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 _____	05/04/2018

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) COMPLETE DATE
F 000	Initial Comments An unannounced biennial State Licensure Inspection was conducted 5/2/18 through 5/4/18. Corrections are required for compliance with the following Virginia Rules and Regulations for the Licensure of Nursing Facilities. The census in this 90 certified bed facility was 83 at the time of the survey. The survey sample consisted of 33 current Resident reviews (Residents #1, #36, #13, #323, #30, #24, #58, #56, #47, #7, #35, #19, #326, #2, #62, #60, #16, #50, #28, #45, #12, #29, #70, #4, #25, #273, #49, #44, #42, #68, #26, #46, and #21) and 3 closed record reviews (Residents #74, #73, and #75).	F 000	State Tag 1. Employee RN #6 and C.N.A. #6 are no longer employed by facility. b. Employee #12 will no longer work until criminal background is obtained. 2. All residents have the risk to be affected by this deficient practice. b.100% audit of current license staff to be done to ensure background and license checks are done. 3. Administrator will in service department managers and human resources on pre-hiring process. 4. a. Administrator or designee will Conduct weekly audits on new hire Paperwork for twelve weeks. b. Administrator 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.	6/4/18
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: 12 VAC 5 - 371 - 220 B cross references to Federal tag - 684 12 VAC 5 - 371 - 300 B cross references to Federal tag - 761 12 VAC 5 - 371 - 140 D 13 and 12 VAC 5 - 371 - 180 C cross references to Federal tag F880 12VAC5-371-140. Policies and Procedures. Cross reference to F622 and F842 12VAC5-371-150. Resident Rights. Cross reference to F622 12VAC5-371-360. Clinical Records. Cross reference to F842	F 001	RECEIVED JUN 04 2018 VDH/OLC	6/4/2018

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Shawanda Jeter, LNHA		5-15-18

Pmaggoba, DON for Shawanda Jeter administrator 6/4/2018

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	495401	A. BUILDING _____ B. WING _____	05/04/2018

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F 550	Continued From page 1 individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that facility staff failed to maintain dignity for two of 26 residents in the survey sample, Resident #28 and #12. 1. Resident #28 received her breakfast 43 minutes after another resident who was sitting at the same table.	F 550	4.a. Unit Managers or designee will audit Restorative Dining Program 5 x a week for 2 months to ensure residents seated at the same time. b. Unit Managers will report the results of the audits to the QAPI committee monthly for 2 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. 6/4/2018 RECEIVED JUN 04 2018 VDH/OLC	

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F 550	Continued From page 2 2. Resident #12 received her breakfast 28 minutes after another resident who was sitting at the same table. The findings include: 1. Resident #28 received her breakfast 43 minutes after another resident who was sitting at the same table. Resident #28 was admitted to the facility on 6/14/2013 with diagnoses that included but were not limited to heart failure, high blood pressure, type two diabetes, and muscle weakness. Resident #28's most recent MDS (minimum data set) was a significant change assessment with an ARD (assessment reference date) of 2/26/18. Resident #28 was coded as severely cognitively impaired in the ability to make daily decisions scoring a three out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #28 was coded as requiring limited assistance from one staff member with meals. On 5/2/18 at 8:05 a.m., observation of the restorative dining room was conducted. There were two CNAs assisting with feeding at this time. At 8:29 a.m., CNA (certified nursing assistant) #4, was observed serving food to a resident who was sitting next Resident #28. CNA #4 then pulled over a chair and started assisting this resident with his breakfast. Resident #28 did not receive her tray until he was finished with his breakfast. Resident #28 did not receive her breakfast until 9:12 a.m. Resident #28 also required feeding assistance. On 5/4/18 at 10:26 a.m., an interview was	F 550		

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F 550	Continued From page 3 conducted with CNA #2, a CNA who feeds residents in the restorative dining room. When asked how staff can maintain residents' dignity while serving and assisting them with meals in the dining room, CNA #2 stated that she will use cover ups to protect the resident's clothes. When asked if it was okay to serve and feed a resident right next to another resident who does not have a meal, CNA #2 stated, "They shouldn't be. We try not to let them wait too long. Sometimes the resident has to wait a little longer." When asked how she would feel if she was at a restaurant and her food did not come out until about 30 minutes or longer after everyone else's meal, CNA #2 stated, "I would be ready to leave, I probably would leave." When asked how many aides are usually in the restorative dining room, CNA #2 stated, "On a good day three, on a bad day one." CNA #2 stated that it was difficult to feed residents at the same time because most of the residents required full assistance with their meals. CNA #4 could not be reached for an interview. On 5/4/18 at 10:39 a.m., ASM (administrative staff member) #1, the administrator was made aware of the above concerns. The facility policy titled, "Dining room Environment," documented in part, the following: "Tables shall be served in a manner so that all residents seated at a table receive meals at the same time." No further information was presented prior to exit. 2. Resident #12 received her breakfast 28 minutes after another resident who was sitting at	F 550		

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F 550	Continued From page 4 the same table. Resident #12 was admitted to the facility on 7/26/17 with diagnoses that included but were not limited to dysphagia (difficulty swallowing), unspecified dementia without behavioral disturbance, high blood pressure, and hypothyroidism. Resident #12's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 2/13/18. Resident #12 was coded as being severely impaired in cognitive function scoring four out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #12 was coded as requiring supervision and set up help only with meals. On 5/2/18 at 8:05 a.m., observation of the restorative dining room was conducted. On 5/2/18 at 8:53 a.m., RN (registered nurse) #2 was directed by CNA (certified nursing assistant) #4, to feed Resident #24. Resident #24 was sitting next to Resident #12 at the same table. RN #2 set up Resident #24's breakfast and began to assist her with feeding. Resident #12 was not able to get her breakfast until after Resident #24 was finished. Resident #12 received her breakfast and started eating at 9:20 a.m. Resident #12 did require some assistance with her breakfast from staff. On 5/4/18 at 10:26 a.m., an interview was conducted with CNA #2, a CNA who feeds residents in the restorative dining room. When asked how staff can maintain residents' dignity while serving and assisting them with meals in the dining room, CNA #2 stated that she will use cover ups to protect the resident's clothes. When asked if it was okay to serve and feed a resident	F 550		

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F 550	Continued From page 5 right next to another resident who does not have a meal, CNA #2 stated, "They shouldn't be. We try not to let them wait too long. Sometimes the resident has to wait a little longer." When asked how she would feel if she was at a restaurant and her food did not come out until about 30 minutes or longer after everyone else's meal, CNA #2 stated, "I would be ready to leave, I probably would leave." When asked how many aides are usually in the restorative dining room, CNA #2 stated, "On a good day three, on a bad day one." CNA #2 stated that it was difficult to feed residents at the same time because most of the residents required full assistance with their meals. CNA #4 could not be reached for an interview. On 5/4/18 at 10:39 a.m., ASM (administrative staff member) #1, the administrator was made aware of the above concerns.	F 550		
F 622 SS=E	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;	F 622	1. No corrections to be made for resident #323, 7, 44, 21, and 47. 2. Any resident transferring to a hospital are at risk for the deficient practice. 3. Director of Nursing or designee will inservice license nursing staff on required components related to hospital transfer including sending a copy of residents care plan to receiving facility. 4. a. Unit Manager or designee will audit all residents transferred to the hospital for 2 months to ensure a copy of the care plan is sent with the resident. b. Unit Managers will report the results of the audits to the QAPI committee monthly for 2 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.	6/4/18

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F 622	Continued From page 6 (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)	F 622		

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F 622	Continued From page 7 (i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that facility staff failed to meet all the required components for a hospital transfer for five of 36 residents in the survey sample, Residents #323, #7, #44, #21, #47.	F 622		

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F 622	Continued From page 8 1. The facility staff failed to ensure Resident # #323's care plan goals were provided to the receiving provider for a facility-initiated transfer to hospital on 4/14/18. 2. The facility staff failed to ensure Resident #7's care plan goals were provided to the receiving provider for a facility-initiated transfer to hospital on 3/1/18. 3. The facility staff failed to ensure Resident # 44's care plan goals were provided to the receiving provider for facility-initiated transfers to hospital on 2/14/18 and 3/25/18. 4. The facility staff failed to ensure Resident #21's care plan goals were provided to the receiving provider for a facility-initiated transfer to hospital on 4/23/18. 5. The facility staff failed to ensure Resident #47's care plan goals were provided to the receiving provider for a facility-initiated transfer to hospital on 1/02/18. The findings include: 1. The facility staff failed to ensure Resident # #323's care plan goals were provided to the receiving provider for a facility-initiated transfer to hospital on 4/14/18. Resident #323 was admitted to the facility on 8/24/17 and readmitted on 4/14/18 with diagnoses that included but were not limited to muscle weakness, enlarged prostate, and aortic stenosis, left femur and left distal radius fracture. Resident #323's most recent MDS (minimum	F 622		

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F 622	Continued From page 9 data set) assessment was a 14 day scheduled assessment with an ARD (assessment reference date) of 4/30/18. Resident #323 was coded as being cognitively intact in the ability to make daily decisions scoring 14 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Review of Resident #323's nursing notes revealed that he had been transferred to the hospital on 4/14/18. The following note was documented at 3:00 p.m., " ...Bleeding (new blood) observed to rolled gauze portion of soft cast (L) (left) arm. No ssx (sign/symptoms) of distress, no c/o (complaints) of pain. Reported to primary care clinician: (Name of MD) (medical doctor) on 4/14/18 at 3:20 PM. Order obtained: Other Send (sic) to ER (emergency room) for eval (Evaluation)." The next note documented on 4/14/18 at 10:41 p.m., revealed that Resident #323 arrived back to the facility the same day. The following was documented, "Resident sent to (Name of Hospital) for eval. (Evaluation). Resident noted with blood to cast on LUE (left upper extremity). Resident denies pain or discomfort. No distress noted. Left via ambulance via stretcher @ (at) 3:50pm (p.m.). Return with N.N.O's (no new orders). Abrasion noted under cast. Area clean and drsg (dressing) put into place by ER (emergency room) nurse. No distress noted. RP (responsible party) aware." There was no evidence documented in the clinical record that all the required information; Resident #323's advanced directives, responsible party contact information, and Resident #323's care plan was provided to the hospital for the facility-initiated transfer.	F 622		

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F 622	Continued From page 10 On 05/03/18 at 2:34 p.m., an interview was conducted with LPN (licensed practical nurse) #4, Resident #323's nurse, regarding the process staff follows when residents are sent out to the hospital. LPN #4 stated call the doctor, explain what was going on with the patient and then send the resident out after she received a doctor's order. When asked if a transfer would be documented in the clinical record, LPN #4 stated that she would document the transfer in a nursing note. LPN #4 stated she would document the symptoms the resident was exhibiting and that the responsible party and the medical doctor was aware of the situation. LPN #4 stated she would also document that the physician gave an order to send the resident to the hospital and the time EMS arrived to pick up the resident. When asked if she documented what documents/papers were sent with the resident at the time of the transfer, LPN #4 stated that nursing does not typically document this information. When asked what documents are sent with residents during a transfer, LPN #4 stated that nurses will send the SBAR (situation, background, assessment, recommendation) note, face sheet, medication listing, advanced directives, and any laboratory tests that are pertinent. When asked if the care plan is sent with residents to the hospital, LPN #4 stated that they do not send the care plan. LPN #4 stated that she was the nurse who sent Resident #323 to the hospital on 4/14/18. LPN #4 stated that the physician wanted the resident sent out because of the area that he was bleeding from, underneath the soft cast. When asked if nurses were able to remove soft casts, LPN #4 stated that nurses were not allowed to remove soft casts at the facility. LPN #4 stated, "We are not allowed to touch that unless the doctor gives	F 622		

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F 622	Continued From page 11 instructions." On 5/4/18 at 10:39 a.m., ASM (administrative staff member) #1, the administrator, was made aware of the above concerns. The facility policy titled, "Discharge/Transfer Letter Policy," did not address the above concerns. No further information was presented prior to exit. 2. The facility staff failed to ensure Resident #7's care plan goals were provided to the receiving provider for a facility-initiated transfer to hospital on 3/1/18. Resident #7 was admitted to the facility on 10/6/16 with the diagnoses of but not limited to high blood pressure, anxiety disorder, depression, history of falls, dementia, osteoarthritis, and atrial fibrillation. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 2/9/18. The resident was coded as cognitively impaired in ability to make daily life decisions. A review of the clinical record revealed that Resident #7 was sent to the hospital on 3/1/18. Further review failed to reveal any documented evidence the required clinical record documentation including the care plan goals for Resident #7 were sent with the resident to the hospital. On 5/04/18 at 8:57 a.m., in an interview with RN #1 (Registered Nurse, the unit manager), she stated, "we send a face sheet, insurance	F 622		

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F 622	Continued From page 12	F 622		

information, transfer sheet, medication list, labs (laboratory tests), x-rays." When asked if the care plan goals are also provided, RN #1 stated, "The care plan is not sent."

A review of the facility policy, "Discharge/Transfer Letter Policy" did not document directions for the required documents to be sent to the hospital upon a resident transfer to the hospital.

On 5/4/18 at 10:12 a.m., the Administrator (administrative staff member) ASM #1, was made aware of the findings. No further information was provided.

3. The facility staff failed to ensure Resident # 44's care plan goals were provided to the receiving provider for facility-initiated transfers to hospital on 2/14/18 and 3/25/18.

Resident #44 was admitted to the facility on 1/25/17 with the diagnoses of but not limited to atrial fibrillation, depression, anxiety disorder, and dysphagia. The most recent MDS (Minimum Data Set) was an annual assessment with an ARD (Assessment Reference Date) of 3/14/18. The resident was cognitively intact in ability to make daily life decisions.

A review of the clinical record revealed Resident #44 was sent to the hospital on 2/14/18 and 3/25/18. Further review failed to reveal any documented evidence the required clinical record documentation including the care plan goals for Resident #44 were sent with the resident to the hospital.

On 5/04/18 at 8:57 AM, in an interview with RN

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 _____	05/04/2018

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 622	Continued From page 13 #1 (Registered Nurse, the unit manager) she stated, "we send a face sheet, insurance information, transfer sheet, medication list, labs, x-rays." When asked if the care plan goals are also provided, she stated, "The care plan is not sent." A review of the facility policy, "Discharge/Transfer Letter Policy" did not document directions for the required documents to be sent to the hospital upon a resident transfer to the hospital. On 5/4/18 at 10:12 a.m., the Administrator (administrative staff member) ASM #1, was made aware of the findings. No further information was provided. 4. The facility staff failed to ensure Resident #21's care plan goals were provided to the receiving provider for a facility-initiated transfer to hospital on 4/23/18. Resident #21 was admitted to the facility on 08/07/17 with recent readmission on 04/30/18, with diagnoses that included but were not limited to: dementia, pneumonia, diabetes, high blood pressure and atrial fibrillation (an irregular heartbeat) (1). The most recent MDS (minimum data set) assessment, a quarterly Medicare assessment, with an assessment reference date of 02/19/18, coded the resident as scoring a "13" on the BIMS (brief interview for mental status) score, indicating she has no cognitive impairment of daily decision making. The "Nurse Practitioner Progress Note" dated	F 622		

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 _____	05/04/2018

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 622	Continued From page 14	F 622		

04/23/18 at 11:28 a.m., documented in part, "HR (heart rate) irregular between 33-130's. Hypotensive (low blood pressure) of 86/48. Lethargic-send to ER (emergency room) stat (immediately) via 911 for possible atrial fibrillation ...Treatment plan discussed with patient and assigned nurse-daughter [Responsible Representative] made aware of hospital transport by charge nurse".

On 05/03/18 at 2:34 p.m., an interview was conducted with LPN (licensed practical nurse) #4, regarding the process staff follows when residents are sent out to the hospital. LPN #4 stated call the doctor, update what is going on with the resident, and then would transfer the resident to the hospital after she received a doctor's order. When asked if a transfer would be documented in the clinical record, LPN #4 stated that she would document the transfer in a nursing note. LPN #4 stated that she would document the symptoms the resident was exhibiting and that the responsible party and the medical doctor were aware of the situation. LPN #4 stated that she would also document that the physician gave an order to send the resident to the hospital and the time EMS (emergency medical services) arrived to pick up the resident. When asked if she documented what documents/papers were sent with the resident at the time of the transfer, LPN #4 stated that nursing does not typically document this information. When asked what documents were sent with residents during a transfer, LPN #4 stated that nurses will send the SBAR (situation, background, assessment, recommendation) note, face sheet, medication listing, advanced directives, and any laboratory tests that are pertinent. When asked if the care plan was sent

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 _____	05/04/2018

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 622	Continued From page 15 with residents to the hospital, LPN #4 stated that they do not send the care plan. During an interview with RN (registered nurse) #1, on 05/04/18 at 8:57 a.m., RN #1 was asked if care plan goals were sent with a resident upon transfer to the hospital. RN #1 stated they do not send care plans or care plan goals in the packet of information sent with a resident upon transfer to the hospital. ASM #1 (Administrative Staff Member), the administrator, was made aware of the above findings on 05/04/18 at 9:57 a.m. No further information was obtained prior to exit. (1) This information was obtained from the following website: https://medlineplus.gov/atrialfibrillation.html 5. The facility staff failed to ensure Resident #47's care plan goals were provided to the receiving provider for a facility-initiated transfer to hospital on 1/02/18. Resident #47 was admitted to the facility on 07/09/2014 with recent readmission on 01/04/18, with diagnoses that included but were not limited to: dementia, end stage kidney disease requiring hemodialysis (dialysis uses a machine to remove waste from the blood when kidneys can no longer do their job (1)), high blood pressure, peripheral vascular disease (narrowing and hardening of the blood vessels that supply the legs and feet (2)), and diabetes . The most recent MDS (minimum data set)	F 622		

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 _____	05/04/2018

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 622	Continued From page 16	F 622		

assessment, an annual Medicare assessment, with an assessment reference date of 03/19/18, coded the resident as scoring a "6" on the BIMS (brief interview for mental status) score, indicating she has severe cognitive impairment of daily decision making.

The nursing note, dated 01/02/18 at 2:50 a.m., documented in part, "Resident noted with elevated Temp (temperature) of 101.4, standing order of Tylenol (fever reducing medication (3)) given per MD (medical doctor). Temp rechecked after an hour Temp elevated to 102.4 ...Resident sent to ER (emergency room) for further Eval (evaluation)".

An MD order dated 01/02/18, documented "Transfer to ER for evaluation".

On 05/03/18 at 2:34 p.m., an interview was conducted with LPN (licensed practical nurse) #4, regarding the process staff follows when residents are sent out to the hospital. LPN #4 stated call the doctor, update what is going on with the resident, and then would transfer the resident to the hospital after she received a doctor's order. When asked if a transfer would be documented in the clinical record, LPN #4 stated that she would document the transfer in a nursing note. LPN #4 stated that she would document the symptoms the resident was exhibiting and that the responsible party and the medical doctor were aware of the situation. LPN #4 stated that she would also document that the physician gave an order to send the resident to the hospital and the time EMS (emergency medical services) arrived to pick up the resident. When asked if she documented what documents/papers were sent with the resident at

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 _____	05/04/2018

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 622	Continued From page 17 the time of the transfer, LPN #4 stated that nursing does not typically document this information. When asked what documents were sent with residents during a transfer, LPN #4 stated that nurses will send the SBAR (situation, background, assessment, recommendation) note, face sheet, medication listing, advanced directives, and any laboratory tests that are pertinent. When asked if the care plan was sent with residents to the hospital, LPN #4 stated that they do not send the care plan. During an interview with RN (registered nurse) #1, on 05/04/18 at 8:57 a.m., RN #1 was asked if care plan goals were sent with a resident upon transfer to the hospital. RN #1 stated they do not send care plans or care plan goals in the packet of information sent with a resident upon transfer to the hospital. ASM #1 (Administrative Staff Member), the administrator, was made aware of the above findings on 05/04/18 at 9:57 a.m. No further information was obtained prior to exit. (1) This information was obtained from the following website: https://medlineplus.gov/ency/patientinstructions/000707.htm (2) This information was obtained from the following website: https://medlineplus.gov/ency/article/000170.htm (3) This information was obtained from the following website: https://www.drugs.com/tylenol.html	F 622		

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 _____	05/04/2018

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 623	Continued From page 18	F 623		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is	F 623	1. No correction to be made for resident #323. 2. Any resident who is transferred to the hospital is at risk for the deficient practice. 3. a. Director of Nursing or designee will inservice license nursing staff on the need to notify the responsible party and document notification in the medical records related to resident transferred to the hospital. 3. b. Administrator will inservice Social Workers on requirements for notification of ombudsman. 4. a. Unit Manger or designee will audit all transfers to the hospital for 2 months to ensure responsible party is notified of hospital transfer. b. Administrator will audit all transfers to the hospital to ensure ombudsman was notified. c. Unit Manager and Administrator or designee will report the results of the audits to the QAPI committee monthly for 2 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.	6/4/2018

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 _____	05/04/2018

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 623	Continued From page 19 required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.	F 623		

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 _____	05/04/2018

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 623	Continued From page 20 §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that facility staff failed to provide written notification to the resident representative and the long term care ombudsman for a facility-initiated transfer for one of 36 residents in the survey sample, Resident #323. The facility staff failed to provide written notification to Resident #323's resident representative and ombudsman for a transfer to the hospital on 4/14/18. The findings include: Resident #323 was admitted to the facility on 8/24/17 and readmitted on 4/14/18 with diagnoses that included but were not limited to	F 623		

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 _____	05/04/2018

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 623	Continued From page 21	F 623		

muscle weakness, enlarged prostate, and aortic stenosis, left femur and left distal radius fracture. Resident #323's most recent MDS (minimum data set) assessment was a 14 day scheduled assessment with an ARD (assessment reference date) of 4/30/18. Resident #323 was coded as being cognitively intact in the ability to make daily decisions scoring 14 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam.

Review of Resident #323's nursing notes revealed that he had been transferred to the hospital on 4/14/18. The following note was documented at 3:00 p.m., " ...Bleeding (new blood) observed to rolled gauze portion of soft cast (L) (left) arm. No ssx (sign/symptoms) of distress, no c/o (complaints) of pain. Reported to primary care clinician: (Name of MD (medical doctor) on 4/14/18 at 3:20 PM. Order obtained: Other Send (sic) to ER (emergency room) for eval (Evaluation)."

The next note documented on 4/14/18 at 10:41 p.m., revealed that Resident #323 arrived back to the facility the same day. The following was documented, "Resident sent to (Name of Hospital) for eval. (Evaluation). Resident noted with blood to cast on LUE (left upper extremity). Resident denies pain or discomfort. No distress noted. Left via ambulance via stretcher @ (at) 3:50pm (p.m.). Return with N.N.O's (no new orders). Abrasion noted under cast. Area clean and drsg (dressing) put into place by ER (emergency room) nurse. No distress noted. RP (responsible party) aware."

Further review of Resident #323's clinical record failed to evidence that the RP (responsible party) was notified in writing of the reason for Resident

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 _____	05/04/2018

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 623	Continued From page 22	F 623		

#323's transfer, and that the ombudsman received a copy of this written notification.

On 5/03/18 at 9:17 a.m., an interview was conducted with RN (registered nurse) #3, the unit manager. RN #3 stated that during a facility-initiated transfer, nurses did not send written notification to the responsible party. RN #3 stated that the family is always notified verbally. RN #3 also stated that the nurses did not notify the ombudsman. RN #3 stated that she was not sure if another department notified the ombudsman.

On 5/03/18 at 2:34 p.m., an interview was conducted with LPN (licensed practical nurse) #4, Resident #323's nurse, regarding the process staff follows when residents are sent out to the hospital. LPN #4 stated call the doctor, explain what was going on with the patient and then send the resident out after she received a doctor's order. When asked if a resident transfer would be documented in the clinical record, LPN #4 stated that she would document the transfer in a nursing note. LPN #4 stated that she would document the symptoms the resident was exhibiting and that the responsible party and the medical doctor was aware of the situation. LPN #4 stated that she would also document that the physician gave an order to send the resident to the hospital and the time EMS (emergency medical services) arrived to pick up the resident. When asked if nurses provide the responsible party with written notification of a facility- initiated transfer, LPN #4 stated that nurses tell the family verbally. When asked if nurses notify the ombudsman of a facility- initiated transfer, LPN #4 stated that the nurses did not do that.

On 5/03/18 at 5:15 p.m., an interview was

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 _____	05/04/2018

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 623	Continued From page 23 conducted with OSM (other staff member) #9, the social worker. OSM #9 stated that social work was supposed to send the ombudsman written notification for a facility-initiated transfer. OSM #9 stated that she sent the ombudsman a list at the end of each month of residents who had been transferred to the hospital. When asked how long she had been doing this, OSM #9 stated, "Since the new regulation had come out." When asked if she had notified the ombudsman of Resident #323's transfer to the hospital on 4/14/18, OSM #9 stated that she would have to check. On 5/03/18 at 5:39 p.m., further interview was conducted with OSM #9. OSM #9 stated that she did not notify the ombudsman of Resident #323's transfer because he came back to the facility the same day. OSM #9 stated, "It was my understanding that I had a 48 hour window to send the notification." On 5/04/18 at 10:30 a.m., ASM (administrative staff member) #1, the administrator was made aware of the above concerns. The facility policy titled, "Discharge/Transfer Letter Policy," documents in part the following: "Social service or designee will assure the original discharge/transfer letter is given to resident or guardian/sponsor if applicable ...2. For emergency transfers, one list can be sent to the Ombudsman at the end of the month." No further information was presented prior to exit.	F 623		
F 624 SS=D	Preparation for Safe/Orderly Transfer/Dschrg CFR(s): 483.15(c)(7) §483.15(c)(7) Orientation for transfer or	F 624	1. No correction to be made for resident #323. 2. Any resident transferred to the hospital is at risk for the deficient practice.	

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 _____	05/04/2018

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 624	Continued From page 24 discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. This REQUIREMENT is not met as evidenced by: Based on staff interview, resident interview, facility document review and clinical record review, it was determined the facility staff failed to ensure preparation and orientation of the resident prior to transfer to the hospital for one of 36 residents in the survey sample, Resident #323. The facility staff failed to document that Resident #323 was properly oriented and prepared for a hospital transfer that occurred on 4/14/18. The findings include: Resident #323 was admitted to the facility on 8/24/17 and readmitted on 4/14/18 with diagnoses that included but were not limited to muscle weakness, enlarged prostate, and aortic stenosis, left femur and left distal radius fracture. Resident #323's most recent MDS (minimum data set) assessment was a 14 day scheduled assessment with an ARD (assessment reference date) of 4/30/18. Resident #323 was coded as being cognitively intact in the ability to make daily decisions scoring 14 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Review of Resident #323's nursing notes revealed that he had been transferred to the hospital on 4/14/18. The following note was	F 624	3. a. Director of Nursing or designee will inservice license nursing staff on preparing and orienting residents prior to the transfer. 4. a. Unit Managers or designee will audit all transfers for 2 months to ensure residents is prepared and oriented prior to transfer. b. Unit Mangers or designee will report the results of the audits to the QAPI committee monthly for 2 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.	6/4/2018

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 _____	05/04/2018

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 624	Continued From page 25	F 624		

documented at 3:00 p.m., "...Bleeding (new blood) observed to rolled gauze portion of soft cast (L) (left) arm. No ssx (sign/symptoms) of distress, no c/o (complaints) of pain. Reported to primary care clinician: (Name of MD (medical doctor) on 4/14/18 at 3:20 PM. Order obtained: Other Send (sic) to ER (emergency room) for eval (evaluation)."

The next note documented on 4/14/18 at 10:41 p.m., revealed that Resident #323 arrived back to the facility the same day. The following was documented, "Resident sent to (Name of Hospital) for eval. (Evaluation). Resident noted with blood to cast on LUE (left upper extremity). Resident denies pain or discomfort. No distress noted. Left via ambulance via stretcher @ (at) 3:50pm (p.m.). Return with N.N.O's (no new orders). Abrasion noted under cast. Area clean and drsg (dressing) put into place by ER (emergency room) nurse. No distress noted. RP (responsible party) aware."

Review of the clinical record failed to reveal any documentation the resident was oriented and prepared for the facility-initiated transfer to the hospital on 4/14/18.

On 5/03/18 at 9:17 a.m., an interview was conducted with RN (registered nurse) #4, the unit manager. RN #4 stated that nursing staff do not document that a resident was oriented and prepared for a facility- initiated transfer.

On 5/03/18 at 11:57 a.m., an interview was conducted with Resident #323. Resident #323 stated that he could not remember being transferred to the hospital in April.

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 _____	05/04/2018

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 624	Continued From page 26 On 5/03/18 at 2:34 p.m., an interview was conducted with LPN (licensed practical nurse) #4, Resident #323's nurse, regarding the process staff follows when residents are sent out to the hospital. LPN #4 stated call the doctor, explain what was going on with the patient and then send the resident out after she received a doctor's order. When asked if a transfer would be documented in the clinical record, LPN #4 stated that she would document the transfer in a nursing note or an SBAR (situation, background, assessment and recommendation) note. LPN #4 stated that she would document the symptoms the resident was exhibiting and that the responsible party and the medical doctor was aware of the situation. LPN #4 stated that she would also document that the physician gave an order to send the resident to the hospital and the time EMS (emergency medical services) arrived to pick up the resident. When asked if she would document that the resident was oriented and prepared for the transfer, LPN #4 stated that there was an option on the SBAR note asking if the resident was alert and oriented but that option did not mean the resident was oriented and prepared for a transfer. On 5/04/18 at 10:30 a.m., ASM (administrative staff member) #1, the administrator was made aware of the above concerns. The facility policy titled, "Discharge/Transfer Letter Policy," did not address the above concerns. No further information was presented prior to exit.	F 624		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)	F 656	F 656 1. No correction to be made for resident #70, 25, 36 or 30. 2. All residents are at risk of the deficient practice.	

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 _____	05/04/2018

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 656	Continued From page 27 §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the	F 656	3. a. Director of Nursing or designee will inservice Nursing Department Staff on following care plan interventions such as tube feeding orders, protective sleeves, administrating Coumadin, completion of pain assessments prior to and after administration of pain medication. 4. a. Unit Managers or designee will audit residents with tube feeding orders to ensure feedings are given as ordered. b. Unit Managers or designee will audit by direct observation residents with an order for protective sleeves 5 x a week for 1 month and then random 3 x a week for 1 month. c. Unit Manager or designee will audit MAR for residents receiving Coumadin 5 x a week for 2 months to ensure medication is administered on time. d. Unit Manager or designee will audit weekly for 2 months for documentation of pain assessment before and after administration of pain medication. e. Unit Managers will report the results of the audits to the QAPI committee monthly for 2 months.	

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 _____	05/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 656	Continued From page 28 requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview, facility document review and clinical record review, it was determined that the facility staff failed to develop and implement the comprehensive care plan for four of 36 residents in the survey sample, Resident #70, 50, 36 and 30. 1. The facility staff failed to follow the comprehensive care plan to provide tube feedings as ordered by the physician for Resident #70. 2. The facility staff failed to follow the comprehensive care plan to apply protective sleeves as ordered by the physician for Resident #25. 3. The facility staff failed to implement the comprehensive care plan for Resident #36 in regards to her medication, Coumadin. 4. The facility staff failed to implement Resident #30's comprehensive care plan to complete a pain assessment prior to and after the administration of PRN (as needed) pain medications. The findings include: 1. The facility staff failed to follow the comprehensive care plan to provide tube feedings as ordered by the physician for Resident #70.	F 656	f. Audit results / trends will be reviewed at QAPI meeting to ensure that Action Plans are effective. Additional action plans will be done as needed.	6/4/18

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 _____	05/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 656	Continued From page 29	F 656		

Resident #70 was admitted to the facility on 12/2/17 with diagnoses that included but were not limited to: irregular heartbeat, dementia, high blood pressure and difficulty swallowing.

The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 4/13/18 coded the resident as having scored a seven out of 15 on the BIMS (brief interview for mental status) indicating the resident was severely impaired cognitively. The resident was coded as requiring assistance from staff for all activities of daily living except for eating, which the resident could perform after the tray was set up. The resident was coded as having a feeding tube.

An observation was made on 5/03/18 at 12:33 p.m. of Resident #70. The resident was sitting up in a wheelchair. The lunch tray was on the table in front of the resident. The resident had eaten less than 25% of ground beef and approximately 25% of the dessert. The resident had not eaten any of the mashed potatoes or vegetables. The resident stated, "They don't taste like potatoes. I don't like this."

An observation was made on 5/3/18 at 1:19 p.m. of OSM (other staff member) #11, a dietary aide picking up the resident's tray and putting it in the cart.

An observation was made on 5/3/18 at 1:30 p.m. OSM #11 took the food cart to the kitchen with this writer in attendance. OSM #11 was asked to take Resident #70's tray out of the cart and see how much the resident had eaten. When asked how much the resident ate, OSM #11 stated, "Not

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 _____	05/04/2018

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 656	Continued From page 30 very much. A couple bites of meat and pumpkin." Review of the resident's care plan initiated on 12/12/17 and revised on 4/17/18 documented, "Focus. PEG (1) only for water flushes, bolus if po (by mouth) < (less than) 50%. Interventions. Provide PEG feedings and water flushes as ordered." Review of the May 2018 physician's orders documented, "IF BY MOUTH INTAKE AT ANY MEAL LESS THAN 60% -- BOLUS 250 ML (milliliter) DIABETISOURCE..." Review of the May 2018 MAR (medication administration record) documented, "If PO intake at any meal is <60% -- Bolus DiabetiSource AC 250 ML (milliliters) via PEG tube as meal replacement." Review of the MAR for 5/3/18 at 12:00 noon documented the nurse's initials with a circle around them indicating the tube feeding was not given. An interview was conducted on 5/3/18 at 3:22 p.m. with LPN (licensed practical nurse) #1. When asked why residents had care plans, LPN #1 stated, "Why? To review what we need to do. To make sure it's in line with their scope of care." When asked who used the care plans, LPN #1 stated, "We all use them." An interview was conducted on 5/03/18 at 3:32 p.m. with CNA (certified nursing assistant) #1, the resident's aide. When asked how staff knew how much a resident ate, CNA #1 stated, "I pick up most of the trays myself." When asked how much Resident #70 had eaten that day, CNA #1 stated, "A hundred percent." When asked if she had picked the resident's tray up, CNA #1 stated she	F 656		

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 _____	05/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 656	Continued From page 31	F 656		

had not. The above observations were shared with CNA #1. CNA #1 stated, "Well she usually eats everything."

On 5/3/18 at 6:45 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings.

On 5/3/18 at 8:20 a.m., a request was made to OSM (other staff member) #1, the medical records staff, for the facility's policy on monitoring food portions. No policy was received.

An interview was conducted on 5/4/18 with ASM #2, the director of nursing. When asked why residents had care plans, ASM #2 stated, "Care plans, why. So that we know their plan of care while they are here." When asked who used them, ASM #2 stated, "Every one of us." When asked if staff were expected to follow the care plan, ASM #2 stated, "Yes."

An interview was conducted on 5/4/18 at 9:15 a.m. with LPN #3, the resident's nurse on 5/3/18. When asked what circled nurses' initials on the MAR meant, LPN #3 stated it meant that it wasn't done. When asked how the nurses are made aware of the amount of food the resident had consumed, LPN #3 stated, "The CNAs tell us." When asked how much Resident #70 had consumed at lunch on 5/3/18, LPN #3 stated that she had been told that morning that the resident hadn't eaten 60 percent of her lunch.

Review of the facility's policy titled, "Care Plan" documented, "POLICY: interdisciplinary plan of care will be established for every resident and updated in accordance with state and federal

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 _____	05/04/2018

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 656	Continued From page 32	F 656		

regulatory requirements and on an as needed basis. In states where pre-admission screening applies, this will be coordinated with the facility assessment. Goals must be measurable and objective. PROCEDURE: D) All staff must be familiar with each resident's Care Plan and all approaches must be implemented. Z) All direct care staff must always know, understand and follow their Resident's Care Plan. If unable to implement any part of the plan, notify your Charge Nurse or MDS Coordinator, so that this can be documented or the Care Plan changed if necessary."

No further information was provided prior to exit.

According to Fundamentals of Nursing Lippincott Williams and Wilkins 2007 pages 65-77 documented, "A written care plan serves as a communication tool among health care team members that helps ensure continuity of care...The nursing care plan is a vital source of information about the patient's problems, needs, and goals. It contains detailed instructions for achieving the goals established for the patient and is used to direct care...expect to review, revise and update the care plan regularly, when there are changes in condition, treatments, and with new orders..." (1)

(1) Fundamentals of Nursing Lippincott Williams & Wilkins 2007 Lippincott Company Philadelphia pages 65-77.

Basic Nursing, Essentials for Practice, 6th edition, (Potter and Perry, 2007, pages 119-127), was a reference for care plans. "A nursing care plan is a written guideline for coordinating nursing care, promoting continuity of care and listing outcome

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	495401	A. BUILDING _____ B. WING _____	05/04/2018

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 656	Continued From page 33 criteria to be used in the evaluation of nursing care. The written care plan communicates nursing care priorities to other health care professionals. The care plan also identifies and coordinates resources used to deliver nursing care. A correctly formulated care plan makes it easy to continue care from one nurse to another. If the patient's status has changed and the nursing diagnosis and related interventions are no longer appropriate, modify the nursing care plan. An out of date or incorrect care plan compromises the quality of nursing care." 1. PEG -- Percutaneous endoscopic gastrostomy (PEG) is the preferred route of feeding and nutritional support in patients with a functional gastrointestinal system who require long-term enteral nutrition. This information was obtained from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4069302/ 2. The facility staff failed to follow the comprehensive care plan to apply protective sleeves as ordered by the physician for Resident #25. Resident #25 was admitted to the facility on 8/13/14 and readmitted on 3/4/15 with diagnoses that included but were not limited to: high blood pressure, heart failure, arthritis, lung disease and chronic pain. The most recent MDS (minimum data set), an annual assessment, with an ARD (assessment reference date) of 2/22/18, coded the resident as having scored a five out of 15 on the BIMS (brief	F 656		

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 _____	05/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 34 interview for mental status) indicating the resident was severely impaired cognitively. The resident was coded as requiring assistance from staff for all activities of daily living. An observation was made on 5/2/18 at 8:20 a.m., of Resident #25. The resident was lying on her back in bed with her eyes closed. She was wearing a hospital gown and her arms were bare. There was a white bandage on the right forearm. An observation was made on 5/3/18 at 8:18 a.m. of Resident #25. The resident was lying in bed with her eyes closed. She was wearing a hospital gown and her arms were bare. There was a white bandage on the right forearm. An observation was made on 5/3/18 at 12:10 p.m. of Resident #25. The resident was lying in bed and was wearing a short-sleeved blouse. There was a white bandage on the resident's right forearm otherwise, her arms were not covered. An observation was made on 5/3/18 at 12:29 p.m. of Resident #25 was up in a wheelchair, the resident had geri sleeves on her arms. Review of the resident's comprehensive care plan initiated on 2/10/18 and revised on 4/29/18 documented, "Focus. (Name of Resident #25) is at risk for impaired skin integrity r/t (related to) impaired mobility, incontinence and obesity. 4/20/18 skin tear to (R) (right) arm. Interventions. Geri sleeves (protective sleeves)." Review of the May 2018 physician's orders documented, "04/20/18: GERI SLEEVES EVERY SHIFT TO BILATERAL ARMS FOR PREVENTION."	F 656		

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 _____	05/04/2018

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 656	Continued From page 35 Review of the May 2018 MAR (medication administration record) documented, "GERI SLEEVES EVERY SHIFT TO BILATERAL ARMS FOR PREVENTION." On 5/1/18 and 5/2/18, the nurse's initials were circled on the 7:00 a.m. to 3:00 p.m. shift indicating the geri sleeves were not on. There was no documentation on the 3:00 p.m. to 11:00 p.m. or 11:00 p.m. to 7:00 a.m. shifts. An interview was conducted on 5/3/18 at 12:19 p.m. with LPN #3, the resident's nurse. When asked who put the geri sleeves on the residents, LPN #3 stated, "The CNA usually puts them on in the morning when they do their care." When asked why residents had care plans, LPN #3 stated, "So we can keep up with how they're doing, so we can better care for them." When asked who used the care plans, LPN #3 stated, "All of us should." When asked who developed and revised the care plan, LPN #3 stated, "They're supposed to be developed on admission or at least within 24 hours. The care plan is based on diagnosis and what the come in with." When asked why Resident #25 had geri sleeves, LPN #3 stated, "Because she has a skin tear." An interview was conducted on 5/3/18 at 3:32 p.m. with CNA #1, the resident's aide, regarding when staff applied the resident's geri sleeves. CNA #1 stated, "We had to order some. I found them in the drawer and then I put them on." When asked if Resident #25 had the geri sleeves on the day before, CNA #1 stated she had not. On 5/3/18 at 6:45 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the	F 656		

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 _____	05/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 36 findings. An interview was conducted on 5/4/18 with ASM #2, the director of nursing. When asked why residents had care plans, ASM #2 stated, "Care plans, why. So that we know their plan of care while they are here." When asked who used them, ASM #2 stated, "Every one of us." When asked if staff were expected to follow the care plan, AM #2 stated, "Yes." No further information was provided prior to exit. 3. The facility staff failed to implement the comprehensive care plan for Resident #36 in regards to her medication, Coumadin*. *Coumadin (Warfarin) is used in prophylaxis and treatment of venous thrombosis and its extension, pulmonary embolism (PE). Instructions for Patients -Advise patients to: Strictly adhere to the prescribed dosage schedule. (1) Resident #36 was admitted to the facility on 11/14/17 with diagnoses that included but were not limited to: high blood pressure, osteoporosis, gallstones and history of pulmonary embolus (clot). The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 3/4/18, coded the resident as scoring a 15 on the BIMS (brief interview for mental status) score, indicating she was capable of making her cognitive daily decisions. Resident #36 was coded as requiring supervision for most of her activities of daily	F 656		

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 _____	05/04/2018

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F 656	Continued From page 37 living. The comprehensive care plan dated, 4/26/18, documented in part, "Focus: Resident is at risk for bleeding/bruising/abnormal labs (laboratory tests) R/T (related to) anticoagulant medication." The "Interventions" documented in part, "Provide medication as ordered." Review of the physician's orders dated 4/26/18, revealed and order that documented, "Coumadin 10 mg (milligrams) po (by mouth) qd (every day) @ (at) 5 p.m. on Monday thru Sat (Saturday). Coumadin 15 mg po @ 5 p.m. on Sunday." An interview was conducted with Resident #36 on 5/2/18 at 10:54 a.m. Resident #36 stated they (the facility) are short staffed and they don't get their evening medications on time. Observation was made of the nursing unit on 5/3/18 starting at 4:30 p.m. The medication cart for the hall on which Resident #36 was observed. There was no nurse around the medication cart. This surveyor stayed at the nursing station. The nurse (RN [registered nurse) #3, unit manager) came to the medication cart at 5:32 p.m. She pushed the cart down the hallway and started to administer medications. At 5:33 p.m., Resident #36 was observed going to the dining room. On 5/3/18 at 6:39 p.m. a copy of the MAR (medication administration record) for May 2018, was requested from ASM (administrative staff member) #6, regional director of clinical services. The MAR documented, "Warfarin (Coumadin) 10 mg tablet ; take 1 tab (tablet) by mouth every evening." It was not documented as having been administered on 5/3/18 at the scheduled time of	F 656		

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	495401	A. BUILDING _____ B. WING _____	05/04/2018

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F 656	Continued From page 38 5:00 p.m. On 5/3/18 at 6:39 p.m., a copy of the MAR (medication administration record) for May 2018 was requested. The MAR documented, "Warfarin (Coumadin) 10 mg tablet; take 1 tab (tablet) by mouth every evening." It was not documented as having been administered on 5/3/18 at the scheduled time of 5:00 p.m. On 5/4/18 at 8:40 a.m., Resident #36 informed this surveyor that she didn't get her Coumadin until 8:04 p.m. An interview was conducted with RN (registered nurse) #1 on 5/4/18 at 9:17 a.m., regarding the purpose of the care plan. RN #1 stated, "It's to care for the patient." When asked if the care plan should be followed, RN #1 stated, "Absolutely." When asked who has access to the care plan, RN #1 stated, "Nurses and the resident or family." ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #4, the regional director of clinical services, were made aware of the above concern on 5/4/18 at 10:40 a.m. (1) This information was obtained from the following website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=d91934a0-902e-c26c-23ca-d5accc4151b6& 4. The facility staff failed to implement Resident #30's comprehensive care plan to complete a pain assessment prior to and after the administration of PRN (as needed) pain medications.	F 656		

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	495401	A. BUILDING _____ B. WING _____	05/04/2018

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F 656	Continued From page 39 Resident #30 was admitted to the facility on 8/24/17 and readmitted on 11/28/17 with diagnoses that included but were not limited to type two diabetes, neuropathy, gout, and unspecified dementia without behavioral disturbance. Resident #30's most recent MDS (minimum data set assessment) was a quarterly assessment with an ARD (assessment reference date) of 3/1/18. Resident #30 was coded as being cognitively intact in the ability to make daily decisions scoring 12 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Review of Resident #30's most recent POS (physician order summary) dated 4/30/18, documented the following pain medication orders: 1) "Hydrocodone- Acetaminophen (Norco) 7.5-325 mg (milligram) Tablet 1 tab by mouth every 6 hours for pain." This order was initiated on 2/21/18. 2) "MAPAP (Tylenol) 325MG tablet Take two tabs (650 mg) by mouth every 4 hours as needed for mild pain/temperature. MAX Acetaminophen 3-4 GM daily. Check daily total." This order was initiated on 11/28/17. Review of Resident #30's April 2018 MAR (medication administration record) revealed that she received Norco on the following dates and times: 4/4/18 at 12:15 a.m., and 6:00 a.m., 4/7/18 at 0600 a.m., and 4/9/18 at 12 a.m. and 6 p.m. Further review of Resident #30's April 2018 MAR revealed that she received Tylenol 650 mg on the following dates and times: 4/6/18 at 6:00 p.m.,	F 656		

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	495401	A. BUILDING _____ B. WING _____	05/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 656	Continued From page 40 4/19/18 at 1:00 a.m., 4/22/18 at 12:00 a.m., 4/23/18 at 12:00 a.m., and 4/30/18 at 2:00 a.m. There was no evidence in the clinical record that a pain assessment was completed prior to the administration of Norco and Tylenol in April of 2018. There was no evidence of a follow up pain assessment after the Norco and Tylenol was administered in April. There was no evidence that non-pharmacological pain interventions were attempted prior to the administration of the PRN (as needed) pain medications. The pain flow sheet for April was missing from the clinical record. Review of Resident #30's May 2018 MAR revealed that she received Tylenol 650 mg on the following dates and times: 5/1/18 and 5/3/18, times administered were illegible. There was no evidence in the clinical record that a pain assessment was completed prior to the administration of Tylenol in May of 2018. There was no evidence of a follow up pain assessment after the Tylenol was administered in May. There was no evidence that non-pharmacological pain interventions were attempted prior to the administration of PRN pain medications. The pain flow sheet for May was completely blank. Review of Resident #30's pain care plan dated 11/28/17, documented in part, the following: "Potential for pain/discomfort related to impaired mobility, neuropathy, gout; Goal: Pain will be resolved within 1 hour of intervention through next review. Interventions: Pain assessment per facility routine and prn (as needed), Administer pain medication as per MD (medical doctor) orders and note the effectiveness."	F 656		

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	495401	A. BUILDING _____ B. WING _____	05/04/2018

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F 656	Continued From page 41 On 5/03/18 at approximately 5:30 p.m., an interview was conducted with Resident #30. When asked if facility staff assess her pain before giving her pain medication, Resident #30 stated that facility staff will ask her pain level and the location. Resident #30 stated that staff never come back and do a follow up assessment on her pain. Resident #30 stated that she thought staff should do this. On 5/03/18 at 5:35 p.m., an interview was conducted with LPN (licensed practical nurse) #1. When asked the purpose of the care plan, LPN #1 stated that the purpose of the care plan was to serve as a guide to take care of the residents. When asked who had access to the care plan, LPN #1 stated that all licensed staff had access to the care plan. When asked if was ever ok to not follow the care plan, LPN #1 stated, "Only if the care plan is not reflecting the resident's current status." On 5/04/18 at 9:30 a.m., an interview was conducted with ASM (administrative staff member) #2, the DON (Director of Nursing). When asked about the process staff follows prior to administering a prn pain medication, ASM #2 stated that staff should be conducted a pain assessment that includes the duration of pain, location, and intensity of pain. ASM #2 stated that this information should be documented on the pain log (pain flow sheet). When asked if she could determine where Resident #30's April 2018 pain flow sheet was located, ASM #2 stated that the unit manager could not find it. ASM #2 stated that the pain flow sheet was part of the clinical record and should have been in Resident #30's chart. ASM #2 stated that she could not	F 656		

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	495401	A. BUILDING _____ B. WING _____	05/04/2018

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F 656	Continued From page 42 determine if nursing staff did the pain assessment and forgot to document, or if it was not done. ASM #2 stated that she could not say. ASM #2 stated, "They probably missed the actual documentation of the assessment." When asked if Resident #30's care plan was followed, ASM #2 stated, "We don't have anything saying it was followed." On 5/03/18 at 10:39 a.m., ASM (administrative staff member) #1, the administrator was made aware of the above concerns. No further information was presented prior to exit.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in	F 657	1. a. Resident #62 care plan was updated with fall intervention on 2/9/18. b. Resident #19 care plan was revised regarding toileting program. 2. All residents are at risk for the deficient practice. 3. MDS will inservice license nursing staff on updating and following care plan interventions. 4.a. Director of Nursing or designee will audit residents with falls to ensure fall huddles are complete and care plan is updated for 2 months. b. Director of Nursing or designee will audit residents with toileting plans on care plan to ensure they are followed 3 x weekly for 2 months. c. Director of Nursing or designee will report the results of the audits to the QAPI committee monthly for 2 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.	6/4/18

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	495401	A. BUILDING _____ B. WING _____	05/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 657	Continued From page 43 disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview, resident interview, facility document review and clinical record review, it was determined that the facility staff failed to review and revise the comprehensive care plan for two of 36 residents in the survey sample, Resident #62 and #19. 1. The facility staff failed to review and revise the comprehensive care plan after the 2/9/18 fall for Resident #62. 2. The facility staff failed to revise Resident #19's comprehensive care plan to reflect she was initially on a toileting program and was non-complaint with her toileting program. The findings include: 1. The facility staff failed to review and revise the comprehensive care plan after the 2/9/18 fall for Resident #62. Resident #62 was admitted to the facility on 9/13/17 with diagnoses that included but were not limited to: repeated falls, diabetes, high blood pressure and dementia. The most recent MDS (minimum data set), a significant change assessment, with an ARD (assessment reference date) of 4/9/18 coded the	F 657		

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F 657	Continued From page 44 resident as having scored a four out of 15 on the BIMS (brief interview for mental status) indicating the resident was severely impaired cognitively. The resident was coded as requiring assistance from staff for all activities of daily living with the exception of eating which the resident could perform after the tray was set up. Review of the 2/9/18 nurse's note documented, "Progress Note: Resident observed on floor in the room near bed. Call bell within reach but not on. No injures noted, Assisted off floor by staff. Unable to state what he was attempting to do." Review of the resident's care plan initiated on 9/14/17 and revised on 3/30/18 documented, "Focus. Risk for Falls." There was no documented evidence that the comprehensive care plan had been reviewed or revised following the fall on 2/9/18. On 5/3/18 at 1:00 p.m. a request for the 2/9/18 fall investigation was requested from ASM (administrative staff member) #1, the administrator. On 5/3/18 at 4:45 p.m., ASM #1 stated they could not locate the fall investigation. An interview was conducted on 5/3/18 at 3:22 p.m., with LPN (licensed practical nurse) #1, the resident's nurse. When asked why residents had care plans, LPN #1 stated, "Why? To review what we need to do. To make sure it's in line with their scope of care." When asked who used the care plan, LPN #1 stated, "We all use them." When asked when the care plan would be revised, LPN #1 stated, "If there was a change." When asked if a fall would be a changed, LPN #1 stated it would.	F 657		

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F 657	Continued From page 45 On 5/3/18 at 6:45 p.m. ASM #1, the administrator and ASM #2, the director of nursing were made aware of the findings. Review of the facility's policy titled, "Care Plan" documented, "POLICY: interdisciplinary plan of care will be established for every resident and updated in accordance with state and federal regulatory requirements and on an as needed basis. In states where pre-admission screening applies, this will be coordinated with the facility assessment. Goals must be measurable and objective. PROCEDURE: D) All staff must be familiar with each resident's Care Plan and all approaches must be implemented. G) In cases of significant changes in the resident's condition, The Care Plan must be updated within seven (7) days of new full MDS. V) The MDS Coordinator is to review the 24- Hour Report daily for significant changes or changes in resident's ADSL (activities of daily living) status. The Care Planning coordinator will add minor changes in resident's status to the existing Care Plans on daily basis. Z) All direct care staff must always know, understand and follow their Resident's Care Plan. If unable to implement any part of the plan, notify your Charge Nurse or MDS Coordinator, so that this can be documented or the Care Plan changed if necessary." An interview was conducted on 5/4/18 with ASM (administrative staff member) #2, the director of nursing. When asked why residents had care plans, ASM #2 stated, "Care plans, why. So that we know their plan of care while they are here." When asked who used them, ASM #2 stated, "Every one of us." When asked if the care plan was updated after a change in a resident's	F 657		

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	495401	A. BUILDING _____ B. WING _____	05/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 657	Continued From page 46 condition ASM #2 stated, "Sure." No further information was provided prior to exit. According to Fundamentals of Nursing Lippincott Williams and Wilkins 2007 pages 65-77 documented, "A written care plan serves as a communication tool among health care team members that helps ensure continuity of care...The nursing care plan is a vital source of information about the patient's problems, needs, and goals. It contains detailed instructions for achieving the goals established for the patient and is used to direct care...expect to review, revise and update the care plan regularly, when there are changes in condition, treatments, and with new orders..." (1) (1) Fundamentals of Nursing Lippincott Williams & Wilkins 2007 Lippincott Company Philadelphia pages 65-77. 2. The facility staff failed to revise Resident #19's comprehensive care plan to reflect she was initially on a toileting program and was non-complaint with her toileting program. Resident #19 was admitted to the facility on 4/20/16 and readmitted on 8/15/17 with diagnoses that included but were not limited to muscle weakness, type two diabetes mellitus, anxiety disorder, and status post stroke. Resident #19's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 2/20/18. Resident #19 was coded as being moderately impaired of cognitive function scoring 08 out of 15 on the BIMS (Brief Interview for Mental Status)	F 657		

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	495401	A. BUILDING _____ B. WING _____	05/04/2018

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F 657	Continued From page 47 exam. Resident #19 was coded as being frequently incontinent of bowel and bladder and requiring limited assistance from one staff member for toileting. Review of Resident #19's POS (physician order sheet) dated 4/30/18, documented the following order: "Toileting program every 3 hours from 9 AM to 10 PM." This order was initiated on 3/26/18. Review of Resident #19's March 2018 restorative ambulation program, documented evidence that staff were implementing the toileting program. Resident #19's April 2018 restorative ambulation program was missing from Resident #19's clinical record. Review of Resident #19's May 2018 restorative ambulation program, failed to evidence that the toileting program was being implemented. The entire May 2018 log for toileting was blank. Review of Resident #19's comprehensive care plan dated 8/16/17 and revised 4/30/18, failed to evidence that she was on a toileting program. On 5/3/18 at 9:40 a.m., an interview was conducted with CNA (certified nursing assistant) # 3, Resident #19's CNA. When asked if Resident #19 was on any special toileting program, CNA #3 stated that she was. CNA #3 stated, "We are supposed to take her every 3 hours." When asked if nursing staff document when they take her to the bathroom, CNA #3 stated that they documented on the restorative ambulation log. CNA #3 presented to this writer Resident #19's May 2018 restorative log. The log was completely blank. When asked why the log was	F 657		

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	495401	A. BUILDING _____ B. WING _____	05/04/2018

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

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F 657	Continued From page 48 blank, CNA #3 stated that Resident #19 always refuses to go to the bathroom when asked. CNA #3 stated that the resident will say she does not have to go and that she can take herself. When asked if she documented this refusal, CNA #3 stated, "No." CNA #3 stated that it was blank for that day 5/3/18 because she had not had a chance to see the resident yet. On 5/3/18 at 12:01 p.m., an interview was conducted with Resident #19. Resident #19 stated that she was totally capable of knowing when she had to go to the bathroom. Resident #19 stated, "I don't need staff coming in here to telling me when to go to the bathroom." On 5/3/18 at 2:34 p.m., an interview was conducted with LPN (licensed practical nurse) #4, Resident #19's nurse. When asked about Resident #19's bowel and bladder status, LPN #4 stated that Resident #19 was incontinent though the resident thought she was very continent. LPN #4 stated that Resident #19 needs a lot of redirection when it comes to toileting. LPN #4 stated that Resident #19 was non-complaint with her toileting program. When asked if Resident #19's non-compliance with her toileting schedule was documented anywhere, LPN #4 stated it may have been in a nursing note. When asked if she would expect to see the toileting program and Resident #19's non-compliance on the care plan, LPN #4 stated that she would expect that information to be updated on the care plan. LPN #4 stated that Resident #19 was just recently placed back on a toileting schedule. Review of Resident #19's nursing notes failed to evidence any documentation that she was non-complaint with her toileting program.	F 657		

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 _____	05/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 657	Continued From page 49 On 5/4/18 at 9:30 a.m., an interview was conducted with ASM (administrative staff member) #2, the DON (Director of Nursing). ASM #2 stated the toileting program should be on the care plan, because the care plan was to reflect the resident's current condition. ASM #2 also stated that she would expect to see the care plan document her non-compliance with the program. ASM #2 stated that all members of the IDT (interdisciplinary) team could develop and review or revise the care plan. ASM #2 stated that anyone caring for the resident had access to the care plan. ASM #2 stated that the unit manager could not evidence the April 2018 restorative ambulation log. On 5/4/18 at 10:39 a.m., ASM (administrative staff member) #1, the administrator was made aware of the above concerns. No further information was presented prior to exit. According to Fundamentals of Nursing Lippincott Williams and Wilkins 2007 pages 65-77 documented, "A written care plan serves as a communication tool among health care team members that helps ensure continuity of care...The nursing care plan is a vital source of information about the patient's problems, needs, and goals. It contains detailed instructions for achieving the goals established for the patient and is used to direct care...expect to review, revise and update the care plan regularly, when there are changes in condition, treatments, and with new orders..."	F 657		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)	F 658	F-658 1. Physician order obtained for oxygen for resident # 50. Pain medication order was clarified for resident # 30. Resident #36 medication order was corrected on 5-4-18.	

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 _____	05/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 658	Continued From page 50 §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined the facility staff failed to follow professional standards of practice for four of 36 residents in the survey sample, Resident #50, #70, #36 and #30. 1. The facility staff failed to obtain a physician's order for oxygen for Resident #50. 2. The facility staff failed to wash their hands after giving medications to Resident #70 and before taking a blood sugar reading from Resident #62. 3. The facility staff failed to follow professional standards of practice for the recapitulation of Resident #36's physician orders. 4. The facility staff failed to clarify Resident #30's medication orders for pain. The findings include: 1. The facility staff failed to obtain a physician's order for oxygen for Resident #50. Resident #50 was admitted to the facility on 3/12/18 and readmitted on 4/20/18 with diagnoses that included but were not limited to: pneumonia, acute respiratory failure, high blood	F 658	2.a. 100% audit of residents receiving Oxygen to identify any at risk for this deficient practice. b. Residents with pain medication orders are at risk for this deficient practice. c. Residents with orders for Blood Sugar monitoring are at risk for this deficient practice. d. All residents are at risk for issues related to hand washing with medication pass. e. All residents are at risk for this deficient practice during recapitulation of physician orders. 3. Director of Nursing or designee will in service licensed nursing staff regarding obtaining oxygen orders, hand washing protocols with medication pass and obtaining a blood sugar, and reviewing monthly orders. 4. a. Unit Manager or designee will audit 3 medication passes weekly x 2 months to ensure handwashing is done per protocol. b. Director of Nursing or designee will audit new medication orders to ensure orders are clear and oxygen ordered if appropriate x 2 months. c. Unit Manager or designee will audit obtaining blood sugars 3x weekly x 2 months to ensure proper hand washing technique is used.	

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	495401	A. BUILDING _____ B. WING _____	05/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 658	Continued From page 51 pressure and chronic pain syndrome. There was no minimum data set available for review. Review of the 3/12/18 nurse's admission assessment documented that the resident was alert and oriented times three, indicating the resident knew who he was, where he was and what year it was. An observation was made on 5/2/18 at 8:40 a.m. of Resident #50. The resident was sitting on the side of the bed. There was an oxygen concentrator in the room and it was turned on and set on two liters per minute. The resident took his nasal cannula (soft plastic prongs that fit in the nose to deliver oxygen) that was hanging off the bedside railing and put it on. An observation was made on 5/3/18 at 8:20 a.m. of Resident #50. The resident was sitting in a wheelchair next to the bed. The oxygen concentrator was on and was set at two liters per minute. The nasal cannula was hanging over the bed rail. Review of the resident's care plan initiated on 4/23/18 documented, "Focus. Resident requires oxygen R/T (related to) resp (respiratory) failure. Interventions. Administer oxygen as ordered." Review of the April and May 2018 physician's orders did not evidence an order for oxygen. \ Review of the nurse's notes dated 4/21/18 at 10:38 a.m. documented, "Method: Oxygen via Nasal Cannula."	F 658	d. Unit Managers or designee will audit 100% of physician orders to ensure orders are transcribe correctly x5 week x 2months. e. Unit Managers will report the results of the audits to the QAPI committee monthly for 2 months. f. Audit results / trends will be reviewed at QAPI meeting to ensure that Action Plans are effective. Additional action plans will be done as needed.	6/4/18

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 _____	05/04/2018

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 658	Continued From page 52 Review of the nurse's notes dated 4/22/18 at 10:08 p.m. documented, "Method: Oxygen via Nasal Cannula." An interview was conducted on 5/03/18 at 12:19 p.m., with LPN (licensed practical nurse) #3, the resident's nurse. When asked if oxygen was considered a medication, LPN #3 stated it was. When asked if staff were allowed to administer oxygen without an order, LPN #3 stated, "No." When asked about Resident #50's oxygen, LPN #3 stated, "He doesn't have an order for oxygen so someone put him on it maybe for comfort." LPN #3 stated, "He typically is not wearing it." When asked if there should be an order for the resident's oxygen, LPN #3 stated, "Yes." On 5/3/18 at 6:45 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings. On 5/4/18 at 8:10 a.m., a request for the facility's policy on oxygen therapy was requested from OSM (other staff member) #1, the medical records staff. An interview was conducted on 5/04/18 at 8:30 a.m. with ASM #2, the director of nursing. When asked if oxygen was considered a medication, ASM #2 sated, "Yes." When asked if staff could administer oxygen without an order, ASM #2 stated, "They should always call the doctor and get an order." On 5/4/18 at 10:00 a.m., ASM #3, the regional director of clinical services stated, "There's no oxygen policy."	F 658		

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	495401	A. BUILDING _____ B. WING _____	05/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 658	Continued From page 53 No further information was obtained prior to exit. According to Fundamentals of Nursing, Perry and Potter, 6th edition, page 1122, Oxygen should be treated as a drug. It has dangerous side effects, such as atelectasis or oxygen toxicity. As with any drug, the dosage or concentration of oxygen should be continuously monitored. The nurse should routinely check the physician's orders to verify that the client is receiving the prescribed oxygen concentration. The six rights of medication administration also pertain to oxygen administration." 2. The facility staff failed to wash their hands after giving medications to Resident #70 and before taking a blood sugar reading from Resident #62. Resident #70 was admitted to the facility on 12/2/17 with diagnoses that included but were not limited to: irregular heartbeat, dementia, high blood pressure and difficulty swallowing. The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 4/13/18 coded the resident as having scored a seven out of 15 on the BIMS (brief interview for mental status) indicating the resident was severely impaired cognitively. The resident was coded as requiring assistance from staff for all activities of daily living except for eating which the resident could perform after the tray was set up. The resident was coded as having a feeding tube. Resident #62 was admitted to the facility on 9/13/17 with diagnoses that included but were not limited to: repeated falls, diabetes, high blood	F 658		

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	495401	A. BUILDING _____ B. WING _____	05/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 658	Continued From page 54 pressure and dementia. The most recent MDS (minimum data set), a significant change assessment, with an ARD (assessment reference date) of 4/9/18 coded the resident as having scored a four out of 15 on the BIMS (brief interview for mental status) indicating the resident was severely impaired cognitively. The resident was coded as requiring assistance from staff for all activities of daily living with the exception of eating which the resident could perform after the tray was set up. An observation was made on 5/3/18 at 5:23 p.m. of LPN (licensed practical nurse) #1 giving medications to Resident #70. The nurse took the medications in applesauce into the resident's room and administered the medications by mouth to the resident. LPN #1 gave the resident a cup of water after giving the medications. LPN #1 then threw away the cup and left the room. LPN #1 did not sanitize her hands after administering the medications. LPN #1 then pushed the medication cart across the hall to Resident #62's room. LPN #1 put on a pair of gloves, got the blood glucose monitor out of the medication cart and wiped it off. LPN #1 then went into the resident's room to take the residents blood sugar. The lancet did not pierce the resident's skin so LPN #1 returned to the medication cart, put her gloved hands into her pockets to get the cart keys out and obtained another lancet from the cart. LPN #1 then obtained another lancet and returned to the resident's room. LPN #1 then obtained the resident's blood sugar. LPN #1 returned to the cart, removed her gloves, wiped off the monitor and put it back into the cart. An interview was conducted on 5/3/18, at 5:30	F 658		

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	495401	A. BUILDING _____ B. WING _____	05/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 658	Continued From page 55 p.m. with LPN #1, regarding when staff washed their hands. LPN #1 stated, "Between patients and I didn't do it between (names of Resident #70 and #62)." When asked what staff did if they put their gloved hands into their pockets, LPN #1 stated, "I should have re-gloved. It's a safety issue. It's contamination." On 5/3/18 at 6:45 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings. An interview was conducted on 5/4/18 at 8:30 a.m. with ASM #2. When asked when staff wash their hands, ASM #2 stated, "Before, after and in-between activities." When asked what staff should do after they put their gloved hands in their pockets, ASM #2 stated, "They should take their gloves off every time." Review of the facility's policy titled, "Hand Washing" documented, "POLICY: Hand washing is the most important component for preventing the spread of infection. Use of gloves does not replace the need for hand cleaning by either hand rubbing or hand washing. PROCEDURE: 3. Perform hand-hygiene: a. Before and after having direct contact with residents b. After removing gloves c. Before handling an invasive device (regardless of whether or not gloves are used) for resident care." No further information was provided prior to exit. 3. The facility staff failed to follow professional standards of practice for the recapitulation of Resident #36's physician orders.	F 658		

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	495401	A. BUILDING _____ B. WING _____	05/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 658	Continued From page 56	F 658		

Resident #36 was admitted to the facility on 11/14/17 with diagnoses that included but were not limited to: high blood pressure, osteoporosis, gallstones and history of pulmonary embolus (clot).

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 3/4/18, coded the resident as scoring a 15 on the BIMS (brief interview for mental status) score, indicating she was capable of making her cognitive daily decisions. Resident #36 was coded as requiring supervision for most of her activities of daily living.

Review of the physician's orders dated 4/26/18, revealed documented, "Coumadin* 10 mg (milligrams) po (by mouth) qd (every day) @ (at) 5 p.m. on Monday thru Sat (Saturday). Coumadin 15 mg po @ 5 p.m. on Sunday."

*Coumadin (Warfarin) is used in prophylaxis and treatment of venous thrombosis and its extension, pulmonary embolism (PE). Instructions for Patients -Advise patients to: Strictly adhere to the prescribed dosage schedule. (1)

The review of the April 2018 MAR (medication administration record) documented, "Coumadin 10 mg one po qd Monday thru Sat. Coumadin 15 mg one po q (every) Sunday."

The review of the May 2018 MAR documented, "Coumadin 10 mg tablet; take 1 tab (tablet) by mouth every evening."

On 5/4/18 at 8:45 a.m., with RN (registered

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	495401	A. BUILDING _____ B. WING _____	05/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 658	Continued From page 57 nurse) #1, the unit manager. The physician orders for Resident #36's Coumadin were reviewed with RN #1. The April MAR (medication administration record) was reviewed with RN #1. The May MAR was reviewed with RN #1. RN #1 stated, "This is a transcription error." When asked who is responsible for comparing the orders at the end of the month for the next month, RN #1 stated, "It's usually (RN #3 - the other unit manager) and myself. We get help from different nurses on the unit. That's a transcription error." The facility policy, "Recapitulation/Reconciliation of Computerized Pharmacy Records" documented in part, "2. Once received by the facility staff, medical record documents should be separated by room number and collated according to resident room number and name. 3. Corrections, additions, and changes to the computerized medical record should be made by a licensed nurse, facility medical records staff or an authorized designee. The original order date should accompany written entries to the computerized medical record. Changes, including demographic, clinical and therapeutic interchange information, should be made on the POS (physician order summary) and to the appropriate Medication Record Form when such documentation is required. Facility staff members who make hand-written changes to the POS should sign and date all entries. 4. Once the written corrections are made to the medical record by facility staff, facility should maintain any further changes in physician/prescriber orders in the ten-current medical record and the computerized medical record until the first day of the new month. On the first day of the month or designated date Facility should place the new computerized medical record in the resident's	F 658		

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 _____	05/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 658	Continued From page 58 individual and permanent medical record. On the first business day of the month or on a date agreed upon with pharmacy, Facility should return the corrected copy of the computerized POS to pharmacy for immediate correction in pharmacy's medical records computer system. 5. Written changes, corrections and additions may be made to the medical record until the time it is signed by the attending physician. Once the medical record is signed, no changes should be made to the POS above the attending physician signature line." ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #4, the regional director of clinical services, were made aware of the above concern on 5/4/18 at 10:40 a.m. No further information was provided prior to exit. (1) This information was obtained from the following website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=d91934a0-902e-c26c-23ca-d5accc4151b6& 4. The facility staff failed to clarify Resident #30's medication orders for pain. Resident #30 was admitted to the facility on 8/24/17 and readmitted on 11/28/17 with diagnoses that included but were not limited to type two diabetes, neuropathy, gout, and unspecified dementia without behavioral disturbance. Resident #30's most recent MDS (minimum data set assessment) was a quarterly assessment with an ARD (assessment reference	F 658		

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 _____	05/04/2018

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 658	Continued From page 59 date) of 3/1/18. Resident #30 was coded as being cognitively intact in the ability to make daily decisions scoring 12 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Review of Resident #30's most recent POS (physician order summary) dated 4/30/18, documented the following pain medication orders: 1) "Hydrocodone- Acetaminophen (Norco) 7.5-325 mg (milligram) Tablet 1 tab by mouth every 6 hours for pain." This order was initiated on 2/21/18. 2) "MAPAP (Tylenol) 325MG tablet Take two tabs (650 mg) by mouth every 4 hours as needed for mild pain/temperature. MAX Acetaminophen 3-4 GM daily. Check daily total." This order was initiated on 11/28/17. Review of Resident #30's April 2018 MAR revealed that she received Norco on the following dates and times: 4/4/18 at 12:15 a.m., and 6:00 a.m., 4/7/18 at 0600 a.m., and 4/9/18 at 12 a.m. and 6 p.m. Further review of Resident #30's April 2018 MAR revealed that she received Tylenol 650 mg on the following dates and times: 4/6/18 at 6:00 p.m., 4/19/18 at 1:00 a.m., 4/22/18 at 12:00 a.m., 4/23/18 at 12:00 a.m., and 4/30/18 at 2:00 a.m. Review of Resident #30's May 2018 MAR revealed that she received Tylenol 650 mg on the following dates and times: 5/1/18 and 5/3/18, times administered were illegible. On 5/3/18 at 2:34 p.m., an interview was conducted with LPN (licensed practical nurse) #4.	F 658		

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 _____	05/04/2018

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 658	Continued From page 60 When asked about the process staff follows when a resident has with two different PRN (as needed) pain medication orders (Norco and Tylenol) and instructions for when each medication should be administered, LPN #4 stated that pain orders usually had a pain scale attached to them. LPN #4 stated that if the order did not have a pain scale attached to it, she would administer the Tylenol first (the least strong) and then the Norco if the Tylenol was ineffective. LPN #4 stated that this also depended on the resident's pain level. When asked if nurses were legally able to determine which pain, medication should be administered at their own discretion, LPN #4 stated no. LPN #4 stated the orders should have been clarified. LPN #4 stated the Tylenol had instructions to give for mild pain, but that nurses may have a different perception of mild pain. LPN #4 stated that mild pain to her was a pain of five on a scale from 1-10. On 5/4/18 at 9:30 a.m., an interview was conducted with ASM (administrative staff member) #2, the DON (Director of Nursing). When asked about the process staff follows when a resident has two different PRN (as needed) pain medication orders (Norco and Tylenol) and no instructions on when each medication should be administered, ASM #2 stated that usually pain medication orders had pain scales on the order. ASM #2 stated that if the order did not have a pain scale then the physician intended for the nurses to decide which medication to give. ASM #2 stated the order for the Tylenol was to be given for mild pain. When asked what mild pain meant, ASM #2 stated that she needed to look at the pain flow sheet. The pain flow sheet did not have any indication of what constituted mild pain. ASM #2 stated she thought mild pain should be	F 658		

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 _____	05/04/2018

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 658	Continued From page 61 less than five on a scale from 1-10. On 5/4/18 at 10:39 a.m., ASM (administrative staff member) #1, the administrator was made aware of the above concerns. ASM #1 stated that the facility used Lippincott as a professional reference. No further information was presented prior to exit. In "Complete Guide to Documentation," 2nd edition, 2008; Lippincott Williams and Wilkins; page 318. "If you believe a practitioner's order is in error, you must refuse to carry it out until you receive clarification."	F 658		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide care and treatments in accordance with professional standards of practice, the comprehensive person-centered care plan and the resident's choices for three of 36 residents in the survey sample, Residents # 36, # 70 and # 25.	F 684	F 684 1. Resident #36's medical doctor was notified and orders given to continue with current dose of Coumadin at 5pm. Resident #70's medical doctor notified with orders to consult dietician for further evaluation of resident's nutritional intake. Staff applied protective sleeves for resident #25. 2. a. Residents with orders for Coumadin are at risk for the deficient practice. b. Residents with medications given via peg tube are at risk for the deficient practice. c. Residents with orders for arm coverings are at risk for the deficient practice.	

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	495401	A. BUILDING _____ B. WING _____	05/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 684	Continued From page 62 1. The facility staff failed to administer Resident #36's Coumadin per the physician order. 2. The facility staff failed to administer medications via the feeding tube as ordered by the physician for Resident #70. 3. The facility staff failed to apply protective arm covers as ordered by the physician for Resident #25. The findings include: 1. The facility staff failed to administer Resident #36's Coumadin* per the physician order. *Coumadin (Warfarin) is used in prophylaxis and treatment of venous thrombosis and its extension, pulmonary embolism (PE). Instructions for Patients -Advise patients to: Strictly adhere to the prescribed dosage schedule. (1) Resident #36 was admitted to the facility on 11/14/17 with diagnoses that included but were not limited to: high blood pressure, osteoporosis, gallstones and history of pulmonary embolus (clot). The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 3/4/18, coded the resident as scoring a 15 on the BIMS (brief interview for mental status) score, indicating she was capable of making her cognitive daily decisions. Resident #36 was coded as requiring supervision for most of her activities of daily living.	F 684	3.a. Director of Nursing or designee will inservice license nursing staff on administering Coumadin and obtaining orders for administrating medications via feeding tubes. b. Director of Nursing or designee will in-service C.N.A's on applying arm coverings. 4.a. Director of Nursing or designee will audit Coumadin orders 5 x a week for 2 months to ensure medication is administered at designated times. b. Unit Manager or designee will audit medications administer via feeding tubes at designated times 3 x weekly for 2 months. c. Unit Manager or designee will audit resident with orders for arm coverings 3 x weekly for 2 months to ensure they are applied. d. Unit Manager or designee will report the results of the audits to the QAPI committee monthly for 2 months. e. Audit results / trends will be reviewed at QAPI meeting to ensure that Action Plans are effective. Additional action plans will be done as needed.	6/4/18

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 _____	05/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 684	Continued From page 63 An interview was conducted with Resident #36 on 5/2/18 at 10:54 a.m. Resident #36 stated they (the facility) are short staffed and they don't get their evening medications on time. Review of the physician's orders dated 4/26/18, revealed the following order that documented, "Coumadin 10 mg (milligrams) po (by mouth) qd (every day) @ (at) 5 p.m., on Monday thru Sat (Saturday). Coumadin 15 mg po @ 5 p.m., on Sunday." The comprehensive care plan dated, 4/26/18, documented in part, "Focus: Resident is at risk for bleeding/bruising/abnormal labs (laboratory tests) R/T (related to) anticoagulant medication." The "Interventions" documented in part, "Provide medication as ordered." Observation was made of the nursing unit on 5/3/18 starting at 4:30 p.m. The medication cart for the hall on which Resident #36 was observed. There was no nurse around the medication cart. The nurse came to the medication cart at 5:32 p.m. She pushed the cart down the hallway and started to administer medications. At 5:33 p.m., Resident #36 was observed going to the dining room. This writer sat with Resident #36 in the dining room on 5/3/18, from 5:32 p.m. until 6:33 p.m. The resident did not receive her Coumadin medication. At 6:38 p.m., Resident #36 left the dining room and walked down the hallway towards her room. She stopped and spoke with the nurse, (RN [registered nurse] #3. On 5/3/18 at 6:39 p.m. a copy of the MAR (medication administration record) for May 2018,	F 684		

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	495401	A. BUILDING _____ B. WING _____	05/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 684	Continued From page 64	F 684		

was requested from ASM (administrative staff member) #6, regional director of clinical services. The MAR documented, "Warfarin (Coumadin) 10 mg tablet ; take 1 tab (tablet) by mouth every evening." It was not documented as having been administered on 5/3/18 at the scheduled time of 5:00 p.m.

On 5/4/18 at 8:40 a.m., Resident #36 informed this surveyor that she didn't get her Coumadin until 8:04 p.m.

An interview was conducted with RN (registered nurse) #5 on 5/4/18 at 8:41 a.m., regarding administering medications as ordered. RN #5 stated, "It can be given an hour before and an hour afterward." When asked what staff does if medication not given during this time frame, RN #5 stated, "You are out of compliance." When asked if Coumadin should be given the same time every day, RN #5 stated, "It should be given at the same time every day. You want to keep the levels (in the blood) at the same level, therapeutic."

An interview was conducted with RN # 3, a unit manager, on 5/4/18 at 8:44 a.m. When asked why she was giving medications on 5/3/18 on the evening shift, RN #3 stated, "I was covering for the shift." When asked if she administered all resident medications on time, RN #3 stated, "Yes." RN #3 was informed of the observation of the medication cart still sitting at the nurse's station at 5:30 p.m. RN #3 stated, "I pulled my cart to the floor and then got called away. I then returned and started doing the blood sugars and insulin's before the residents ate dinner.

An interview was conducted with administrative

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 _____	05/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 684	Continued From page 65 staff member (ASM) #2, the director of nursing, on 5/4/18 at 8:53 a.m., regarding when medications should be given. ASM #2 stated, "As ordered." When asked if the order is for a specific time, when should it be given, ASM #2 stated it should be given one hour before or one hour afterwards. When asked when Coumadin should be given, ASM #2 stated, "The preference is to give it in the evening between 5:00 p.m. and 6:00 p.m." When asked if it is ordered for 5:00 p.m. when should it be given, ASM #2 stated, "Between 4:00 p.m. and 6:00 p.m. The above observation was shared with ASM #2. The facility policy, "General Dose Preparation and Medication Administration" documented in part, "5. During medication administration, facility staff should take all measures required by facility policy and applicable law, including, but not limited to the following: 5.4 Administer medications within timeframes specified by facility policy." ASM #1, the administrator, ASM #2, the director of nursing and ASM #4, the regional director of clinical services, were made aware of the above concern on 5/4/18 at 10:40 a.m. No further information was provided prior to exit. (1) This information was obtained from the following website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=d91934a0-902e-c26c-23ca-d5accc4151b6& 2. The facility staff failed to administer medications via the feeding tube as ordered by the physician for Resident #70.	F 684		

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 _____	05/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 684	Continued From page 66 Resident #70 was admitted to the facility on 12/2/17 with diagnoses that included but were not limited to: irregular heart beat, dementia, high blood pressure and difficulty swallowing. The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 4/13/18 coded the resident as having scored a seven out of 15 on the BIMS (brief interview for mental status) indicating the resident was severely impaired cognitively. The resident was coded as requiring assistance from staff for all activities of daily living except for eating which the resident could perform after the tray was set up. The resident was coded as having a feeding tube. An observation was made on 5/3/18 at 8:45 a.m. of LPN (licensed practical nurse) #3 entering Resident #70's room with a cup of applesauce with medications in it. LPN #3 gave the medications in the applesauce to the resident by mouth. An observation was made on 5/3/18 at 5:23 p.m. of LPN (licensed practical nurse) #1 giving medications to Resident #70. The nurse took the medications in applesauce into the resident's room and administered the medications by mouth to the resident. Review of the care plan initiated on 12/5/17 and revised on 12/5/17 did not evidence documentation specifically regarding giving the medications through the feeding tube. Review of the May 2018 physician's orders documented, "LEVOTHYROXINE SODIUM	F 684		

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 _____	05/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 684	Continued From page 67 (1)...VIA PEG (2)TUBE...; OMEPRAZOLE (3)...VIA PEG TUBE; ASPIRING ORANGE ...VIA PEG TUBE; FOLIC ACID (4) VIA PEG TUBE; VALSARTAN (5) VIA PEG TUBE; CARVEDILOL (6)...VIA PEG TUBE; CARBIDOPA-LEVODOPA VIA PEG TUBE (7)." Review of the May 2018 medication administration record documented, "LEVOTHYROXINE SODIUM...VIA PEG (2)TUBE...; OMEPRAZOLE...VIA PEG TUBE; ASPIRING ORANGE ...VIA PEG TUBE; FOLIC ACID VIA PEG TUBE; VALSARTAN VIA PEG TUBE; CARVEDILOL...VIA PEG TUBE; CARBIDOPA-LEVODOPA VIA PEG TUBE." The medications were documented as being administered during May. An interview was conducted on 5/3/18 at 8:45 a.m. with LPN #3. When asked how Resident #70 took her medications, LPN #3 stated, "She takes them by mouth" When asked how they were ordered to be given, LPN #3 stated, "They're by PEG." When asked if staff could administer the medications by mouth if the order was for them to be given via the PEG tube, LPN #3 stated, "No. We need to follow the order." When asked if she had followed the order, LPN #3 stated, "No." An interview was conducted on 5/03/18 at 12:33 p.m. with Resident #70. When asked how she took her medications, Resident #70 stated she took them in applesauce by mouth. When asked how long she had been taking her medications by mouth, Resident #70 stated, "About two weeks." An interview was conducted on 5/3/18 at 3:22 p.m. with LPN #1. When asked how Resident #70 took her medications, LPN #1 stated, "By mouth."	F 684		

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 _____	05/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 684	Continued From page 68 When asked what the physician's orders documented, LPN #1 stated, "I thought there was an order to give them either way." On 5/3/18 at 6:45 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings. An interview was conducted on 5/4/18 at 8:30 a.m. with ASM #2, director of nursing. When asked if staff should give medications by mouth when they were ordered via PEG tube, ASM #2 stated, "No they shouldn't they should follow the order or get it clarified." No further information was provided prior to exit. 1. Levothyroxine sodium -- Levothyroxine Sodium is the major hormone derived from the thyroid gland. This information was obtained from: https://pubchem.ncbi.nlm.nih.gov/compound/Levothyroxine_sodium#section=Top 2. PEG -- Percutaneous endoscopic gastrostomy (PEG) is the preferred route of feeding and nutritional support in patients with a functional gastrointestinal system who require long-term enteral nutrition. This information was obtained from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4069302/ 3. Omeprazole -- PRILOSEC is indicated for short-term treatment of active duodenal ulcer in adults. Most patients heal within four weeks. Some patients may require an additional four weeks of therapy. This information was obtained from:	F 684		

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 _____	05/04/2018

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 684	Continued From page 69 https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=A1B077E6-B070-43F2-A98E-380CC635419D 4. Folic acid -- Folic acid is a B vitamin. It helps the body make healthy new cells. This information was obtained from: https://medlineplus.gov/folicacid.html 5. Valsartan -- Valsartan Tablets, USP are indicated for the treatment of hypertension, to lower blood pressure. Lowering blood pressure reduces the risk of fatal and nonfatal cardiovascular events, primarily strokes and myocardial infarctions. 6. Carvedilol -- Carvedilol is indicated for the management of essential (hypertension). It can be used alone or in combination with other antihypertensive agents, especially thiazide-type diuretics. This information was obtained from: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=7d485d38-5d43-4a54-bc63-82734035c66a 7. Carbidopa-levodopa -- Carbidopa and levodopa extended release tablets are indicated in the treatment of the symptoms of idiopathic Parkinson's disease (paralysis agitans), postencephalitic parkinsonism, and symptomatic parkinsonism which may follow injury to the nervous system by carbon monoxide intoxication and/or manganese intoxication. This information was obtained from: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=abff005f-23fc-4d1e-b469-88aa07589a43	F 684		

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 _____	05/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 70 3. The facility staff failed to apply protective arm covers as ordered by the physician for Resident #25. Resident #25 was admitted to the facility on 8/13/14 and readmitted on 3/4/15 with diagnoses that included but were not limited to: high blood pressure, heart failure, arthritis, lung disease and chronic pain. The most recent MDS (minimum data set), an annual assessment, with an ARD (assessment reference date) of 2/22/18, coded the resident as having scored a five out of 15 on the BIMS (brief interview for mental status) indicating the resident was severely impaired cognitively. The resident was coded as requiring assistance from staff for all activities of daily living. An observation was made on 5/2/18 at 8:20 a.m., of Resident #25. The resident was lying on her back in bed with her eyes closed. She was wearing a hospital gown and her arms were bare. There was a white bandage on the right forearm. An observation was made on 5/3/18 at 8:18 a.m., of Resident #25. The resident was lying in bed with her eyes closed. She was wearing a hospital gown and her arms were bare. There was a white bandage on the right forearm. An observation was made on 5/3/18 at 12:10 p.m., of Resident #25. The resident was lying in bed and was wearing a short-sleeved blouse. There was a white bandage on the resident's right forearm otherwise the arms were not covered. An observation was made on 5/3/18 at 12:29 p.m., of Resident #25 was up in a wheelchair,	F 684		

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 _____	05/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 71 and she had geri sleeves on her arms. Review of the resident's care plan initiated on 2/10/18 and revised on 4/29/18 documented, "Focus. (Name of Resident #25) is at risk for impaired skin integrity r/t (related to) impaired mobility, incontinence and obesity. 4/20/18 skin tear to (R) (right) arm. Interventions. Geri sleeves (protective sleeves)." Review of the May 2018 physician's orders documented, "04/20/18: GERI SLEEVES EVERY SHIFT TO BILATERAL ARMS FOR PREVENTION." Review of the May 2018 MAR documented, "GERI SLEEVES EVERY SHIFT TO BILATERAL ARMS FOR PREVENTION." On 5/1/18 and 5/2/18, the nurse's initials were circled on the 7:00 a.m. to 3:00 p.m. shift indicating the geri sleeves were not on. There was no documentation on the 3:00 p.m. to 11:00 p.m. or 11:00 p.m. to 7:00 a.m. shifts. An interview was conducted on 5/3/18 at 12:19 p.m. with LPN #3, the resident's nurse. When asked who put the geri sleeves on the residents, LPN #3 stated, "The CNA usually puts them on in the morning when they do their care." When asked why Resident #25 had geri sleeves ordered, LPN #3 stated, "Because she has a skin tear." An interview was conducted on 5/3/18 at 3:32 p.m. with CNA #1, the resident's aide. When asked when the resident's geri sleeves were put on, CNA #1 stated, "We had to order some. I found them in the drawer and then I put them on." When asked if the resident had the sleeves on	F 684		

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 _____	05/04/2018

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 684	Continued From page 72 the day before, CNA #1 stated she had not. On 5/3/18 at 6:45 p.m. ASM #1, the administrator and ASM #2, the director of nursing were made aware of the findings. An interview was conducted on 5/4/18 with ASM #2, the director of nursing. When asked if she expected staff to follow the physician's orders, ASM #2 stated, she did. No further information was provided prior to exit.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined the facility staff failed to provide an environment free of accidents and hazards for one of 36 residents in the survey sample, Resident #25; and for one of one shower stretchers. 1. The facility staff failed to use two staff while using the Hoyer lift for Resident #25. 2. The facility staff failed to provide an environment free of accidents and hazards on	F 689	1. No corrections to be made for resident #25. Shower pad was immediately removed from the unit. 2.a. Residents who are transferred using a Hoyer Lift are at risk for the deficient practice. b. All residents are at risk for issues with shower pad. 3. a. Director of Rehab will inservice Nursing Department Staff on proper use of Hoyer Lift to include having two people during transfers. b. New shower pad obtained and placed on stretcher. 4.a. Director of Nursing or designee will audit use of Hoyer Lift 3x a week for 2 months. b. Director of Nursing or designee will report the results of the audits to the QAPI committee monthly. 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.	6/4/18

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 _____	05/04/2018

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 689	Continued From page 73 one of one-shower stretchers. The findings include: 1. The facility staff failed to use two staff while using the Hoyer lift for Resident #25. Resident #25 was admitted to the facility on 8/13/14 and readmitted on 3/4/15 with diagnoses that included but were not limited to: high blood pressure, heart failure, arthritis, lung disease and chronic pain. The most recent MDS (minimum data set), an annual assessment, with an ARD (assessment reference date) of 2/22/18 coded the resident as having scored a five out of 15 on the BIMS (brief interview for mental status) indicating the resident was severely impaired cognitively. The resident was coded as requiring assistance from staff for all activities of daily living. The resident was coded as requiring two or more staff for transfers out of the bed. An observation was made on 5/3/18 at 12:10 p.m., of CNA (certified nursing assistant) #1 entering Resident #25's room alone. The CNA closed the door. An observation was made on 5/3/18 at 12:29 p.m. of Resident #25 being pushed by CNA #1 in her wheelchair out of the resident's room. An observation of the resident's room was made. A Hoyer lift (a mechanical lift) was next to the resident's bed. There was no one else in the room. A review of the resident's care plan initiated on	F 689		

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	495401	A. BUILDING _____ B. WING _____	05/04/2018

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 689	Continued From page 74	F 689		

4/15/16 and revised on 2/25/18 documented, "Focus. Risk for falls related to impaired mobility...Interventions. 2 person assist with ADLs (activities of daily living) and bed mobility. Staff education for transfers."

An interview was conducted on 5/3/18 at 3:32 p.m. with CNA #1. When asked how the resident got out of bed, CNA #1 stated, "The Hoyer lift." When asked how many staff were needed to get a resident out of bed with a Hoyer lift, CNA #1 stated, "Two." When asked why two staff were needed, CNA #1 stated, "In case anything happens." When asked who got the resident out of bed that day, CNA #1 stated, "The hospice nurse was here." When asked again, who got the resident out of the bed that day, CNA #1 stated, "I did." When asked if she got the resident out of bed with the Hoyer lift by herself, CNA #1 stated, "Yes ma'am." When asked if that was correct, CNA #1 stated, "I couldn't find anyone else."

On 5/3/18 at 6:45 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings.

An interview was conducted on 5/4/18 at 8:30 a.m. with ASM #2. When asked how many staff were needed when using a Hoyer lift, ASM #2 stated, "Two, at least." When asked why, ASM #2 stated, "It's for safety reasons."

Review of the facility's policy titled, "HOW TO TRANSFER WITH THE HOYER LIFT" documented, "A Hoyer lift, or mechanical lift as it is also know, is a caregiver's co-worker when he needs to transfer an immobile patient from one spot to another. 8. Press the button that will

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 _____	05/04/2018

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 689	Continued From page 75 engage the lift and slowly lift the patient, maintaining control of both the sling and the lift. The Hoyer Lift MUST always be used with two people. " No further information was obtained prior to exit. 2. The facility staff failed to provide an environment free of accidents and hazards on one of one-shower stretchers. Observation was made on 5/4/18 at 10:10 a.m., of a resident in the shower room on the 100/200 unit. The resident was on the shower stretcher being assisted by a staff member. On 5/4/18 at 10:20 a.m. the shower room on the 100/200 unit was observed with other staff member (OSM [other staff member]) #4. The shower stretcher was observed with 13 drain holes in the cushion on top of the mess stretcher. Of the 13 holes, only three of the holes did not have any tears in the plastic coating. The other 10 drain holes had cracks and tears in the plastic ranging from approximately 1/2 inch to approximately eight inches. The white material inside of the stretcher pad was visible in four of the tears. When asked if the shower stretcher was safe and sanitary, OSM #4 stated, "I wouldn't want to take a shower on it." An interview was conducted with RN (registered nurse) #4 on 5/4/18 at 10:32 a.m. RN #4 was shown the shower stretcher in the shower room on the 100/200 hall. When asked why it was a concern that the stretcher cushion had rips and tears in it, RN #4 stated, "Germs in there. Also, these residents have such fragile skin, it would hurt them."	F 689		

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	495401	A. BUILDING _____ B. WING _____	05/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 689	Continued From page 76 An interview was conducted with ASM (administrative staff member) #1, the administrator, on 5/4/18 at 10:40 a.m. When asked who maintains the shower stretchers, ASM #1 stated, "Maintenance repairs anything that is needed and the nurses and CNAs (certified nursing assistants) observe them when they use them." When asked if it was acceptable to have rips and tears in the cushion of the shower stretcher, ASM #1 stated, "No." When asked why it would be a concern, ASM #1 stated, "It's an infection control concern and it's a safety hazard. A request was made for the facility policy on maintaining the shower stretchers. On 5/4/18 at 11:11 a.m. ASM #4, the regional director of clinical services informed this surveyor the facility staff did not have a policy on maintaining the shower stretchers. ASM #4 informed this surveyor that the cushion has been removed and place in the trash. No further information was provided prior to exit.	F 689		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff	F 697	1. No correction to be made for resident # 30. 2. Residents with complaints of pain are at risk for this deficient practice. 3. Director of Nursing or designee will inservice licensed nursing staff on assessing pain prior to and after administering pain medication and non-pharmacological interventions.	

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 _____	05/04/2018

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 697	Continued From page 77 failed to ensure a comprehensive pain management program for one of 36 residents in the survey sample, Resident #30. The facility staff could not provide evidence that pain was assessed prior to the administration of as needed (PRN) pain medication to Resident #30, on several occasions in April of 2018 and on two occasions in May of 2018. The facility staff could also not evidence that non-pharmacological interventions were attempted prior the administration of prn pain medications. The findings include: Resident #30 was admitted to the facility on 8/24/17 and readmitted on 11/28/17 with diagnoses that included but were not limited to type two diabetes, neuropathy, gout, and unspecified dementia without behavioral disturbance. Resident #30's most recent MDS (minimum data set assessment) was a quarterly assessment with an ARD (assessment reference date) of 3/1/18. Resident #30 was coded as being cognitively intact in the ability to make daily decisions scoring 12 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Review of Resident #30's most recent POS (physician order summary) dated 4/30/18, documented the following pain medication orders: 1) "Hydrocodone- Acetaminophen (Norco) 7.5-325 mg (milligram) Tablet 1 tab by mouth every 6 hours for pain." This order was initiated on 2/21/18. 2) "MAPAP (Tylenol) 325 MG tablet Take two	F 697	4. a. Unit Manager or designee will audit 5 residents weekly x 2 months to ensure that pain assessments were done prior to and after pain medication was administered and that non-pharmacological interventions were tried and documented. b. Unit Managers will report the results of the audits to the QAPI committee monthly for 2 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.	6/4/18

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 _____	05/04/2018

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 697	Continued From page 78	F 697		

tabs (650 mg) by mouth every 4 hours as needed for mild pain/temperature. MAX (maximum) Acetaminophen 3-4 GM daily. Check daily total." This order was initiated on 11/28/17.

Review of Resident #30's April 2018 MAR (medication administration record) revealed that she received Norco on the following dates and times: 4/4/18 at 12:15 a.m., and 6:00 a.m., 4/7/18 at 0600 a.m., and 4/9/18 at 12 a.m. and 6 p.m.

Further review of Resident #30's April 2018 MAR revealed that she received Tylenol 650 mg on the following dates and times: 4/6/18 at 6:00 p.m., 4/19/18 at 1:00 a.m., 4/22/18 at 12:00 a.m., 4/23/18 at 12:00 a.m., and 4/30/18 at 2:00 a.m.

There was no evidence in the clinical record that a pain assessment was completed prior to the administration of Norco and Tylenol in April of 2018. There was no evidence of a follow up pain assessment after the Norco and Tylenol was administered in April. There was no evidence that non-pharmacological pain interventions were attempted prior to the administration of PRN pain medications. The pain flow sheet for April was missing from the clinical record.

Review of Resident #30's May 2018 MAR revealed that she received Tylenol 650 mg (milligram) on the following dates and times: 5/1/18 and 5/3/18, times administered were illegible.

There was no evidence in the clinical record that a pain assessment was completed prior to the administration of Tylenol in May of 2018. There was no evidence of a follow up pain assessment

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 _____	05/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 697	Continued From page 79 after the Tylenol was administered in May. There was no evidence that non-pharmacological pain interventions were attempted prior to the administration of PRN pain medications. The pain flow sheet for May was completely blank. Review of Resident #30's pain care plan dated 11/28/17, documented in part, the following: "Potential for pain/discomfort related to impaired mobility, neuropathy, gout; Goal: Pain will be resolved within 1 hour of intervention through next review. Interventions: Pain assessment per facility routine and prn (as needed), Administer pain medication as per MD (medical doctor) orders and note the effectiveness." On 5/03/18 at 2:34 p.m., an interview was conducted with LPN (licensed practical nurse) #4, regarding the process staff follows prior to administering a prn (as needed) pain medication. LPN #4 stated she would conduct a pain assessment and first attempt non-pharmacological pain relief interventions prior to the administration of pain medications. LPN #4 stated, "You want to try something as far as ROM (range of motion), repositioning." LPN #4 stated that if those interventions did not work she would move on to prn medications. When asked if pain would be assessed prior to attempting non-pharmacological interventions and administering pain medications, LPN #4 stated that it should be. LPN #4 stated that she would assess for pain location, intensity of pain, and the effectiveness of her interventions. When asked if this information would be documented anywhere in the clinical record, LPN #4 stated, "Yes, it should be on the pain flow sheet." LPN #4 stated that a pain assessment might also be documented in a nursing note. LPN #4 could not	F 697		

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	495401	A. BUILDING _____ B. WING _____	05/04/2018

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 697	Continued From page 80 recall giving Resident #30-pain medication. On 5/03/18 at approximately 5:30 p.m., an interview was conducted with Resident #30. When asked if facility staff assess her pain before giving her pain medication, Resident #30 stated that facility staff will ask her pain level and the location. Resident #30 stated that staff never come back and do a follow up assessment on her pain. Resident #30 stated that she thought staff should do this. Resident #30 stated that she just gets her pain medication when she requests it. Resident #30 stated that staff do not attempt non-pharmacological interventions before pain medications are administered. On 5/04/18 at 9:30 a.m., an interview was conducted with ASM (administrative staff member) #2, the DON (Director of Nursing), regarding the process staff follows prior to administering a prn pain medication, ASM #2 stated that staff should conducted a pain assessment that includes the duration of pain, location, and intensity of pain. ASM #2 stated this information should be documented on the pain log (pain flow sheet). When asked if non-pharmacological interventions should be attempted prior to the administration of pain medications, ASM #2 stated that they should. ASM #2 stated this information should also be documented on the pain flow sheet or in the progress note. When asked if she could determine where Resident #30's April 2018 pain flow sheet was located, ASM #2 stated that the unit manager could not find it. ASM #2 stated that the pain flow sheet was part of the clinical record and should have been in Resident #30's chart. ASM #2 stated she could not determine if nursing staff did the pain assessment and forgot	F 697		

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 _____	05/04/2018

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 697	Continued From page 81	F 697		

to document, or if it was not done. ASM #2 stated that she could not say. ASM #2 stated, "They probably missed the actual documentation of the assessment."

On 5/4/18 at 10:39 a.m., ASM (administrative staff member) #1, the administrator was made aware of the above concerns.

The facility policy titled, "Pain Management and Pain Protocol," documented in part, the following: "3. Non-pharmacological intervention will be attempted prior to the administration of PRN pain medications. When it is determined the resident's pain will need pharmacological interventions: a. Documentation of administration of medications will be located on the Medication Administration Record. b. The response of the medication(s) will be located on the Medication Administration Record. 5. The information on the pain flow record will identify a. Location of pain- Ask the resident to point to the side(s) of pain. b. Pain intensity- Provide the resident with the 10 point Pain Intensity Scale and ask the resident to choose the best description of his/her pain experience. c. Pain quality- Encourage the resident to use adjectives to describe the quality of pain (sharp, dull, aching, shooting, burning, intense, agonizing, and unbearable). d. onset and duration of pain. - Ask the resident about the time of onset and periods of relief (if any). e. Aggravating factors- Ask the resident if there are any circumstances or activities that help reduce the pain. f. Accompanying symptoms- Ask the resident if there are any accompanying symptoms, such as nausea, vomiting, and sensitivity to light and sounds. g. Non pharmacological interventions will be attempted prior to the administration of PRN pain

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 _____	05/04/2018

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 697	Continued From page 82 medications. 6. The resident will be reassessed for pain a regular intervals. The physician will be notified of ineffective pain management as needed." No further information was presented prior to exit. (1) Norco- Hydrocodone and acetaminophen combination is used to relieve moderate to moderately severe pain. This information was obtained from the National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010590/?report=details (2) Tylenol- Treats minor aches, pains, and also reduces fever. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0008785/?report=details.	F 697		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized	F 761	1. Flu vaccine vials were immediately discarded. The nurse who left the medication cart unlocked was spoken with after the exit conference. 2. All residents are at risk for this deficient practice. 3. Director of Nursing or designee will inservice licensed nursing staff on storage of biologicals to include monitoring expiration dates and locking of medication carts when not in use.	

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 _____	05/04/2018

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 761	Continued From page 83 personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, it was determined the facility staff failed to ensure medications were not expired in one of two medication rooms, and failed to store drugs in a safe manner for one of four medication carts. 1. The facility staff failed to ensure influenza vaccines, that were available for use, were not expired in one of two medication rooms. 2. The facility staff failed to lock the medication cart on the Sherwood unit. The findings include: 1. The facility staff failed to ensure influenza vaccines*, that were available for use, were not expired in one of two medication rooms. *The influenza virus vaccine is used to prevent infection by the influenza virus. The vaccine works by causing your body to produce your own protection (antibodies) against the disease. It's also called a flu shot. There are many types of	F 761	4. a.Unit Managers will audit the medication rooms 2x weekly x 2 months to ensure biologicals are stored properly including checking for expiration dates. b.Unit Managers or designee will audit medication carts via direct observation M-F to ensure they are locked x 2 months. c. Unit Managers will report the results of the audits to the QAPI committee monthly for 2 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.	6/4/18

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 _____	05/04/2018

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 761	Continued From page 84	F 761		

influenza viruses but not all will cause problems in any given year. The influenza vaccine is made every year. It is necessary to receive your influenza vaccine every year as different viruses and the protection only lasts for less than a year." (1)

Observation was made of the unit 100/200 medication room on 5/2/18 at 3:15 p.m. Sixteen unit dose syringes of influenza vaccine were found in the units refrigerator. All sixteen of the syringes were expired on 4/2018.

An interview was conducted with LPN (licensed practical nurse) #1 on 5/17/18 at 3:17 p.m. When asked if you can give a medication that is expired, LPN #1 stated, "I was told you cannot give them if they are expired." When asked who's responsible for checking medications to ensure they are not expired, LPN #1 stated, "If we (the nurses) see things we should take it out. All nurses are responsible because we all give medications." When the syringes of influenza vaccines were shown to LPN #1, she just shook her head.

An interview was conducted with RN (registered nurse) #1 on 5/2/18 at 3:20 p.m. When asked whose responsibility it is to check the drugs in the refrigerators to ensure they are not expired, RN #1 stated, "Myself and the nurses. It's a group effort to get rid of things when it's expired or the resident dies." The expired unit dose syringes of influenza were shown to RN #1.

The facility policy, "General Dose Preparation and Medication Administration" documented in part, "The facility staff should...Check the expiration date on the medication."

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 _____	05/04/2018

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 761	Continued From page 85 The administrator ASM (administrative staff member) #5, vice president of operations, and ASM #4, corporate nurse were made aware of these findings on 5/4/18 at 11:29 a.m. No further information was provided prior to exit. 2. The facility staff failed to lock the medication cart on the Sherwood unit. An observation was made on 5/3/18 at 5:11 p.m. The medication cart was sitting at a diagonal between two rooms. LPN (licensed practical nurse) #1 was in a resident's room out of the line sight of the cart. The cart was unlocked. Approximately 30 to 40 seconds later the nurse came out of the resident's room and then pushed the cart up the hall to the nurse's stations. An interview was conducted on 5/3/18 at 5:30 p.m. with LPN #1, when asked what staff did when leaving the medication cart out of sight, LPN #1 stated, "It was unlocked. I should have locked it." When asked why, LPN #1 stated, "Safety issues." On 5/3/18 at 6:45 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings. An interview was conducted on 5/4/18 at 8:30 a.m. with ASM #2. When asked what staff did when leaving the medication cart out of sight, ASM #2 stated, "They're supposed to lock it." When asked why, AM #2 stated, "For safety reasons." Review of the facility's policy titled, "General Dose	F 761		

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 _____	05/04/2018

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 761	Continued From page 86 Preparation and Medication Administration" documented, "7. Facility should ensure that medication carts are always locked when out of sight or unattended." No further information was obtained prior to exit. (1) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0046150/	F 761		
F 804 SS=B	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review it was determined the facility staff failed to ensure food was palatable in one of two dining areas, the restorative dining area. The facility staff failed to serve food at a palatable temperature in the restorative dining area. The findings include: Observation was made of the tray line in the kitchen on 5/3/18 at 11:35 a.m. The temperatures were taken of all of the food being served. The	F 804	1. No correction to be made since no resident cited. 2. All residents are at risk for this deficient practice. 3. Director of Nursing or designee will inservice nursing staff on timely passing of meal trays to include serving all the residents at the same table in a timely manner. 4. a. Dietary Manager will test tray/food temps 3x weekly x 2 months to ensure food is served at a palatable temp on the Restorative Food Cart. b. Unit Manager or designee will observe Restorative Dining to ensure trays are served timely M-F x 2 months. c. Unit Managers will report the results of the audits to the QAPI committee monthly for 2 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.	6/4/18

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 _____	05/04/2018

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 804	Continued From page 87 temperature of the puree meat was recorded at 180 degrees. The temperature of the peas was recorded at 180 degrees. The food trays were served to the residents in the restorative dining area at 12:22 p.m. The last resident to receive assistance from the staff for eating was at 12:37 p.m. The test tray was started at 12:40 p.m. with two surveyors and the dietary manager, other staff member (OSM) # 10. The test tray consisted of soup, ground beef, ground ham, puree peas, puree meat, puree bread, mashed potatoes, peas and a dessert of pumpkin mousse. The recorded temperature of the puree meat was recorded at 110 degrees. The recorded temperature of the peas was 96 degrees. Both surveyors and OSM #10 tasted the food. It was agreed that the peas and ground meat was not hot enough for palatability. When asked if she felt it should be hotter to taste, OSM #10 stated that she felt it could be a bit warmer for taste. The facility policy, "Food Temperatures" documented in part, "4. Hot food should be palatable when served, which is defined as point of delivery." Administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing, and ASM # 6, the regional director of clinical services, were made aware of the above concern on 5/3/18 at 6:50 p.m. No further information was provided prior to exit.	F 804		
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)	F 842	1. No correction to be made for residents 7, 44,26,46,30 or 19.	

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 _____	05/04/2018

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 842	Continued From page 88 §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted	F 842	2. 100% audit of current resident orders to identify those at risk for this deficient practice. 3. Director of Nursing or designee will inservice licensed nursing staff on obtaining a diagnosis or indication for use with new medication orders, completion of pain flow sheet and restorative log and placement in clinical record. 4. a. Unit Manager will audit new orders for diagnosis or indication for use M-F x 2 months. b. Unit Manager or designee will audit 5 pain flow sheets weekly x 2 months to ensure they are in the medical record. c. MDS will audit 5 Restorative logs weekly x 2 months to ensure they are in the medical record. d. Unit Managers will report the results of the audits to the QAPI committee monthly for 2 months. e. Audit results / trends will be reviewed at QAPI meeting to ensure that Action Plans are effective. Additional action plans will be done as needed.	6/4/18

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 _____	05/04/2018

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 842	Continued From page 89 by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to ensure a complete and accurate clinical record for five of 36 residents in the survey sample; Residents #7, #44, #26, #46, #30, and #19. 1. The facility failed to document in the clinical record, the reason Resident #7 was prescribed a treatment.	F 842		

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 _____	05/04/2018

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 842	Continued From page 90 2. The facility staff failed to document in the clinical record, the reason Resident #44 was prescribed a treatment. 3. The facility staff failed to document in the clinical record, the reason Resident #26 was prescribed a treatment. 4. The facility staff failed to document in the clinical record, the reason Resident #46 was prescribed a treatment. 5. The facility staff failed to ensure Resident #30's April 2018 pain flow sheet was in the clinical record. 6. The facility staff failed to ensure Resident #19's April 2018 restorative log for toileting was on the clinical record. The findings include: 1. The facility failed to document in the clinical record, the reason Resident #7 was prescribed a treatment. Resident #7 was admitted to the facility on 10/6/16 with the diagnoses of but not limited to high blood pressure, anxiety disorder, depression, history of falls, dementia, osteoarthritis, and atrial fibrillation. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 2/9/18. The resident was coded as cognitively impaired in ability to make daily life decisions. The resident was coded as requiring extensive care for bathing, hygiene, toileting, dressing, and transfers; supervision for	F 842		

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 _____	05/04/2018

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 842	Continued From page 91 eating; and as incontinent of bladder. A review of the clinical record revealed a physician's telephone order dated 3/19/18 for "Permethrin cream [1] 5% - Apply to entire body, leave on 8-14 hours, then shower off." The order did not document the reason for the Permethrin cream. Further review of the clinical record failed to reveal any evidence of a note documenting a reason for the Permethrin cream and failed to evidence any indication the resident had any signs or symptoms requiring the use of the Permethrin cream. On 5/3/18 at 12:30 p.m., in an interview with RN #1 (Registered Nurse, the unit manager), she stated that there was one identified case of scabies on the unit and everyone else was treated prophylactically. When asked about documenting in a clinical record why a treatment was provided, RN #1 stated the record should reflect everything going on with a patient and the reason why. A review of the facility policy, "Resident Medical Records" failed to include any direction for ensuring complete documentation of care provided to a resident. On 5/4/18 at 10:12 a.m., the Administrator was made aware of the findings. No further information was provided. Potter-Perry, Fundamentals of Nursing, 6th edition, Patricia Potter and Anne Perry; page 480, was used as a reference regarding assessments and documentation. "The record needs to	F 842		

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 _____	05/04/2018

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 842	Continued From page 92 describe exactly what happened to a client." "Nurses need to indicate all assessments, interventions, client responses, instructions, and referrals in the medical record". [1] Permethrin is used to treat scabies. Information obtained from https://medlineplus.gov/druginfo/meds/a698037.html 2. The facility staff failed to document in the clinical record, the reason Resident #44 was prescribed a treatment. Resident #44 was admitted to the facility on 1/25/17 with the diagnoses of but not limited to atrial fibrillation, depression, anxiety disorder, and dysphagia. The most recent MDS (Minimum Data Set) was an annual assessment with an ARD (Assessment Reference Date) of 3/14/18. The resident was coded as cognitively intact in ability to make daily life decisions. The resident was coded as requiring extensive care for bathing, hygiene, toileting, dressing, and transfers; supervision for eating; and as continent of bowel and bladder. A review of the clinical record revealed a physician's telephone order dated 3/19/18 for "Permethrin cream [1] 5% - Apply to entire body, leave on 8-14 hours, then shower off." The order did not document the reason for the Permethrin cream. Further review of the clinical record failed to reveal any evidence of a note documenting a reason for the Permethrin cream and failed to	F 842		

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 _____	05/04/2018

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 842	Continued From page 93 evidence any indication the resident had any signs or symptoms requiring the use of the Permethrin cream. On 5/3/18 at 12:30 p.m., in an interview with RN #1 (Registered Nurse, the unit manager), she stated that there was one identified case of scabies on the unit and everyone else was treated prophylactically. When asked about documenting in a clinical record why a treatment was provided, RN #1 stated the record should reflect everything going on with a patient and the reason why. A review of the facility policy, "Resident Medical Records" failed to include any direction for ensuring complete documentation of care provided to a resident. On 5/4/18 at 10:12 a.m., the Administrator was made aware of the findings. No further information was provided. 3. The facility staff failed to document in the clinical record, the reason Resident #26 was prescribed a treatment. Resident #26 was admitted to the facility on 3/14/16 with the diagnoses of but not limited to depression, history of falls, aphasia, insomnia, hypothyroidism, stroke, high blood pressure, dementia, mood disorder, psychotic disorder, and dysphagia. The most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 2/23/18. The resident was coded as cognitively impaired in ability to make daily life	F 842		

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 _____	05/04/2018

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 842	Continued From page 94	F 842		

decisions. The resident was coded as requiring limited assistance for bathing and transfers; supervision for dressing and eating; was independent for hygiene and toileting; and as continent of bowel and bladder.

A review of the clinical record revealed a physician's telephone order dated 3/19/18 for "Permethrin cream [1] 5% - Apply to entire body, leave on 8-14 hours, then shower off." The order did not document the reason for the Permethrin cream.

Further review of the clinical record failed to reveal any evidence of a note documenting a reason for the Permethrin cream and failed to evidence any indication the resident had any signs or symptoms requiring the use of the Permethrin cream.

On 5/3/18 at 12:30 p.m., in an interview with RN #1 (Registered Nurse, the unit manager), she stated that there was one identified case of scabies on the unit and everyone else was treated prophylactically. When asked about documenting in a clinical record why a treatment was provided, RN #1 stated the record should reflect everything going on with a patient and the reason why.

A review of the facility policy, "Resident Medical Records" failed to include any direction for ensuring complete documentation of care provided to a resident.

On 5/4/18 at 10:12 a.m., the Administrator was made aware of the findings. No further information was provided.

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 _____	05/04/2018

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 842	Continued From page 95	F 842		

4. The facility staff failed to document in the clinical record, the reason Resident #46 was prescribed a treatment.

Resident #26 was admitted to the facility on 10/10/12 with the diagnoses of but not limited to high blood pressure, dementia, osteoarthritis, stroke, aphasia, and hemiplegia/hemiparesis. The most recent MDS (Minimum Data Set) was an annual assessment with an ARD (Assessment Reference Date) of 3/16/18. The resident was cognitively impaired in ability to make daily life decisions. The resident required extensive care for bathing, hygiene, toileting, and transfers; supervision for dressing and eating; and was incontinent of bowel and bladder.

A review of the clinical record revealed a physician's telephone order dated 3/19/18 for "Permethrin cream [1] 5% - Apply to entire body, leave on 8-14 hours, then shower off." The order did not document the reason for the Permethrin cream.

Further review of the clinical record failed to reveal any evidence of a note documenting a reason for the Permethrin cream and failed to evidence any indication the resident had any signs or symptoms requiring the use of the Permethrin cream.

On 5/3/18 at 12:30 p.m., in an interview with RN #1 (Registered Nurse, the unit manager), she stated that there was one identified case of scabies on the unit and everyone else was treated prophylactically. When asked about documenting in a clinical record why a treatment

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 _____	05/04/2018

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 842	Continued From page 96 was provided, RN #1 stated the record should reflect everything going on with a patient and the reason why. A review of the facility policy, "Resident Medical Records" failed to include any direction for ensuring complete documentation of care provided to a resident. On 5/4/18 at 10:12 a.m., the Administrator was made aware of the findings. No further information was provided. 5. The facility staff failed to ensure Resident #30's April 2018 pain flow sheet was in the clinical record. Resident #30 was admitted to the facility on 8/24/17 and readmitted on 11/28/17 with diagnoses that included but were not limited to type two diabetes, neuropathy, gout, and unspecified dementia without behavioral disturbance. Resident #30's most recent MDS (minimum data set assessment) was a quarterly assessment with an ARD (assessment reference date) of 3/1/18. Resident #30 was coded as being cognitively intact in the ability to make daily decisions scoring 12 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Review of Resident #30's most recent POS (physician order summary) dated 4/30/18, documented the following pain medication orders: 1) "Hydrocodone- Acetaminophen (Norco) 7.5-325 mg (milligram) Tablet 1 tab by mouth every 6 hours for pain." This order was initiated	F 842		

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 _____	05/04/2018

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 842	Continued From page 97 on 2/21/18.	F 842		

2) "MAPAP (Tylenol) 325MG tablet Take two tabs (650 mg) by mouth every 4 hours as needed for mild pain/temperature. MAX Acetaminophen 3-4 GM daily. Check daily total." This order was initiated on 11/28/17.

Review of Resident #30's April 2018 MAR revealed that she received Norco on the following dates and times: 4/4/18 at 12:15 a.m., and 6:00 a.m., 4/7/18 at 0600 a.m., and 4/9/18 at 12 a.m. and 6 p.m.

Further review of Resident #30's April 2018 MAR revealed that she received Tylenol 650 mg on the following dates and times: 4/6/18 at 6:00 p.m., 4/19/18 at 1:00 a.m., 4/22/18 at 12:00 a.m., 4/23/18 at 12:00 a.m., and 4/30/18 at 2:00 a.m.

There was no in the clinical record documentation evidencing that a pain assessment was completed prior to the administration of Norco and Tylenol in April of 2018. There was no documentation in the clinical record evidencing a follow up pain assessment after the Norco and Tylenol was administered in April. There was no evidence that non-pharmacological pain interventions were attempted prior to the administration of PRN pain medications. The pain flow sheet for April was missing from the clinical record.

On 5/04/18 at 9:30 a.m., an interview was conducted with ASM (administrative staff member) #2, the DON (Director of Nursing), regarding the process staff follows prior to administering a prn pain medication. ASM #2 stated that staff should be conducted a pain

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 _____	05/04/2018

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 842	Continued From page 98 assessment that includes the duration of pain, location, and intensity of pain. ASM #2 stated that this information should be documented on the pain log (pain flow sheet). When asked if non-pharmacological interventions should be attempted prior to the administration of pain medications, ASM #2 stated that they should. ASM #2 stated that this information should also be documented on the pain flow sheet or in the progress note. When asked if she could determine where Resident #30's April 2018 pain flow sheet was located, ASM #2 stated that the unit manager could not find it. ASM #2 stated that the pain flow sheet was part of the clinical record and should have been in Resident #30's chart. On 5/04/18 at 10:39 a.m., ASM (administrative staff member) #1, the administrator was made aware of the above concerns. No further information was presented prior to exit. (1) Norco- Hydrocodone and acetaminophen combination is used to relieve moderate to moderately severe pain. This information was obtained from the National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010590/?report=details (2) Tylenol- Treats minor aches and pains and also reduces fever. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0008785/?report=details. 6. The facility staff failed to ensure Resident #19's April 2018 restorative log for toileting was on the	F 842		

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 _____	05/04/2018

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 842	Continued From page 99 clinical record. Resident #19 was admitted to the facility on 4/20/16 and readmitted on 8/15/17 with diagnoses that included but were not limited to muscle weakness, type two diabetes mellitus, anxiety disorder, and status post stroke. Resident #19's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 2/20/18. Resident #19 was coded as being moderately impaired of cognitive function scoring 08 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #19 was coded as being frequently incontinent of bowel and bladder and requiring limited assistance from one staff member for toileting. Review of Resident #19's POS (physician order sheet) dated 4/30/18, documented the following order: "Toileting program every 3 hours from 9 AM to 10 PM." This order was initiated on 3/26/18. Review of Resident #19's March 2018 restorative ambulation program, showed evidence that staff were implementing the toileting program. Resident #19's April 2018 restorative ambulation program was missing from Resident #19's clinical record. On 5/4/18 at 9:30 a.m., an interview was conducted with ASM (administrative staff member) #1, the DON (Director of Nursing). ASM #1 stated that the unit manager could not evidence the April 2018 restorative ambulation log. ASM #1 stated that she would expect to find this on the clinical record because this document	F 842		

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 _____	05/04/2018

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 842	Continued From page 100 was a part of the clinical record. On 5/04/18 at 10:39 a.m., ASM (administrative staff member) #1, the administrator was made aware of the above concerns. No further information was presented prior to exit.	F 842		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other	F 880	1. No correction to be made for residents70, 62, or 24. 2. All residents are at risk for this deficient practice. 3.a. Facility will develop a policy for detection and prevention of Legionella Disease. b. Administrator or designee will inservice all departments on checking of equipment for repairs needed and reporting them to the Maintenance Director. c. The Director of Nursing or designee will inservice the licensed nursing staff on hand washing protocols related to obtaining a Blood Sugar. d. Director of Nursing or designee will inservice CNAs on infection control and hand washing when assisting residents with meals. e. Maintenance Director will adjust washers to reach required temp while washing clothes.	

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 _____	05/04/2018

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 880	Continued From page 101 persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and medication administration observation, it was determined the facility staff	F 880	4. a. Administrator will audit equipment 3x weekly x 2 months to ensure equipment needing repair is corrected or removed from the area. b. Unit Manager or designee will audit Blood Sugar monitoring 3x weekly x 2 months to ensure proper hand washing technique is used. c. Unit Manager or designee will audit Restorative Dining room 3x weekly x 2 months to ensure staff is following hand washing protocols. d. Maintenance Director will audit water temps in the laundry M-F x 2 months to ensure required temperature is maintained. e. Unit Managers and Maintenance Director will report the results of the audits to the QAPI committee monthly for 2 months. f. Audit results / trends will be reviewed at QAPI meeting to ensure that Action Plans are effective. Additional action plans will be done as needed. Preparation and submission of this POC is required by state and federal law. This POC does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding.	6/4/18

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 _____	05/04/2018

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 880	Continued From page 102 failed to have a complete infection control program and failed to maintain infection control practices for one of one shower stretchers and two of two washing machines. 1. The facility staff failed to have a policy and procedure for the detection and prevention of Legionella Disease. 2. The facility staff failed to maintain a shower stretcher in a manner to prevent infections. 4. The facility staff failed to wash their hands after giving medications to Resident #70 and taking a blood sugar sample from Resident #62. 3. The facility staff failed to maintain the residents' clothes washer's water temperature at 160 degrees as recommended by the manufacturer. 5. The facility staff failed to maintain infection control practices while assisting Resident #24 with her meals in the restorative dining room. The findings include: 1. The facility staff failed to have a policy and procedure for the detection and prevention of Legionella Disease. Upon entrance to the facility on 5/1/18 at approximately 8:00 a.m. A request was made for the documentation of the facility's water management policy and procedures to reduce the risk of growth and spread of Legionella and other opportunistic pathogens in the building water systems.	F 880		

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 _____	05/04/2018

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 880	Continued From page 103 On 5/2/18 at 1:00 p.m., administrative staff member (ASM) #1, the administrator, presented a document titled, "Legionella Environmental Assessment Form." Review of the document failed to reveal a completed assessment. Questions that should have been answered were left blank. The form documented, "4. Total number of rooms that can be occupied overnight (e.g., patient rooms, hotel rooms)" was left blank. The form further documented, "7. Average length of stay for occupants (check one)" was also left blank. "10. Are there any whirlpool spas, hot tubs or hydrotherapy spas on the facility premises?" was left blank. The facility has two whirlpool tubs in two spa rooms. There was no documentation of a date when the form was completed. An interview was conducted with ASM (administrative staff member) #1, the administrator, on 5/2/18 at 1:33 p.m. The form above was reviewed with ASM #1. When asked why the form was incomplete with many questions not answered, ASM #1 stated the former director of maintenance completed the form. When asked for the facility water treatment program, ASM #1 stated, "We don't have a water management program." When asked if the water had been tested, ASM #1 stated the water was tested to her recollection. ASM #1 was asked to provide documentation of the water testing completed. When asked if the new maintenance director is involved in the water management program, ASM #1 stated, "Not at this time." On 5/2/18 at 1:54 p.m., ASM #1 presented a completed copy of the water testing and stated, "We don't have a program yet."	F 880		

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 _____	05/04/2018

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 880	Continued From page 104 ASM #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services were made aware of the above concern on 5/3/18 at 6:50 p.m. No further information was provided prior to exit. 2. The facility staff failed to maintain a shower stretcher in a manner to prevent infections. Observation was made on 5/4/18 at 10:10 a.m. of a resident in the shower room on the 100/200 unit. The resident was on the shower stretcher being assisted by a staff member. On 5/4/18 at 10:20 a.m. the shower room on the 100/200 unit was observed with other staff member (OSM) #4. The shower stretcher was observed with 13 drain holes in the cushion on top of the mess stretcher. Of the 13 holes, only three of the holes did not have any tears in the plastic coating. The other 10 drain holes had cracks and tears in the plastic ranging from approximately 1/2 inch to approximately eight inches. The white material inside of the stretcher pad was visible in four of the tears. When asked if that is safe and sanitary, OSM #4 stated, "I wouldn't want to take a shower on it." An interview was conducted with RN (registered nurse) #4 on 5/4/18 at 10:32 a.m. RN #4 was shown the shower stretcher in the shower room on the 100/200 hall. When asked why it was a concern that the stretcher cushion had rips and tears in it, RN #4 stated, "Germs in there." An interview was conducted with ASM	F 880		

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 _____	05/04/2018

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 880	Continued From page 105	F 880		

(administrative staff member) #1, the administrator, on 5/4/18 at 10:40 a.m. When asked who maintains the shower stretchers, ASM #1 stated, "Maintenance repairs anything that is needed and the nurses and CNAs (certified nursing assistants) observe them when they use them." When asked if it was acceptable to have rips and tears in the cushion of the shower stretcher, ASM #1 stated, "No." When asked why it would be a concern, ASM #1 stated, "It's an infection control concern and it's a safety hazard. A request was made for the facility policy on maintaining the shower stretchers.

On 5/4/18 at 11:11 a.m. ASM #4, the regional director of clinical services informed this surveyor the facility staff did not have a policy on maintaining the shower stretchers. "ASM #4 informed this surveyor that the cushion has been removed.

No further information was provided prior to exit.

3. The facility staff failed to follow infection control practices to wash their hands after giving medications to Resident #70 and before taking a blood sugar reading from Resident #62.

Resident #70 was admitted to the facility on 12/2/17 with diagnoses that included but were not limited to: irregular heartbeat, dementia, high blood pressure and difficulty swallowing.

The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 4/13/18 coded the resident as having scored a seven out of 15 on the BIMS (brief interview for mental status) indicating the

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 _____	05/04/2018

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 880	Continued From page 106	F 880		

resident was severely impaired cognitively. The resident was coded as requiring assistance from staff for all activities of daily living except for eating which the resident could perform after the tray was set up. The resident was coded as having a feeding tube.

Resident #62 was admitted to the facility on 9/13/17 with diagnoses that included but were not limited to: repeated falls, diabetes, high blood pressure and dementia.

The most recent MDS (minimum data set), a significant change assessment, with an ARD (assessment reference date) of 4/9/18 coded the resident as having scored a four out of 15 on the BIMS (brief interview for mental status) indicating the resident was severely impaired cognitively. The resident was coded as requiring assistance from staff for all activities of daily living with the exception of eating which the resident could perform after the tray was set up.

An observation was made on 5/3/18 at 5:23 p.m. of LPN (licensed practical nurse) #1 giving medications to Resident #70. The nurse took the medications in applesauce into the resident's room and administered the medications by mouth to the resident. LPN #1 gave the resident a cup of water after giving the medications. LPN #1 then threw away the cup and left the room. LPN #1 did not sanitize her hands after administering the medications. LPN #1 then pushed the medication cart across the hall to Resident #62's room. LPN #1 put on a pair of gloves, got the blood glucose monitor out of the medication cart and wiped it off. LPN #1 then went into the resident's room to take the residents blood sugar. The lancet did not pierce the resident's skin so

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 _____	05/04/2018

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 880	Continued From page 107 LPN #1 returned to the medication cart, put her gloved hands into her pockets to get the cart keys out and obtained another lancet from the cart. LPN #1 then obtained another lancet and returned to the resident's room. LPN #1 then obtained the resident's blood sugar. LPN #1 returned to the cart, removed her gloves, wiped off the monitor and put it back into the cart. An interview was conducted on 5/3/18, at 5:30 p.m. with LPN #1, regarding when staff washed their hands. LPN #1 stated, "Between patients and I didn't do it between (names of Resident #70 and #62)." When asked what staff did if they put their gloved hands into their pockets, LPN #1 stated, "I should have re-gloved. It's a safety issue. It's contamination." On 5/3/18 at 6:45 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings. An interview was conducted on 5/4/18 at 8:30 a.m. with ASM #2. When asked when staff wash their hands, ASM #2 stated, "Before, after and in-between activities." When asked what staff should do after they put their gloved hands in their pockets, ASM #2 stated, "They should take their gloves off every time." Review of the facility's policy titled, "Hand Washing" documented, "POLICY: Hand washing is the most important component for preventing the spread of infection. Use of gloves does not replace the need for hand cleaning by either hand rubbing or hand washing. PROCEDURE: 3. Perform hand-hygiene: a. Before and after having direct contact with residents b. After removing	F 880		

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 _____	05/04/2018

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 880	Continued From page 108 gloves c. Before handling an invasive device (regardless of whether or not gloves are used) for resident care." No further information was provided prior to exit. 4. The facility staff failed to maintain the water temperature in the residents' clothes washer at 160 degrees as recommended by the manufacturer. An observation was on 5/4/18 at 9:10 a.m. of the laundry with OHM (other staff member) #6, the director of laundry services. There were two washing machines. There was no temperature control reading on the machines. When asked what the water temperature in the machines was, OSM #6 stated, "Hmmm, we just had that conversation the other day. It was in the 90's." When asked if, and how the staff checked the temperature in the washing machines, OSM #6 stated, "No. (Name of OSM #4, the director of maintenance) comes in and he checks the temperature in the faucet." When asked why the water temperature needed to be at a certain level, OSM #6 stated, "It's not going to get clean if it's not hot. Especially the soiled linens." An interview was conducted on 5/4/18 at 9:55 a.m. with OSM #4, the director of maintenance. When asked how the water temperature in the washing machines was checked, OSM #4 stated, "When I go in there I do the sink." A request for the temperature logs of the sink and a policy on water temperatures was requested at that time. On 5/4/18 at 10:00 ASM (administrative staff member) #3, the director of clinical services	F 880		

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 _____	05/04/2018

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 880	Continued From page 109 stated, "There's no policy on water temperatures." On 5/4/18 at 10:10 a.m., OSM #4 returned with the April and May 2018 water temperature log for the sink in the laundry room. The temperature was documented as ranging from 88 to 100 degrees Fahrenheit. When asked if the washing machine alarmed if the water temperature was below 160 degrees, OSM #4 stated, "No it does not." When asked how they knew if they were washing resident's linens at the correct temperature, OSM #4 stated, "I'll call the manufacturer." On 5/4/18 at 10:41 a.m., OSM #4 returned and stated, "So the manufacturer says whatever that unit is giving out is what you're going to get. The manufacturer says it has to run at 160 degrees." When asked what the temperature was set at, OSM #4 stated, "140 degrees. All the water heaters in the back are set at 140." On 5/4/18 at 11:05 a.m. ASM #1, the administrator was notified of the findings. Review of the manufacturer's information for the washing machines documented, "Hot water 90 (degrees) C (centigrade) [194 degrees Fahrenheit]." Per interview with OSM #4, the manufacturer said on the telephone that the water temperature should be at least 160 degrees Fahrenheit. No further information was provided prior to exit. 5. The facility staff failed to maintain infection control practices while assisting Resident #24 with her meals in the restorative dining room.	F 880		

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 _____	05/04/2018

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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 880	Continued From page 110	F 880		

Resident #24 was admitted to the facility on 6/2/17 with diagnoses that included but were not limited to high cholesterol, high blood pressure, stroke, and muscle weakness. Resident #24's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 2/25/18. Resident #24 was cognitively impaired in the ability to make daily decisions scoring 03 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #24 was coded as being totally dependent on one staff member with meals.

On 5/02/18 at 8:05 a.m., observation of the restorative dining room was conducted. At 8:53 a.m., RN (registered nurse) #2 was observed setting up Resident #24's breakfast and then assisting Resident #24 with feeding. RN #2 was not observed to wash or sanitize her hands prior to feeding. At 8:58 a.m., RN #2 touched Resident #24's hair and stated, "You have pretty curls." RN #2 then proceeded to grab Resident #24's spoon and feed Resident #24 her oatmeal. At 9:00 a.m., RN#2 got up from her chair and walked over to speak to another resident. RN #2 had her bare hand (right) on the other resident's back while she was talking to her. RN #2 then sat back down and proceeded to feed Resident #24 the rest of her breakfast. RN #2 did not wash or sanitize her hands.

On 5/03/18 at 4:17 p.m., an interview was conducted with RN #2. When asked how to maintain infection control while assisting a resident with their meals, RN #2 stated that she would wash her hands prior to feeding and to not touch the residents food. When asked if she was the nurse who fed Resident #24, RN #2 stated

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	495401	A. BUILDING _____ B. WING _____	05/04/2018

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F 880	Continued From page 111 that she was. RN #2 stated that had washed her hands before feeding Resident #24. When RN #2 was informed of the above observations, RN #2 stated, "I guess I should probably wash my hands." When asked why she should wash her hands in between touching another resident and feeding another or after touching a resident's hair, RN #2 stated, "To maintain infect on control." On 5/4/18 at 10:39 a.m., ASM (administrative staff member) #1, the administrator was made aware of the above findings. The facility policy titled, "Hand Washing," documents in part, the following: "Hand washing is the most important component for preventing the spread of infection ...Perform hand hygiene: a. Before and after having direct contact with residents." No further information was presented prior to exit.	F 880		

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 5/2/18 through 5/4/18. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 5/2/18 through 5/4/18. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 90 certified bed facility was 83 at the time of the survey. The survey sample consisted of 33 current Resident reviews (Residents #1, #36, #13, #323, #30, #24, #58, #56, #47, #7, #35, #19, #326, #2, #62, #60, #16, #50, #28, #45, #12, #29, #70, #4, #25, #273, #49, #44, #42, #68, #26, #46, and #21) and 3 closed record reviews (Residents #74, #73, and #75).	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's	F 550	`F 550 1. No corrections to be made for resident #28 or #12. 2. All residents in the restorative dining program are at risk for the deficient practice. 3. a. Social Worker will inservice Nursing Department Staff on Resident Rights and Dignity. b. Facility will reassess set up in restorative dining room and staffing to alleviate wait times.	

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

Pmaybo, DON for Shawanda Jeter administrator 6/4/18

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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	VA0402	A. BUILDING: _____ B. WING _____	05/04/2018

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F 001	Continued From page 1 12VAC5-250.F cross references to F656 12VAC5-250.F cross references to F657 12VAC-200.B cross references to F685 F12VAC5-371-140. E Based on staff interview and facility document review, it was determined facility staff failed to obtain complete background checks on three of 25 employees prior to employment, RN (registered nurse) #6, CNA (certified nursing assistant) #6 and OSM (other staff member) #12. 1. Facility staff failed to obtain the license verification for RN (registered nurse) #6 prior to employment. 2. Facility staff failed to obtain the license verification for CNA (certified nursing assistant) #6. 3. Facility staff failed to obtain the background check for OSM (other staff member) #12, the speech therapist. The findings include: 1. Review of RN #6's employee record failed to evidence verification of the nursing license. On 5/4/18 at 10:05 a.m., a request was made to OSM #8, the business office manager for a copy of the license verification for RN #6. On 5/4/18 at 10:55 a.m., OSM #8 returned and stated, "I didn't find it." OSM #8 was asked about	F 001		

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F 001	Continued From page 2 the process followed for hiring staff, OSM #8 stated, "When I hear from a department head they want to hire someone we do the background check and license verification." When asked why they checked the staff's license, OSM #8 stated, "To ensure they are certified and have a legal right to be giving care to the residents." On 5/4/18 at 11:05 a.m. ASM (administrative staff member) #1, the administrator was made aware of the findings. Review of the facility's policy titled, "Virginia Resident Abuse Policy" documented, "POLICY: This facility will not tolerate abuse, neglect, mistreatment, exploitation of residents, and misappropriation of resident property by anyone. PROCEDURE: 1. Screening - 1) It is the policy of the Facility to undertake background checks of all employees and to retain on file applicable records of current employees regarding such checks. a. The facility will do the following prior to hiring a new employee: ii. Check with all applicable licensing and certification authorities to ensure that employees hold the requisite license and/or certification status to perform their nob functions and have no disciplinary action as a result of abuse or neglect." 2. Review of CNA #6's employee record failed to evidence verification of the CNA certification. On 5/4/18 at 10:05 a.m., a request was made to OSM #8, the business office manager for a copy of the verification of the certification for CNA #6. On 5/4/18 at 10:55 a.m., OSM #8 returned and stated, "I didn't find it." OSM #8 was asked about the process followed for hiring staff, OSM #8	F 001		

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F 001	Continued From page 3 stated, "When I hear from a department head they want to hire someone we do the background check and license verification." When asked why they checked the staff's license, OSM #8 stated, "To ensure they are certified and have a legal right to be giving care to the residents." On 5/4/18 at 11:05 a.m. ASM (administrative staff member) #1, the administrator was made aware of the findings. 3. Review of OSM #12's employee file failed to evidence documentation that a background check was done. On 5/4/18 at 10:05 a.m., a request was made to OSM #8, the business office manager for a copy of the background check for OSM #12. On 5/4/18 at 10:55 a.m., OSM #8 returned and stated, "I didn't find it." OSM #8 was asked about the process followed for hiring staff, OSM #8 stated, "When I hear from a department head they want to hire someone we do the background check and license verification. For (name of OSM #8) she was a transfer from a sister community and we got a lot of the information from them." When asked if they would still require a background check, OSM #8 stated they would. When asked why they get a background check, OSM #8 stated, "To make sure they don't have any criminal history that would prohibit them from working." On 5/4/18 at 11:05 a.m. ASM (administrative staff member) #1, the administrator was made aware of the findings. No further information was obtained prior to exit.	F 001		

State of Virginia

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