STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495401	A. BUILDING _____ B. WING _____	03/24/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TYLER'S RETREAT AT IRON BRIDGE	12001 IRON BRIDGE RD CHESTER, VA 23831

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 3/22-24/2016. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The life safety report will follow. The census in this 90 certified bed facility was 83 at the time of the survey. The survey sample consisted of 14 current resident reviews (Residents 1-14), and 3 closed records (Residents 15-17).	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in	F 157	RECEIVED APR 14 2016 VDH/OLC **F 157 SS=D** The facility will notify the physician of blood sugar testing results exceeding the physician ordered parameters. **1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.** a. Resident #9's MD was notified on 3/23/16 concerning the Blood Sugars exceeding the parameters. MD order for sliding scale insulin given on 3/29/16. **2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice.** a. Residents with Blood Sugar tests / parameters will have their charts reviewed to ensure MD order parameters are being followed and MD is notified. b. Residents found with Blood Sugars out of Parameters will have their MD notified with follow up as appropriate.	3/29/16 5/8/16 5/8/16

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

Lucinda G. Nunn, Administrator — 4-14-16

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

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F 157	Continued From page 1 resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, clinical record review, the facility staff failed for 1 resident (Resident #9) of 17 residents in the survey sample to notify the physician of elevated blood sugars outside of the physician ordered parameters. For Resident #9, the physician was not notified of Accuchecks (blood sugars testing results) exceeding the physician ordered parameter of 300. The findings included: Resident #9 was admitted to the facility 5/31/13 and readmitted after hospitalization on 9/1/14. Diagnoses included hypertension, depression, obstructive pulmonary disease, and diabetes mellitus (DM). Resident #9's most recent MDS (minimum data set) with an ARD (assessment reference date) of 3/16/16 was coded as an annual assessment. Resident #9 was coded as having a BIMS (brief interview of mental status) of "13" out of a possible 15, or no cognitive impairment. Resident #9 was also coded as requiring	F 157	**3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.** a. Nurses will be in-serviced on MD notification policy by Director of Nursing / Designee. **4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.** a. Unit Managers will audit 3 residents with Blood Sugars weekly for three months to ensure proper MD notification occurs. b. Unit Managers will report the results of the audits to the QAPI committee monthly for 3 months. c. Audit results / trends will be reviewed at QAPI meeting to ensure that Action Plans are effective. Additional action plans will be done as needed.	5/8/16 5/8/16 5/8/16 5/8/16

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F 157	Continued From page 2 extensive assistance of one to two staff members to perform activities of daily living, such as bed mobility and transfer. Resident #9 was coded as requiring limited assistance of one staff member for eating. Resident #9's comprehensive care plan included a plan of care that read, "Resident is at risk for hypo/hyperglycemia episodes R/T (related to): IDDM (insulin dependent diabetes mellitus). Interventions included, "Labs (laboratory test) as ordered and report abnormalities in results to MD (medical doctor)." A review of the clinical record revealed the following physician order initially dated 10/29/14 for blood glucose monitoring, "ACCUCHECKS BEFORE MEALS AND AT BEDTIME FOR DM. CALL MD (MEDICAL DOCTOR) IF BLOOD SUGAR > (greater than) 300 or < (less than) 60. Accuchecks- are blood glucose checks completed with a glucose monitor. "To do the test, prick your finger with the needle and place a drop of blood on a special strip. This strip measures how much glucose is in your blood. The meter shows your blood sugar results as a number on a digital display." This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/patientinstructions/000324.htm Review of the clinical record revealed the following Accucheck Readings on the February and March 2016 MAR (medication administration record) 2/3 at 9:00 p.m. - 316 2/10 at 5:30 p.m. - 319	F 157		

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F 157	Continued From page 3 2/15 at 5:30 p.m. - 357 2/16 at 5:30 p.m. - 392 2/19 at 9:00 p.m. - 318 2/20 at 9:00 p.m. - 316 2/21 at 9:00 p.m. - 318 3/3 at 5:30 p.m. - 377 3/3 at 9:00 p.m. - 410 3/4 at 9:00 p.m. - 323 3/7 at 5:30 p.m. - 345 3/23 at 9:00 p.m. - 349 Review of Resident #9's clinical record did not reveal physician notification of the Accuchecks that were > 300. Review of the clinical record revealed a Hemoglobin A1C on 3/1/16 of 7.8 - H (high) Reference Range 4.0 - 6.0. "The A1C is a lab test that shows the average level of blood sugar (glucose) over the previous 3 months. It shows how well you are controlling your diabetes." https://www.nlm.nih.gov/medlineplus/ency/article/003640.htm The clinical record revealed Resident #9 was receiving Prednisone (a steroid, or corticosteroid) during the month of February. "Prednisone: Adverse Reactions: ...hyperglycemia (elevated blood sugar)... Nursing Actions: Physical Assessment:.. monitor serum glucose levels closely; corticosteroids can alter glucose tolerance...." This information was obtained from Drug Information Handbook for Nursing 2007 8th Edition, published by Lexi-Comp's, Turonski, Lance and Bonfiglio; pages 1019-1021.	F 157		

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F 157	Continued From page 4 The physician visit dated 3/1/16 revealed a progress note that stated, "increased BG (blood Glucose) with Prednisone." On 3/23/16 at 3:15 p.m., at the end of day briefing, the unit manager, RN (Registered Nurse) A and the DON (Director of Nursing) were in attendance. RN A was informed of the Accuchecks that were greater than 300 and that there was no documentation that the physician was notified of elevated blood sugars. RN A said she would review Resident #9's clinical record to see if there were any physician notifications. On 3/24/16 at 12:25 p.m., the DON reported that RN A was unable to find any notifications to the physician of the Accuchecks that were outside of the physician ordered parameters. In Basic Nursing, Essential for Practice, 6th edition (Potter and Perry, 2007, pages 56-59), was a reference source for physician's orders and notification. Failure to monitor the patient's condition appropriately and communicate that information to the physician or health care provider are causes of negligent acts. The best way to avoid being liable for negligence is to follow standards of care, to give competent health care, and to communicate with other health care providers. On page 336, "The physician is responsible for directing medical treatment. Nurses follow physician's orders unless they believe the orders are in error or harm clients." On 3/24/16 at 12:45 p.m., the administration was notified of above findings. No additional information was provided.	F 157		

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F 157	Continued From page 5 * This information was obtained from the website: http://www.nhlbi.nih.gov/news/spotlight/fact-sheet/systolic-blood-pressure-intervention-trial-sprint-questions-and-answers	F 157		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance	F 225	**F 225** **SS=D** The facility will ensure that all alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). **1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.** a. Resident #6's injury of unknown origin was reported on 9/14/2015. She was sent to the hospital on 9/12/2015 and was readmitted from the hospital on 9/22/2015. **2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice.** a. All residents have the potential to be affected. **3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.** a. Staff will be in-serviced on the abuse policy and procedures with particular attention paid to timely notification by the Director of Nursing/Designee.	5/8/16 5/8/16 5/8/16

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F 225	Continued From page 6 with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review, the facility staff failed to report an injury of unknown origin to the State Agency in a timely manner for one resident (Resident #6) of 17 residents in the survey sample. For Resident #6, an injury of unknown origin (right hip pain and bruising of hip and knee) was reported by the resident, to facility staff, and assessed on 9-12-15. The Resident could not say how it happened. The injury of unknown origin was not reported to the State Agency until 9-14-15. Injuries of unknown origin are to be reported to the State Agency immediately, and not to exceed, within 24 hours. The findings included: Resident #6 was originally admitted to the facility on 6-4-12 with diagnoses of, but not limited to, high cholesterol, dementia with behaviors, Congestive Obstructive Pulmonary Disorder, anxiety, hypertension, stroke, seizures, depression, congestive heart failure, and Gastro-esophageal reflux disease. The most recent Minimum Data Set (MDS) was a quarterly assessment, with an Assessment Reference Date (ARD) of 1-29-16. The MDS	F 225	b. Injuries will be reviewed immediately by the RN Unit Manager/Designee and if they are of unknown origin they will immediately report this to the Administrator/Supervisor. **4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.** a. Director of Nursing/designee will audit Incident reports weekly for 3 months to ensure all injuries of unknown origin have been reported timely. b. Director of Nursing/designee will report the results of audits to the QAPI committee monthly for 3 months. c. Audit results / trends will be reviewed at QAPI meeting to ensure that Action Plans are effective. Additional action plans will be done as needed.	5/8/16 5/8/16 5/8/16 5/8/16

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F 225	Continued From page 7 coded Resident #6 with severe cognitive impairment, and requiring total dependence on staff for activities of daily living. On 3-24-16 a Facility Reported Incident (FRI) was reviewed with the Administrator and Director of Nursing (DON). The Review of the FRI revealed Resident #6 informed facility staff on 9-12-15 that her right hip hurt, and she was assessed by nursing to have "new bruises" on her right knee and right hip. Resident #6 was ordered by the physician on 9-12-15 to have an x-ray, which showed fracture of the right hip, and the Resident was sent to the hospital where a second x-ray revealed an acute fracture of the right hip on 9-12-15. Resident #6 underwent surgery to repair the hip fracture on 9-13-15, and the injury of unknown origin was not reported to the state until the facility investigation into the injury was completed on 9-14-15. The final 5 day follow up Facility Incident Report was received at the State Agency-Office of Licensure and Certification (OLC) on 9-16-15. Review of facility policy titled "Resident Abuse" with an effective date of May 2008 and a revised date of January 2016 included: "7. Initial Reports a.) Timing. All allegations of Abuse, Neglect, Involuntary Seclusion, Injuries of Unknown Source, and Misappropriation of resident property must be reported immediately* to the Administrator, Director of Nursing (DON), and to the applicable State Agency." b.) Regional Director of Clinical Services (RDCS) will be notified of the allegation by the Administrator or DON (director of nursing), prior to submitting the immediate state self reported	F 225		

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F 225	Continued From page 8 incident form to the applicable state agency. Once approved by the RDCS, the immediate report will be submitted. * Immediately means as soon as possible but ought not exceed 24 hours. This information is from the State Operations Manual Appendix PP Long Term Care Facilities, 12/12/2014. The facility conducted an investigation prior to reporting this injury of unknown origin to the State Agency. The Administrator was asked when injuries of unknown origin should be reported, and the reply was that they had to do the investigation to ascertain if this was a reportable incident, prior to reporting. On 3-24-16 at approximately 12:15 p.m. the Administrator was informed of the findings. No further information was provided by the facility.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review, the facility staff failed to implement the facility abuse policy to immediately report an injury of unknown origin to the State	F 226	**F 226** **SS=D** The facility will immediately report any injury of unknown origin to the State Agency. **1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.** a. Resident #6's injury of unknown origin was reported on 9/14/2015. She was sent to the hospital on 9/12/2015 and was readmitted from the hospital on 9/22/2015.	5/8/16

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F 226	Continued From page 9 Agency for one resident (Resident #6) of 17 residents in the survey sample. For Resident #6, an injury of unknown origin (right hip pain and bruising of hip and knee) was reported by the resident, to facility staff, and assessed on 9-12-15. The Resident could not say how it happened. The facility staff failed to immediately report Resident #6's injury of unknown origin to the State Agency. The injury of unknown origin was not reported to the State Agency until 9-14-15. The findings included: Resident #6 was originally admitted to the facility on 6-4-12 with diagnoses of, but not limited to, high cholesterol, dementia with behaviors, Congestive Obstructive Pulmonary Disorder, anxiety, hypertension, stroke, seizures, depression, congestive heart failure, and Gastro-esophageal reflux disease. The most recent Minimum Data Set (MDS) was a quarterly assessment, with an Assessment Reference Date (ARD) of 1-29-16. The MDS coded Resident #6 with severe cognitive impairment, and requiring total dependence on staff for activities of daily living. On 3-24-16 a Facility Reported Incident (FRI) was reviewed with the Administrator and Director of Nursing (DON). The Review of the FRI revealed Resident #6 informed facility staff on 9-12-15 that her right hip hurt, and she was assessed by nursing to have "new bruises" on her right knee and right hip. Resident #6 was ordered by the physician on 9-12-15 to have an x-ray, which showed fracture of the right hip, and the Resident	F 226	**2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice.** a. All residents have the potential to be affected. **3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.** a. Staff will be in-serviced on the abuse policy and procedures with particular attention paid to timely notification by the Director of Nursing/Designee. b. Injuries will be reviewed immediately by the RN Unit Manager/Designee and if they are of unknown origin they will immediately report this to the Administrator/Supervisor. **4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.** a. Director of Nursing/designee will audit Incident reports weekly for 3 months to ensure all injuries of unknown origin have been reported timely. b. Director of Nursing/designee will report the results of audits to the QAPI committee monthly for 3 months. c. Audit results / trends will be reviewed at QAPI meeting to ensure that Action Plans are effective. Additional action plans will be done as needed.	5/8/16 5/8/16 5/8/16 5/8/16 5/8/16 5/8/16

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F 226	Continued From page 10 was sent to the hospital where a second x-ray revealed an acute fracture of the right hip on 9-12-15. Resident #6 underwent surgery to repair the hip fracture on 9-13-15, and the injury of unknown origin was not reported to the state until the facility investigation into the injury was completed on 9-14-15. The final 5 day follow up Facility Incident Report was received at the State Agency-Office of Licensure and Certification (OLC) on 9-16-15. Review of facility policy titled "Resident Abuse" with an effective date of May 2008 and a revised date of January 2016 included: "7. Initial Reports a.) Timing. All allegations of Abuse, Neglect, Involuntary Seclusion, Injuries of Unknown Source, and Misappropriation of resident property must be reported immediately* to the Administrator, Director of Nursing (DON), and to the applicable State Agency." b.) Regional Director of Clinical Services (RDCS) will be notified of the allegation by the Administrator or DON (director of nursing), prior to submitting the immediate state self reported incident form to the applicable state agency. Once approved by the RDCS, the immediate report will be submitted. * Immediately means as soon as possible but ought not exceed 24 hours. This information is from the State Operations Manual Appendix PP Long Term Care Facilities, 12/12/2014. The facility did not immediately report Resident #6's injury of unknown origin and conducted an investigation prior to reporting.	F 226		

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F 226	Continued From page 11 The Administrator was asked when injuries of unknown origin should be reported, and the reply was that they had to do the investigation to ascertain if this was a reportable incident, prior to reporting, and then immediately. On 3-24-16 at approximately 12:15 p.m. the Administrator was informed of the findings. No further information was provided by the facility.	F 226		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, clinical record review, the facility staff failed to follow physician orders for 2 residents (Resident #9 and Resident #15) of 17 residents in the survey sample. 1. On multiple occasions during February and March 2016 the facility staff did not notify the physician of Resident #9's blood sugar readings above the physician ordered parameter of 300 as ordered. 2. The facility staff failed to follow the physician orders for administration of Carvedilol (blood	F 309	**F 309 SS=D** The facility will ensure that each resident receives the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. **1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.** a. Resident #9's MD was notified on 3/23/16 concerning the Blood Sugars exceeding the parameters. MD order for sliding scale insulin given on 3/29/16. b. Resident # 15 was a closed record review and resident is no longer in the facility. **2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice.** a. Residents with Blood Sugar tests / parameters will have their charts reviewed to ensure MD order parameters are being followed and MD is notified b. Residents found with Blood Sugars out of Parameters will have their MD notified with follow up as appropriate.	3/29/16 5/8/16 5/8/16 5/8/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495401	A. BUILDING _____ B. WING _____	03/24/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TYLER'S RETREAT AT IRON BRIDGE	12001 IRON BRIDGE RD CHESTER, VA 23831

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 12 pressure medication) to Resident #15. The facility staff administered Carvediol to Resident #15, on two occasions when the residents systolic blood pressure (Systolic pressure [top number] is the pressure on the arteries when the heart beats and pumps blood through the arteries*) and heart rate was less than the physician prescribed parameter. The findings included: 1. Resident #9 was admitted to the facility 5/31/13 and readmitted after hospitalization on 9/1/14. Diagnoses included hypertension, depression, obstructive pulmonary disease, and diabetes mellitus (DM). Resident #9's most recent MDS (minimum data set) with an ARD (assessment reference date) of 3/16/16 was coded as an annual assessment. Resident #9 was coded as having a BIMS (brief interview of mental status) of "13" out of a possible 15, or no cognitive impairment. Resident #9 was also coded as requiring extensive assistance of one to two staff members to perform activities of daily living, such as bed mobility and transfer. Resident #9 was coded as requiring limited assistance of one staff member for eating. Resident #9's comprehensive care plan included a plan of care that read, "Resident is at risk for hypo/hyperglycemia episodes R/T (related to): IDDM (insulin dependent diabetes mellitus). Interventions included, "Labs (laboratory test) as ordered and report abnormalities in results to MD (medical doctor)." A review of the clinical record revealed the	F 309	c. Resident's receiving a Blood Pressure Medication with parameters will be audited to see if Medication held if Heart rate or Blood Pressure is outside of parameters. d. MD will be notified of any residents found where medications were not held if outside of parameters and new orders obtained as needed. **3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.** a. Nurses will be in-serviced on MD notification policy by Director of Nursing / Designee. b. Nurses will be in-serviced on following MD Orders as it relates to parameters by Director of Nursing / Designee. **4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.** a. Unit Managers will audit 3 residents with Blood Sugars weekly for three months to ensure proper MD notification occurs. b. Unit Managers will audit 3 residents with Blood Pressure Medications with parameters weekly for three months to ensure Medications are held as ordered. c. Unit Managers will report the results of the audits to the QAPI committee monthly for 3 months. d. Audit results / trends will be reviewed at QAPI meeting to ensure that Action Plans are effective. Additional action plans will be done as needed.	5/8/16 5/8/16 5/8/16 5/8/16 5/8/16 5/8/16 5/8/16

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TYLER'S RETREAT AT IRON BRIDGE	12001 IRON BRIDGE RD CHESTER, VA 23831

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F 309	Continued From page 13 following physician order initially dated 10/29/14 for blood glucose monitoring, "ACCUCHECKS BEFORE MEALS AND AT BEDTIME FOR DM. CALL MD (MEDICAL DOCTOR) IF BLOOD SUGAR > (greater than) 300 or < (less than) 60. Accuchecks- are blood glucose checks completed with a glucose monitor. "To do the test, prick your finger with the needle and place a drop of blood on a special strip. This strip measures how much glucose is in your blood. The meter shows your blood sugar results as a number on a digital display." This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/patientinstructions/000324.htm Review of the clinical record revealed the following Accucheck Readings on the February and March 2016 MAR (medication administration record) 2/3 at 9:00 p.m. - 316 2/10 at 5:30 p.m. - 319 2/15 at 5:30 p.m. - 357 2/16 at 5:30 p.m. - 392 2/19 at 9:00 p.m. - 318 2/20 at 9:00 p.m. - 316 2/21 at 9:00 p.m. - 318 3/3 at 5:30 p.m. - 377 3/3 at 9:00 p.m. - 410 3/4 at 9:00 p.m. - 323 3/7 at 5:30 p.m. - 345 3/23 at 9:00 p.m. - 349 Review of Resident #9's clinical record did not reveal physician notification of the Accuchecks that were > 300.	F 309		

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	495401	A. BUILDING _____ B. WING _____	03/24/2016

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F 309	Continued From page 14 Review of the clinical record revealed a Hemoglobin A1C on 3/1/16 of 7.8 - H (high) Reference Range 4.0 - 6.0. "The A1C is a lab test that shows the average level of blood sugar (glucose) over the previous 3 months. It shows how well you are controlling your diabetes." https://www.nlm.nih.gov/medlineplus/ency/article/003640.htm The clinical record revealed Resident #9 was receiving Prednisone (a steroid) during the month of February. "Prednisone: Adverse Reactions: ...hyperglycemia (elevated blood sugar)... Nursing Actions: Physical Assessment:.. monitor serum glucose levels closely; corticosteroids can alter glucose tolerance...." This information was obtained from Drug Information Handbook for Nursing 2007 8th Edition, published by Lexi-Comp's, Turonski, Lance and Bonfiglio; pages 1019-1021. The physician visit dated 3/1/16 revealed a progress note that stated, "increased BG (blood Glucose) with Prednisone." On 3/23/16 at 3:15 p.m., at the end of day briefing, the unit manager, RN (Registered Nurse) A and the DON (Director of Nursing) were in attendance. RN A was informed of the Accuchecks that were greater than 300 and that there was no documentation that the physician was notified of elevated blood sugars. RN A said she would review Resident #9's clinical record to see if there were any physician notifications. On 3/24/16 at 12:25 p.m., the DON reported that	F 309		

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F 309	Continued From page 15 RN A was unable to find any notifications to the physician of the Accuchecks that were outside of the physician ordered parameters. Mosby's Manual of Medical-Surgical Nursing Care (sixth edition 2007 page 478) states "the most important factor in delaying progression to long-term complications (in Diabetic Care) is stabilization of blood glucose levels to normal range". Guidance for nursing practice for the administration of medications was included in, "Fundamentals of Nursing 7th Edition, p 336, The physician is responsible for directing medical treatment. Nurses follow physician's orders unless they believe the orders are in error or harm clients." On 3/24/16 at 12:45 p.m., the administration was notified of above findings. No additional information was provided. * This information was obtained from the website: http://www.nhlbi.nih.gov/news/spotlight/fact-sheet/systolic-blood-pressure-intervention-trial-sprint-questions-and-answers 2. Resident #15 was admitted to the facility 3/4/16. Diagnoses included heart disease, hypertension and arthritis. Resident #15 had not been at the facility long enough to have an MDS (minimum data set) completed. Review of the admitting nursing assessment revealed she had been assessed as alert, oriented to person, place and time and as	F 309		

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F 309	Continued From page 16 showing no signs of emotional distress. She was also assessed as requiring transfer assistance of one person for transfers and with activities of daily living. Review of the clinical record revealed a physician visit and progress note dated 3/11/16. Under Physical Examination read BP (blood pressure) - 89/42. Under Assessment/Plans and Medical Decision Making read, "Diagnosis Hypotension - Decrease Meds (medications)." Review of Resident #15's clinical record revealed a telephone order dated 3/11/16 that was a change to the admission order of Carvedilol which read, "D/C (discontinue) 6.25 mg (milligram) po (by mouth BID (twice a day). Start Carvedilol 3.125 mg po BID. HOLD if HR < 60 or SBP < 110." An accompanying entry on the MAR (medication administration record) indicated Carvedilol 3.125 mg was administered twice daily from 3/12/16 through 3/16/16. On 3/13 at 5:00 p.m. the blood pressure reading was 116/62, HR 56. On 3/14 at 5:00 p.m. the blood pressure reading was 104/62, HR 58. Above each of these readings were nurses ' initials indicating the medication, Carvedilol, was administered on those dates and times. A thorough review of the clinical record did not reveal documentation of Resident #15's blood pressure having been held per the physician ordered parameters on 3/13 and 3/14. The clinical record did not reveal physician notification of the administration of the medication that, according to the physician parameters, was ordered to be held.	F 309		

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F 309	Continued From page 17 On 3/24/16 at 9:50 a.m., the unit manager, Registered Nurse (RN) A, was informed of the blood pressure readings on the dates in question. After reviewing the clinical record, RN A stated, "There was no documentation of the medication having been held." Review of the facility's policy entitled "Medication Administration-General Guidelines" included: "1). Facility staff should comply with Facility policy, Applicable Law and the State Operations Manual when administering medications. 4.1.1.) Verify each time a medication is administered that it is correct medication, at the correct dose, at the correct dose, at the correct route, at the correct rate, at the correct time, for the correct resident." Guidance for nursing practice for the administration of medications was included in, "Fundamentals of Nursing 7th Edition, p 336, The physician is responsible for directing medical treatment. Nurses follow physician's orders unless they believe the orders are in error or harm clients." The administration was informed of the failure of the staff failure to follow the physician order for administration of a medication on 3/24/16 at 12:45 p.m.	F 309		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of	F 329	**F 329** **SS=D** The facility will ensure that each resident's drug regimen is free from unnecessary drugs. **1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.** a. Resident # 15 was a closed record review and resident is no longer in the facility.	5/8/16

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F 329	Continued From page 18 adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation and clinical record review, the facility staff failed to ensure one Resident (Resident #15) in a survey sample of 17 Residents was free from unnecessary medication. Facility staff administered Carvedilol (blood pressure medication) to Resident #15 on 2 occasions when the residents systolic blood pressure (SBP) and or heart rate was below the physician prescribed parameters. Systolic pressure [top number] is the pressure on the arteries when the heart beats and pumps blood through the arteries* The findings included:	F 329	**2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice.** a. Residents receiving a Blood Pressure Medication with parameters will be audited to see if Medication held if Heart rate or Blood Pressure is outside of parameters. b. MD will be notified of any residents found where medications were not held if outside of parameters and new orders obtained as needed. **3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.** a. Nurses will be in-serviced on following MD Orders as it relates to parameters by Director of Nursing / Designee. **4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.** a. Unit Managers will audit 3 residents with Blood Pressure Medications with parameters weekly for three months to ensure proper MD notification occurs. b. Unit Managers will report the results of the audits to the QAPI committee monthly for 3 months. c. Audit results / trends will be reviewed at QAPI meeting to ensure that Action Plans are effective. Additional action plans will be done as needed.	5/8/16 5/8/16 5/8/16 5/8/16 5/8/16 5/8/16

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	495401	A. BUILDING _____ B. WING _____	03/24/2016

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F 329	Continued From page 19 Resident #15 was admitted to the facility 3/4/16. Diagnoses included heart disease, hypertension and arthritis.. Resident #15 had not been at the facility long enough to have an MDS (minimum data set) completed. Review of the admitting nursing assessment revealed she had been assessed as alert, oriented to person, place and time and as showing no signs of emotional distress. She was also assessed as requiring transfer assistance of one person for transfers and with activities of daily living. Review of the clinical record revealed a physician visit and progress note dated 3/11/16. Under Physical Examination read BP (blood pressure) "89/42". Under Assessment/Plans and Medical Decision Making read, "Diagnosis Hypotension - Decrease Meds (medications)." Review of Resident #15's clinical record revealed a telephone order dated 3/11/16 that was a change to the admission order of Carvedilol: "D/C (discontinue) 6.25 mg (milligram) po (by mouth) BID (twice a day). Start Carvedilol 3.125 mg po BID. HOLD if HR (heart rate) < 60 or SBP < 110." An accompanying entry on the MAR (medication administration record) indicated Carvedilol 3.125 mg was administered twice daily from 3/12/16 through 3/16/16. On 3/13 at 5:00 p.m. the blood pressure reading was 116/62, HR 56. On 3/14 at 5:00 p.m. the blood pressure reading was 104/62, HR 58. Above each of these reading were nurse's initials indicating the medication,	F 329		

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F 329	Continued From page 20 Carvedilol, was administered on those dates and times. A thorough review of the clinical record did not reveal documentation of Resident #15's Carvedilol having been held per the physician ordered parameters on 3/13 and 3/14. On 3/24/16 at 9:50 a.m., the unit manager, Registered Nurse (RN) A, was informed of the blood pressure readings on the dates in question. After reviewing the clinical record, RN A stated, "I don't see where the medication was held on the dates in question." Review of the facility's policy entitled "Medication Administration-General Guidelines" included: "1). Facility staff should comply with Facility policy, Applicable Law and the State Operations Manual when administering medications. 4.1.1.) Verify each time a medication is administered that it is correct medication, at the correct dose, at the correct dose, at the correct route, at the correct rate, at the correct time, for the correct resident." Guidance for nursing practice for the administration of medications was included in, "Fundamentals of Nursing 7th Edition, p 336, The physician is responsible for directing medical treatment. Nurses follow physician's orders unless they believe the orders are in error or harm clients." The administration was informed of the failure of the staff to ensure Resident #15's blood pressure medication was held according to the physician ordered parameters, 3/24/16 at 12:45 p.m. No additional information was provided.	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495401	A. BUILDING _____ B. WING _____	03/24/2016

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TYLER'S RETREAT AT IRON BRIDGE	12001 IRON BRIDGE RD CHESTER, VA 23831

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F 329	Continued From page 21 * This information was obtained from the website: http://www.nhlbi.nih.gov/news/spotlight/fact-sheet/systolic-blood-pressure-intervention-trial-sprint-questions-and-answers	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0402	A. BUILDING _____ B. WING _____	03/24/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TYLER'S RETREAT AT IRON BRIDGE	12001 IRON BRIDGE RD CHESTER, VA 23831

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F 000	Initial Comments An unannounced Medicare/Medicaid standard survey and biennial State Licensure Inspection was conducted 3/22-24/2016. Corrections are required for compliance with 42 CFR Part 483 Federal Long term Care Requirements and Virginia Rules and Regulations for the Licensure of Nursing Facilities. The Life Safety Report/Survey will follow. The census in this 90 certified bed facility was 83 at the time of the survey. The survey sample consisted of 14 current residents (Residents 1-14) and 3 closed records (Residents 15-17).	F 000		
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: The facility was not in compliance with the following Virginia Rules and Regulations for the Licensure of Nursing Facilities: 12 VAC 5-371-220 (H)-Please cross refernce to F157 12 VAC 5-371-110 (B.2-3)-Please cross reference to F225 12 VAC 5-371-140-Please cross reference F226 12VAC5-371-220. Nursing services - Please cross reference to F309. 12 VAC 5-371-220 (A)-Please cross reference F329	F 001	12 VAC 5-371-220 (H)-Please cross referenced to F157 12 VAC 5-371-110 (B.2-3)-Please cross reference to F225 12 VAC 5-371-140-Please cross referenced to F226 12 VAC 5-371-220. Nursing Services – Please cross referenced to F 309 12 VAC 5-371-220 (A)-Please cross referenced to F329	

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