) In accordance wi standards and practic	box of powered thickener fourteen pounds left in the box ed to the air on the bottom dry storage room. roximately 12:45 p.m. the re shown to OSM (other staff ary manager. OSM #1 stated nickener should have been storing Dry Food" documented bulk items Packaged items at be stored in a container or id insect infestation." roximately 4:40 p.m. the ASM member) # 1, the # 2, the director of nursing rate consultant, were made is. on was provided prior to exit. ETE/ACCURATE/ACCESSIB th accepted professional ces, the facility must cords on each resident that	F 3	F 514 SS=D The facility will ensure that clinical recorare maintained on each resident in accorwith accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. 1. Address how corrective action will be accomplished for those residents found have been affected by the deficient practice. a. Resident #4 and 7's medications have documented in the clinical record by lice nurses since 3/19/17. b. Resident # 9 had the incorrect form	dance de
	-			removed from her medical record on 3-1	- 17. 3/1/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION G		ATE SURVEY IMPLETED
	495401	B. WING		0.3	C 3/02/2017
NAME OF PROVIDER OR SUPPLIER		'	STREET ADDRESS, CITY, STATE, ZIP CODE	, 0,	JIOL/2011
		1	12001 IRON BRIDGE RD		
TYLER'S RETREAT AT IRON E	BRIDGE		CHESTER, VA 23831		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	ILD BE	(X5) COMPLETION DATE
			DEFICIENCY)		1
•			2. Address how the facility will ide	entify	
F 514 Continued From page	ge 50	F 514	other residents having the potentia	l to be	
			affected by the same deficient prac	tice.	
(iv) Systematically o	rganized		a. All residents have the potential to affected.	be	4/14/17
(5) The medical reco	ord must contain-		2 A 3 3		
			3. Address what measures will be p	ut into	and the same of th
(i) Sufficient informa	tion to identify the resident;		place or systemic changes made to that the deficient practice will not a	ensure Tecur	
(ii) A record of the re	esident's assessments;		a. Staff will be in-serviced on medica	tion	
(ii) A record of the re	soldent's assessments,		administration policy by DON/design	ee by	
(iii) The comprehens	sive plan of care and services		4/1/17.	•	4/1/17
provided;	nro plan of oure and services		b. Department Managers, Nurse Mana	agers	
	:		and Medical Records staff will be in-	serviced	And the same
(iv) The results of an	y preadmission screening		on HIPPA policy by Administrator / o	lesignee	
and resident review			by 3/31/17		3/31/17
determinations cond	ucted by the State;				1
,			4. Indicate how the facility plans to		
	e's, and other licensed		monitor its performance to make su	re that	
professional's progre	ess notes; and		solutions are sustained.		- Control of the Cont
	:		a. Medical Records / designee will aud	dit 4	
	logy and other diagnostic		Medical Records per week for 3 mont	hs to	
	equired under §483.50.		ensure no reports are misfiled and will the results of audits to the QAPI comm	report	
	is not met as evidenced		monthly for 3 months.	nittee	4/1 4:37
by: Based on stoff intend	iew, facility documents		b. RN Unit Manager/designee will aud	lir 10	4/ 14 / 17
review and clinical re			resident MAR's and TAR's per week	for A	
	ty staff failed to maintain a	!	weeks and 10 per month for 2 months	to 4	
	te clinical record for three of		ensure complete and accurate document		4/14/17
	vey sample, Resident #7,	i	c. Unit Manager / designee will observ	e 4	7/1-7/1/
Resident #4 and Resi	ident #9.		Medication passes per month to ensure	,	
	;		medications are given and documented	per	i
1. The facility staff fail	ed to document that		MD order.	F	4/14/17
	levothyroxine (thyroid		d. RN Unit Managers / designee will re	eport	
	lered by the physician on		the results of their records audit and		
	istration record (MAR) on		Medication Pass observations to the Q.	API	and the state of t
	er 2016 and two dates in	1	committee monthly for 3 months.		4/14/17
January 2017.	d days	1	e. Audit results / trends will be reviewe	d at	
in the contract of			QAPI meeting to ensure that Action Pl	ans are	
2. The facility staff faile			effective. Additional action plans will	- 1	
resident #4 (eceived)	estrace cream (hormone .		done as needed.		4/14/17

		- WHEDIONID OCIVIOLO			JIVID IVU. I	J 9 J8-U39	
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	CONSTRUCTION	(X3) DATE COMP		
495401		495401	B. WING	AND THE RESIDENCE OF THE PARTY	C 03/02/2017		
	PROVIDER OR SUPPLIER RETREAT AT IRON		120	REET ADDRESS, CITY, STATE, ZIP CODE 001 IRON BRIDGE RD IESTER, VA 23831			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE	(X5) COMPLETION DATE	
F 514	Continued From pa	age 51	F 514				
	cream 2) as ordere December 2016 M	ed by the physician on the AR.			10 10 10 10 10 10 10 10 10 10 10 10 10 1		
		had filed another resident's dent #9's clinical record.			** ***********************************		
	The findings includ	e :					
	Resident #7 receive medication (1)) as a the medication admit four dates in Decen January 2017.	failed to document that ed levothyroxine (thyroid ordered by the physician on sinistration record (MAR) on order 2016 and two dates in	:				
1	and readmitted on 1 included but were n	mitted to the facility on 3/5/14 //25/17 with diagnoses that ot limited to: arthritis, ntia, high blood pressure and			**************************************		
	day assessment, will reference date) of 2 having scored an 11 interview for mental was moderately impresident was coded a staff for activities of the staff for activities a	os (minimum data set), a 14 th an ARD (assessment /8/17 coded the resident as out of 15 on the brief status indicating the resident aired cognitively. The as requiring assistance from daily living except for eating as coded as able to do after epared.					
` ((focumented, "Levoth micrograms) i (one)	ian's orders dated 1/31/17 hyroxine 75 mcg po (by mouth) every other 0 mcg I po qod (every other	: : :			A PARTICULAR AND	
F	Review of the Decem	ber 2016 MAR documented,	1				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	IPLE CONSTRUCTION IG		ATE SURVEY OMPLETED
		495401	B. WING_		n	C 3/02/201 7
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE ZIP O 12001 IRON BRIDGE RD CHESTER, VA 23831		3/02/2017
(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 COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLET ON DATE
	(tablet) BY MOUTH (ALTERNATING WILEVOTHYROXINE MOUTH EVERY OF WITH 75 MCG). 3/1 12/29/16 and 12/3 documentation that administered. Review of the January (EVOTHYROXINI (tablet) BY MOUTH (ALTERNATING WILEVOTHYROXINE MOUTH EVERY OF WITH 75 MCG). 3/4 there was no documentated been administed on 3/1/17 at 4:45 periodic process of nursing with the medication of the process staff follow LPN #3 stated, "When the undocument were reviewed, LPN why I didn't do it"	E 75 MCG TABLET1 TAB H EVERY OTHER DAY JITH 75 MCG). E 50 MCG TABLET1 TAB BY OTHER DAY(ALTERNATING JO5/14." On 12/12/16, 12/21/16, I/16 there was no it the medication had been lary 2017 MAR documented, E 75 MCG TABLET1 TAB H EVERY OTHER DAY ITH 75 MCG). ISO MCG TABLET1 TAB BY THER DAY(ALTERNATING JO5/14." on 1/6/17 and 1/17/17 Inentation that the medication ored. Im. ASM (administrative staff Iministrator and ASM #2, the overe made aware of the law was conducted on 3/2/17 at I #3, the nurse who did not inedication was given in Id on 1/6/17. When asked the to document medications, en I come back (from giving in the MAR that I gave it." ented doses of levothyroxine #3 stated, "I don't remember	F 51			
	12:55 p.m. with LPN	w was conducted on 3/2/17 at #6, the nurse who did not ledication was given. When	:			The second secon

PRINTED: 03/14/2017 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	4 ' '	TIPLE CONSTRUCTION	(X3) E	DATE SURVEY OMPLETED
		495401	B. WING			C 3/02/2017
	PROVIDER OR SUPPLIER RETREAT AT IRON			STREET ADDRESS, CITY, STATE 12001 IRON BRIDGE RD CHESTER, VA 23831		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
	stated yes she had she had not docum been given to the range oversight in singing medications were in "So I know they had a interview was comproximately 1:10 of nursing and the shared. ASM #2 re MAR which revealed had documented shad documented shad documented shad documented shad in the missing documented in the missing documented in the nurse most likely medication was given the nurse of the facility Preparation and Medication was given the intervent of the following the medication in the following the intervent of the following the medications and the following the medications and the following the medications and the following the fol	for Resident #7, LPN #6 d. When asked about the dates be nented that the medication had resident, LPN #6 stated, "I live it. It might have been an g." When asked why documented, LPN #6 stated, we been given." Inducted on 3/2/17 at p.m. with ASM #2, the director above staff interviews were eviewed the December 2016 and documentation that LPN #3 he had administered the sadjacent to the dates with entation. ASM #2 stated that y administered the ed to document the en. Inducted on 3/2/17 at p.m. with ASM #2, the director above staff interviews were eviewed the December 2016 and documentation that LPN #3 he had administered the estate of the edition of the dates with entation. ASM #2 stated that y administered the ed to document the edition administration, take all measures required by opplicable Law, including, but owing: 6.1 Document on administration/treatment and medications are opened,	F 5			

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

Event ID: J9DN11

Facility ID: VA0402

If continuation sheet Page 54 of 58



-48 29 **207**

H/OLG

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			ATE SURVEY OMPLETED
		495401	B. WING		0	C 3/02/2017
	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z 12001 IRON BRIDGE RD CHESTER, VA 23831		<i>5102/2011</i>
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
from a a real a	and explanation dministering a tall ecord: drug given dministration, signationts medication. Levothyroxine for the following incompenital or acquisiology, except trace recovery phase ecific indications econdary (pituitary pothyroidism and imary hypothyroidism and im	les accurate documentation " Page 165 reads, "After plet or capsule, be sure to dose given, date and time of ning out the drug on the ning of subacute therapy in the ning of subacute the drug of	F 5			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495401		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DA	(X3) DATE SURVEY COMPLETED	
		495401	B. WING				C
	PROVIDER OR SUPPLIER			120	REET ADDRESS, CITY, STATE, ZIP CODE 01 IRON BRIDGE RD ESTER, VA 23831	1 03	3/02/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	x	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	having 13 out of 18 for mental status) is cognitively intact to resident was coded staff for all activitie. Review of Resident 3/21/16 and resolve. "Focus Risk for infe UTIs (urinary tract is kidney disease). Infordered." Review of the physical documented, "ESTI CREAM/APPL (app	3/17 coded the resident as 5 on the BIMS (brief interview indicating that the resident was 5 make daily decisions. The das requiring assistance from s of daily living. It #4's care plan initiated on ed on 12/20/16 documented, ection R/T (related to) chronic infections) and CKD (chronic terventions medications as cian's orders dated 1/2/17 RACE (1) 0.01%	F	14			
	"ESTRACE 0.01% (APPLY AS DIRECTI A WEEK 08/10/16. I TRACT INFECTION evidence documenta been administered of and 12/23/16. Review of the Decer	mber 2016 MAR documented, CREAM/APPL (application) ED VAGINALLY TWO TIMES FOR RECURRENT URINARY IS." The MAR did not ation that the Estrace had on 12/6/16, 12/9/16, 12/13/16 mber 2016 nurses' notes did entation regarding the ministered.					
1 ti : p n	0:28 a.m. with LPN he resident on 12/6/ process followed by shedication, LPN #4 s	wwas conducted on 3/2/17 at #4, the nurse who cared for 16. When asked about the staff after administering a stated they sign it off on the why staff documents the					

PRINTED: 03/14/2017 FORM APPROVED 91

	RE & MEDICAID SERVICES	7		OMB NO	0.0938-03
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDING	PLE CONSTRUCTION G	(X3) DA	TE SURVEY MPLETED
	495401	B. WING			
NAME OF PROVIDER OR SUPPLIEF	NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE	1 03	/02/2017
TYLER'S RETREAT AT IRON	BRIDGE		12001 IRON BRIDGE RD		
			CHESTER, VA 23831		
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y 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)	LDBF	(X5) COMPLETION DATE
hadn't signed it, it o When asked about	ege 56 4 stated "It is important. If I could mean I didn't give it." giving Resident #4 the LPN #4 stated, "I gave it to	F 514			
her but I didn't sign at night I can't see	it off. Sometimes it's so dark	; ;			
the resident on 12/9 When asked about they administer a m sign it off." When as documented, LPN # don't document it do missing documentat 12/23/16 was then restated, "I remember of aide) in there with					
(1) Estrace – treats I symptoms related to	menopause or low estrogennih.gov/pubmedhealth/PMH			a companies of the state of the	
3. The facility staff ha information in Reside	d filed another resident's nt #9's clinical record.	i			
diagnoses that include diabetes, high blood p	readmission on 9/3/16 with ed but were not limited to: ressure, stroke, ma (cancer of the lymph	;			
The most recent MDS	(minimum data set)				

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

Event ID: J9DN11

Facility ID: VA0402

If continuation sheet Page 57 of 58



war 29 2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	TIPLE CONSTRUCTION	(X3) DAT	. 0938-0: E SURVEY MPLETED
	495401	B. WING	1	C	
NAME OF PROVIDER OR SUPPLIER TYLER'S RETREAT AT IRON I	BRIDGE		STREET ADDRESS, CITY, STATE, ZI 12001 IRON BRIDGE RD CHESTER, VA 23831	P CODE	02/2017
PREFIX (EACH DEFICIENCY	NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET (DATE
resident as being seidecisions. The resident totally dependent up activities of daily living Review of the clinical with another resident doctor's name, and not resident's name was member (ASM) #2, the asked if this was a precident." When asked Resident #9's clinical "No." When asked will documents in the clini "A lot of people; nurse manager." The administrator, ASI the corporate nurse, we above findings on 3/1/A policy on a complete record was requested. No further information (1) Barron's Dictionary	terly assessment, with and ce date of 12/9/16 coded the everely impaired to make daily dent was coded as being on the staff for all of her ng. I record revealed a paper t's name, date of birth, nedical information. In the paper with the other shown to administrative staff ne director of nursing. When evious or current resident, leve this was a previous of if this should be in record, ASM #2 stated, no filed reports and cal record, ASM #2 stated, i's medical records, unit M #1, ASM #2 and ASM #3, were made aware of the 17 at 4:37 p.m.	F 51	4		
Chapman Page 346		:			

