PRINTED: 05/10/2018 FORM APPROVED

AND PLAN	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DATE SURVEY COMPLETED
	······	VA0402	B. WING		05/04/2018
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY	/ STATE, ZIP CODE	
TYLER'S	RETREAT AT IRON B	NDGE	ON BRIDGI R, VA 2383		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLI DATE
F 000	Initial Comments		F 000		
	Inspection was cond Corrections are required following Virginia Ru Licensure of Nursing The census in this 90 at the time of the sur consisted of 33 currer (Residents #1, #36, # #56, #47, #7, #35, #1 #50, #28, #45, #12, # #44, #42, #68, #26, # record reviews (Resident	0 certified bed facility was 83 vey. The survey sample		 State Tag Employee RN #6 and C.N.A. #6 are no longer employed by facility. Employee #12 will no longer wor until criminal background is obtained. All residents have the risk to be affected by this deficient practice. 100% audit of current license staff to be done to ensure background and license checks are done. Administrator will in service department managers and human 	k
- - - - - - - - - - - - - - - - - - -	Federal tag - 684 12 VAC 5 - 371 - 300 Federal tag - 761 12 VAC 5 - 371 - 140 1 80 C cross reference	ure requirements: et as evidenced by: B cross references to B cross references to D 13 and 12 VAC 5 - 371 - es to Federal tag F880		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
C	Cross reference to F6 2VAC5-371-150. Res	ident Rights.		RECEIVED	
	cross reference to F62				
	2VAC5-371-360. Clin cross reference to F84			VDH/OLC	6/4/2018
		SUPPLIER REPRESENTATIVE'S SIGNA			1
57na	mande a	etc. LNHA	5-	TITLE 15-18 BJ11 Jeter administration 6/4/2018	(X6) DATE
	doba, Do,	N for (Shama	BC	BJ11 La adjustinistration	ation sheet 1 of

DEPAR CENTE	TMENT OF HEALTH	AND HUMAN SERVICES				FORM	D: 05/10/201 MAPPROVE	Ð
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DA). 0938-039 TE SURVEY MPLETED	11
		495401	B. WING	÷		05	j/04/2018	
	PROVIDER OR SUPPLIER	BRIDGE		1	STREET ADDRESS, CITY, STATE, ZIP CODE 12001 IRON BRIDGE RD CHESTER, VA 23831	1 05	104/2018	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	-
	individuality. The fac promote the rights of §483.10(a)(2) The fac access to quality can severity of condition must establish and in practices regarding provision of services residents regardless §483.10(b) Exercises The resident has the rights as a resident of or resident of the Un §483.10(b)(1) The fac resident can exercise interference, coercio from the facility. §483.10(b)(2) The re- free of interference, or reprisal from the faci- rights and to be supp exercise of his or her subpart. This REQUIREMENT by: Based on observation document review and was determined that dignity for two of 26 r sample, Resident #28 rece	cility must protect and of the resident. Acility must provide equal re regardless of diagnosis, , or payment source. A facility maintain identical policies and transfer, discharge, and the a under the State plan for all of payment source. of Rights. eright to exercise his or her of the facility and as a citizen ited States. Acility must ensure that the e his or her rights without n, discrimination, or reprisal esident has the right to be coercion, discrimination, and lity in exercising his or her ported by the facility in the rights as required under this T is not met as evidenced on, staff interview, facility d clinical record review, it facility staff failed to maintain esidents in the survey	F	550	4.a. Unit Managers or designee audit Restorative Dining Progra x a week for 2 months to ensure residents seated at the same tab served at the same time. b. Unit Managers will report the results of the audits to the QAP committee monthly for 2 month c. Audit results / trends will be reviewed at QAPI meeting to en that Action Plans are effective. Additional action plans will be a as needed. RECEIVED JUN 0 4 2018 VDH/OLC	um 5 e le are e I s. asure	6/4/2018	

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Facility ID: VA0402

If continuation sheet Page 2 of 112

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			P		APPROVED
		& MEDICAID SERVICES			0		0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '				E SURVEY IPLETED
	,	495401	B. WING			05/	04/2018
NAME OF F	PROVIDER OR SUPPLIER		T	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
TYLER'S	RETREAT AT IRON E	BRIDGE			2001 IRON BRIDGE RD CHESTER, VA 23831		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFID TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 550		ceived her breakfast 28 er resident who was sitting at	F 5	50			
	1. Resident #28 rea minutes after anoth the same table. Resident #28 was a 6/14/2013 with diag not limited to heart to type two diabetes, a Resident #28's most set) was a significant	ceived her breakfast 43 er resident who was sitting at admitted to the facility on noses that included but were failure, high blood pressure, and muscle weakness. et recent MDS (minimum data ant change assessment with an					
	Resident #28 was of impaired in the abili scoring a three out (Brief Interview for I Resident #28 was of	reference date) of 2/26/18. soded as severely cognitively ty to make daily decisions of possible 15 on the BIMS Mental Status) exam. soded as requiring limited the staff member with meals.					
	restorative dining ro were two CNAs ass At 8:29 a.m., CNA (was observed servir sitting next Residen over a chair and sta with his breakfast. her tray until he was Resident #28 did no 9:12 a.m. Resident assistance.	m., observation of the own was conducted. There isting with feeding at this time. certified nursing assistant) #4, ng food to a resident who was t #28. CNA #4 then pulled arted assisting this resident Resident #28 did not receive a finished with his breakfast. ot receive her breakfast until #28 also required feeding					
		a.m., an interview was	<u> </u>				
·ORM CMS-25	67(02-99) Previous Versions	Obsolete Event ID: 3FC71	1	Fac	cility ID: VA0402 If continuation	on sheet	Page 3 of 112

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VDH/OLC

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 05/10/2018 APPROVED . 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(x2) Mui A. Buile		IPLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		495401	B. WING	€		05/	04/2018
NAME OF F	PROVIDER OR SUPPLIER			Γ	STREET ADDRESS, CITY, STATE, ZIP CODE		
TYLER'S	RETREAT AT IRON E	BRIDGE			12001 IRON BRIDGE RD CHESTER, VA 23831		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 550	residents in the rest asked how staff car while serving and as the dining room, CN cover ups to protect asked if it was okay right next to another a meal, CNA #2 stat try not to let them w resident has to wait how she would feel her food did not com or longer after every stated, "I would be r would leave." When usually in the restor stated, "On a good of CNA #2 stated that residents at the sam residents required for CNA #4 could not be On 5/4/18 at 10:39 a staff member) #1, th aware of the above The facility policy titt Environment," docu "Tables shall be sem residents seated at same time." No furt presented prior to ex	A #2, a CNA who feeds torative dining room. When a maintain residents' dignity ssisting them with meals in IA #2 stated that she will use the resident's clothes. When to serve and feed a resident r resident who does not have ted, "They shouldn't be. We ait too long. Sometimes the a little longer." When asked if she was at a restaurant and ne out until about 30 minutes yone else's meal, CNA #2 ready to leave, I probably n asked how many aides are ative dining room, CNA #2 day three, on a bad day one." it was difficult to feed ne time because most of the ull assistance with their meals. e reached for an interview. a.m., ASM (administrative ne administrator was made concerns. ed, "Dining room mented in part, the following: yed in a manner so that all a table receive meals at the ther information was	F				
	minutes after anothe	er resident who was sitting at					

Event ID: 3FC711

Facility ID: VA0402 RECEIVED continuation sheet Page 4 of 112

JUN 0 4 2018 VDH/OLC

Description ONE NO. 0338-0391 MARE OF PROVIDERS UPPORED TO THE APPROPRIATE SUMPEY ABULTIPLE CONSTRUCTION POLICIPACIENCE MARE OF PROVIDERS OF SUMPLY 495401 Is wind OS(04/2018) MARE OF PROVIDERS OF SUMPLY STREET ADDRESS. CITY STAT. 2# 000E OS(04/2018) MARE OF PROVIDERS OF SUMPLY STREET ADDRESS. CITY STAT. 2# 000E OS(04/2018) MARE OF PROVIDERS OF SUMPLY SUMMARY STATEMENT OF DEPERSIONES OS(04/2018) MARE OF PROVIDERS OF SUMPLY SUMMARY STATEMENT OF DEPERSIONES OS(04/2018) MARE OF PROVIDERS OF SUMPLY SUMMARY STATEMENT OF DEPERSIONES OS(04/2018) MARE OF PROVIDERS OF SUMMARY STATEMENT OF DEPERSIONES SUMMARY STATEMENT OF DEPERSIONES OS(04/2018) MARE OF PROVIDERS OF SUMMARY STATEMENT OF DEPERSIONES SUMMARY STATEMENT OF DEPERSIONES OS(04/2018) F 550 Confinued From page 4 F 550 F 550 Confinued From page 4 F 550 MDS (minimum data set) assessment was a quarterly within a APR Departer impaired in cognitive and introvide more than the date of the facility on T/266/11 with diagnostical HT2/2 more than the date of the facility on T/266/11 with diagnostical HT2/2 more than the date of the optitive and the optitive diagnostical HT2/2 more than easistanthe state of the optitive andin gradient HT2/2 more t			AND HUMAN SERVICES				FORI	D: 05/10/2018 M APPROVED
MAKE OF PROVIDER OR SUPPLIER STREET ADDRESS. CITY, STATE, ZP CODE TYLERS RETREAT AT IRON BRIDGE 2001/04/2018 (M) ID PRETX TWO SUMMARY STATEMENT OF DEFICIENCIES (EAD) DEFICENCY WIST THE RECED BY FULL (EAD) DEFICIENCY AND THE PROVIDERS PLANO FOR CONSECTION (EAD) DEFICIENCY AND THE PLANO (EAD) DEFICIENCY AND THE RECED TO THE APPROPRIATE DEFICIENCY AND THE PLANO (EAD) DEFICIENCY AND THE PLANO (EAD) DEFICIE	STATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				(X3) DA	TE SURVEY
TYLER'S RETREAT AT IRON BRIDE STREET ADDRESS. CTY, STRE1, 20 CODE Image: Control of the strength SUMMARY STREAM OF OR DEPORTORS Image: Control of Control of Rom BRIDES SUMMARY STREAM OF OR DEPORTORS Image: Control of Rom BRIDES SUMMARY STREAM OF OR DEPORTORS Image: Control of Rom BRIDES SUMMARY STREAM OF OR DEPORTORS Image: Control of Rom BRIDES SUMMARY STREAM OF OR DEPORTORS Image: Control of Rom Bride Resident #12 was admitted to the facility on 7726/17 with diagnoses that included but were not limited to dysphagia (difficulty swallowing), unspecified dementia without behavioral disturbance, high blood pressure, and hypothypoldism. Resident #12 was coded as sequing severely inpaired to Caseessment the as a coded as being severely inpaired to Caseessment with an ARD (assessment treference date) of 2/13/18. Resident #12 was coded as requiring supervision and set up hep only with meals. Stream table. On 5/2/18 at 8:05 a.m., observation of the restorative dining room was conducted. On 5/2/18 at 8:05 a.m., not prevision and set up hep only with meals. Stream table. On 5/2/18 at 8:05 a.m., abservation of the restorative dining room was conducted. On 5/2/18 at 8:05 a.m., not review was conducted with CNA 42, a CNA who feeds resident #12 was not assist her with feeding. Resident with the hor breakfast until after Res			495401	B. WING			0	5/04/2018
PPEERX Two (EACH DEFICIENCY MUST BE PRECEDED BY FULL ReGULTORY OR LSC DEMINIFYING INFORMATION) PAGEX (EACH DEFICIENCY) Converting DEFICIENCY F 550 Continued From page 4 the same table. F 550 F 550 F 550 F 550 F 550 Resident #12 was admitted to the facility on 7/26/17 with clignoses that included but were not limited to dysphagia (difficulty swallowing), unspecified dementia without behavioral disturbance, high blood pressure, and hypothyroidism. 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 conducted. On 5/2/18 at 8:53 a.m., RN (registered nurse) #2 was coded as being severely impaired assisting them eable. RN #2 set up Resident #24. Resident #24 was sitting next to Resident #12 at the same table. RN #2 set up Resident #21 at the same table. RN #2 was finished. Resident #12 was not able to get her breakfast and began to assists her with feeding. Resident #12 was not able to get her breakfast and began to assisting them staff. On 5/2/18 at 10:28 a.m., an interview was conducted with CNA #2, a CNA who feeds creakfast not staff can maintain resident #24 was conducted the contrave dring from. When asked how staff can maintain resident siding to wos finished. Resident #24 stated batts he will use cover ups to protect the resident sichts. When asked finit was okay to serve and feed a resident CMCM252070249) Provide Vestors Observe Text10.212			BRIDGE		12001 IRON BR	IDGE RD		5/04/2018
the same table. Resident #12 was admitted to the facility on 726/17 with diagnoses that included but were not limited to dysphagia (difficulty swallowing), unspecified dementia without behavioral disturbance, high blood pressure, and hypothyroidism. Resident #12 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 #12 the same table. RN #2 was finished. Resident #12 received her breakfast mid lafter Resident #24 was not able to get her breakfast and began to assist her with feeding. Resident #12 was not able to get her breakfast and lafter Resident #24 was finished. Resident #12 received her breakfast mid lafter Resident #24 was not able to get her breakfast mid lafter Resident #24 was finished. Resident #12 received her breakfast mid lafter Resident #24 was not able to get her breakfast mid lafter Resident #24 was finished. Resident #12 received her breakfast mod started eating at 9:20 a.m. Resident #12 did require some assistance with her breakfast mod started eating at 9:20 a.m. Resident #12 cid require some assistance with her breakfast mod started eating at 9:20 a.m. Resident #12 cid require some assistance with her breakfast mod started eating at 9:20 a.m. Resident #12 cid require some assistance with her breakfast mod started eating at 9:20 a.m. Resident #12 cid requires the weak conducted with Not #24 started hat she will use cover ups to protect the residents' cidne	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH	CORRECTIVE ACTION EFERENCED TO THE	SHOULD BE	COMPLETION
ORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 3FC711 Facility ID: VA0402 JUN 1/4 2018 VDH/OLC		the same table. Resident #12 was a 7/26/17 with diagno- limited to dysphagia unspecified dement disturbance, high bl- hypothyroidism. Re MDS (minimum data quarterly assessme reference date) of 2 coded as being seve function scoring four BIMS (Brief Interview Resident #12 was co and set up help only On 5/2/18 at 8:05 a. restorative dining ro at 8:53 a.m., RN (re directed by CNA (ce to feed Resident #22 next to Resident #12 set up Resident #12 set up Resident #24 assist her with feedin able to get her bread- was finished. Resid breakfast and starte Resident #12 did rec her breakfast from s On 5/4/18 at 10:26 a conducted with CNA residents in the resto asked how staff can while serving and as the dining room, CNA cover ups to protect asked if it was okay	admitted to the facility on ses that included but were not a (difficulty swallowing), ia without behavioral ood pressure, and sident #12's most recent a set) assessment was a nt with an ARD (assessment /13/18. Resident #12 was erely impaired in cognitive r out of possible 15 on the w for Mental Status) exam. oded as requiring supervision r with meals. m., observation of the om was conducted. On 5/2/18 gistered nurse) #2 was rtified nursing assistant) #4, 4. Resident #24 was sitting 2 at the same table. RN #2 's breakfast and began to ng. Resident #12 was not cfast until after Resident #24 ent #12 received her d eating at 9:20 a.m. quire some assistance with taff. a.m., an interview was a.#2, a CNA who feeds prative dining room. When maintain residents' dignity sisting them with meals in A #2 stated that she will use the resident's clothes. When to serve and feed a resident		50			
JUN 0 4 2018 VDH/OLC			-	F	Facility ID: VA0402	RECEIV	Intinuation sheet	Page 5 of 112
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						VDH/O	LC	

		ID HUMAN SERVICES MEDICAID SERVICES			FORM	D: 05/11/2018
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	9. 0938-0391 SURVEY LETED
		495401	B. WING		05/	04/2018
	ROVIDER OR SUPPLIER RETREAT AT IRON BRID	GE		STREET ADDRESS, CITY, STATE, ZIP CODE 12001 IRON BRIDGE RD CHESTER, VA 23831		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 550 F 622 SS=E	right next to another r a meal, CNA #2 state try not to let them wai resident has to wait a how she would feel if her food did not come or longer after everyo stated, "I would be rea would leave." When a usually in the restorat stated, "On a good da CNA #2 stated that if residents at the same residents required full CNA #4 could not be On 5/4/18 at 10:39 a.t staff member) #1, the aware of the above co Transfer and Discharg CFR(s): 483.15(c)(1)(§483.15(c) Transfer a §483.15(c)(1) Facility (i) The facility must per remain in the facility, a discharge the resident (A) The transfer or dis resident's welfare and cannot be met in the f (B) The transfer or dis because the resident's sufficiently so the resi services provided by t (C) The safety of indiv	esident who does not have d, "They shouldn't be. We t too long. Sometimes the little longer." When asked she was at a restaurant and e out until about 30 minutes ne else's meal, CNA #2 ady to leave, I probably asked how many aides are ive dining room, CNA #2 ny three, on a bad day one." was difficult to feed time because most of the assistance with their meals. reached for an interview. m., ASM (administrative administrator was made oncerns. ge Requirements i)(ii)(2)(i)-(iii) nd discharge- requirements- ermit each resident to and not transfer or t from the facility unless- charge is necessary for the the resident's needs facility; ccharge is appropriate s health has improved dent no longer needs the the facility; riduals in the facility is e clinical or behavioral	F 550	1. No corrections to be made for res #323 7 44 21 and 47	spital are vill quired sfer ts care audit all for 2 plan is sults of nonthly ewed at n Plans	6/4/18

Event ID: 3FC711

Facility ID: VA0402

If continuation sheet Page 6 of 112

		AND HUMAN SERVICES			FORN	APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		495401	B. WING _		05	/04/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z		
TYLER'S	RETREAT AT IRON E	RIDGE		12001 IRON BRIDGE RD		
TTEENO				CHESTER, VA 23831		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 622	otherwise be endam (E) The resident has appropriate notice, under Medicare or I Nonpayment applie submit the necessa payment or after the Medicare or Medicar resident refuses to resident who becom admission to a facili resident only allowa or (F) The facility ceas (ii) The facility ceas (iii) The facility may resident while the a § 431.230 of this ch exercises his or her discharge notice fro 431.220(a)(3) of this discharge or transfe or safety of the resid facility. The facility tra- resident under any of in paragraphs (c)(1) section, the facility ra- resident under any of in stitution or provide (i) Documentation ir must include:	dividuals in the facility would orgered; s failed, after reasonable and to pay for (or to have paid Medicaid) a stay at the facility. s if the resident does not ry paperwork for third party e third party, including hid, denies the claim and the pay for his or her stay. For a nes eligible for Medicaid after ity, the facility may charge a ble charges under Medicaid; es to operate. not transfer or discharge the ppeal is pending, pursuant to apter, when a resident right to appeal a transfer or on the facility pursuant to § s chapter, unless the failure to er would endanger the health dent or other individuals in the must document the danger er or discharges a of the circumstances specified h(i)(A) through (F) of this must ensure that the transfer umented in the resident's appropriate information is the receiving health care	F 63	22		
FORM CMS-25			1	Facility ID: VA0402	If continuation shee	Page 7 of 112

		AND HUMAN SERVICES				FORM): 05/10/2018 1 APPROVED
STATEMEN	TOF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DAT	0. 0938-0391 TE SURVEY MPLETED
		495401	A. BUILI		G		
NAME OF	PROVIDER OR SUPPLIER		D. 11110		STREET ADDRESS, CITY, STATE, ZIP CODE	05	/04/2018
TYLER'S	RETREAT AT IRON E	BRIDGE			12001 IRON BRIDGE RD CHESTER, VA 23831		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IL	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
	 (i) of this section. (B) In the case of pasection, the specific be met, facility attern needs, and the serve facility to meet the resident's part of this section (A) The resident's part of this section (A) The resident's part of this section. (ii) The documentation (A) The resident's part of this section. (iii) Information provements include a minin (A) Contact information provemust include a minin (A) Contact information (C) Advance Direction (D) All special instruongoing care, as ap (E) Comprehensive (F) All other necessary of the resident's consistent with §483 any other document a safe and effective This REQUIREMEN by: Based on staff interreview, and clinical required component 	aragraph (c)(1)(i)(A) of this resident need(s) that cannot inpts to meet the resident ice available at the receiving need(s). ion required by paragraph (c) must be made by- hysician when transfer or ary under paragraph (c) (1) etion; and n transfer or discharge is ragraph (c)(1)(i)(C) or (D) of ided to the receiving provider mum of the following: tion of the practitioner eare of the resident. entative information including ve information ctions or precautions for propriate. care plan goals; ary information, including a s discharge summary, 3.21(c)(2) as applicable, and ation, as applicable, to ensure transition of care. T is not met as evidenced view, facility document ecord review, it was lity staff failed to meet all the s for a hospital transfer for n the survey sample,	F	622			

Facility ID: VA0402

If continuation sheet Page 8 of 112

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	05/10/2018 APPROVED
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DAT	0938-0391 E SURVEY PLETED
		495401	B. WING			05/	04/2018
	ROVIDER OR SUPPLIER	BRIDGE		-	STREET ADDRESS, CITY, STATE, ZIP CODE 12001 IRON BRIDGE RD CHESTER, VA 23831		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 622	 #323's care plan go receiving provider for hospital on 4/14/18. 2. The facility staff care plan goals wer provider for a facility on 3/1/18. 3. The facility staff 44's care plan goals receiving provider for hospital on 2/14/18 4. The facility staff #21's care plan goal receiving provider for hospital on 4/23/18. 5. The facility staff #47's care plan goal receiving provider for hospital on 1/02/18. The findings includes 1. The facility staff #323's care plan go receiving provider for hospital on 1/02/18. The findings includes 1. The facility staff #323's care plan go receiving provider for hospital on 4/14/18. Resident #323 was 8/24/17 and readmin diagnoses that inclu- muscle weakness, or stenosis, left femur 	failed to ensure Resident # als were provided to the br a facility-initiated transfer to failed to ensure Resident #7's re provided to the receiving y-initiated transfer to hospital failed to ensure Resident # a were provided to the br facility-initiated transfers to and 3/25/18. failed to ensure Resident is were provided to the br a facility-initiated transfer to failed to ensure Resident is were provided to the br a facility-initiated transfer to failed to ensure Resident is were provided to the br a facility-initiated transfer to a facility-initiated transfer to a facility-initiated transfer to a facility-initiated transfer to admitted to the facility on tted on 4/14/18 with ided but were not limited to enlarged prostate, and aortic and left distal radius fracture.	F	522			
	muscle weakness, o stenosis, left femur	enlarged prostate, and aortic					

Facility ID: VA0402

If continuation sheet Page 9 of 112

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 05/10/2018 APPROVED : 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	(X3) DAT	E SURVEY IPLETED
		495401	B. WING	;		05/	04/2018
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
TYLER'S	RETREAT AT IRON E	BRIDGE		1	12001 IRON BRIDGE RD CHESTER, VA 23831		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 622	data set) assessme assessment with an date) of 4/30/18. Re being cognitively int decisions scoring 14 BIMS (Brief Intervie Review of Resident revealed that he had hospital on 4/14/18. documented at 3:00 blood) observed to r cast (L) (left) arm. N distress, no c/o (cor primary care clinicia doctor) on 4/14/18 a Other Send (sic) to eval (Evaluation)." The next note docur p.m., revealed that f the facility the same documented, "Resic Hospital) for eval. (E with blood to cast or Resident denies pai noted. Left via ambu 3:50pm (p.m.). Retu orders). Abrasion no and drsg (dressing) (emergency room) r (responsible party) a There was no evide clinical record that a Resident #323's adv party contact inform	And was a 14 day scheduled ARD (assessment reference esident #323 was coded as act in the ability to make daily 4 out of possible 15 on the w for Mental Status) exam. #323's nursing notes d been transferred to the The following note was p.m., "Bleeding (new rolled gauze portion of soft to ssx (sign/symptoms) of mplaints) of pain. Reported to in: (Name of MD) (medical at 3:20 PM. Order obtained: ER (emergency room) for mented on 4/14/18 at 10:41 Resident #323 arrived back to day. The following was dent sent to (Name of Evaluation). Resident noted n LUE (left upper extremity). n or discomfort. No distress ulance via stretcher @ (at) irn with N.N.O's (no new oted under cast. Area clean put into place by ER hurse. No distress noted. RP aware." nce documented in the II the required information; vanced directives, responsible ation, and Resident #323's ded to the hospital for the	F	622	2		

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Facility ID: VA0402

If continuation sheet Page 10 of 112

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 05/10/2018 APPROVED
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DAT	. 0938-0391 E SURVEY IPLETED
		495401	B. WING	i		05/	/04/2018
NAME OF	PROVIDER OR SUPPLIER	·			STREET ADDRESS, CITY, STATE, ZIP CODE		0.02010
TYLER'S	RETREAT AT IRON E	BRIDGE			12001 IRON BRIDGE RD CHESTER, VA 23831		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 622	Continued From pa	ge 10	Fe	622	2		
	conducted with LPN Resident #323's nut staff follows when re- hospital. LPN #4 st what was going on the resident out after order. When asked documented in the of that she would docu- note. LPN #4 states symptoms the resident the responsible part aware of the situation also document that to send the resident EMS arrived to pick if she documented with sent with the resident LPN #4 stated that in document this inform documents are sent transfer, LPN #4 states SBAR (situation, ba recommendation) me listing, advanced dir tests that are pertine plan is sent with resist stated that they do re #4 stated that she we Resident #323 to the stated that the physion to stated that nurses we soft casts at the fact	P.m., an interview was I (licensed practical nurse) #4, rse, regarding the process esidents are sent out to the ated call the doctor, explain with the patient and then send or she received a doctor's I if a transfer would be clinical record, LPN #4 stated ument the transfer in a nursing d she would document the ent was exhibiting and that y and the medical doctor was on. LPN #4 stated she would the physician gave an order to the hospital and the time up the resident. When asked what documents/papers were nt at the time of the transfer, nursing does not typically mation. When asked what with residents during a ated that nurses will send the ckground, assessment, ote, face sheet, medication ectives, and any laboratory ent. When asked if the care idents to the hospital, LPN #4 not send the care plan. LPN was the nurse who sent e hospital on 4/14/18. LPN #4 ician wanted the resident sent area that he was bleeding e soft cast. When asked if remove soft casts, LPN #4 vere not allowed to remove lity. LPN #4 stated, "We are that unless the doctor gives					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 05/10/2018 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		PLE CONSTRUCTION G	(X3) DAT	E SURVEY IPLETED
		495401	B. WING	;		05/	04/2018
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
TYLER'S	RETREAT AT IRON E	BRIDGE			12001 IRON BRIDGE RD CHESTER, VA 23831		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRON DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 622	 instructions." On 5/4/18 at 10:39 a staff member) #1, th aware of the above The facility policy tit Letter Policy," did na concerns. No furthe prior to exit. 2. The facility staff a care plan goals wer provider for a facility on 3/1/18. Resident #7 was ad 10/6/16 with the diaghigh blood pressure depression, history o osteoarthritis, and a concerns. 	a.m., ASM (administrative he administrator, was made concerns. led, "Discharge/Transfer ot address the above er information was presented failed to ensure Resident #7's e provided to the receiving y-initiated transfer to hospital lmitted to the facility on gnoses of but not limited to e, anxiety disorder,	F	622			
	coded as cognitively daily life decisions. A review of the clinic	ARD (Assessment 2/9/18. The resident was y impaired in ability to make cal record revealed that nt to the hospital on 3/1/18.					
	Further review failed evidence the require documentation inclu	d to reveal any documented					
	#1 (Registered Nurs	a.m., in an interview with RN se, the unit manager), she ace sheet, insurance					

Facility ID: VA0402

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		AND HUMAN SERVICES				FORM	APPROVED	
		& MEDICAID SERVICES	r			OMB NO. 0938-0391		
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495401	B. WING			05/	04/2018	
NAME OF F	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE			
TYLER'S	RETREAT AT IRON E	BRIDGE			12001 IRON BRIDGE RD CHESTER, VA 23831			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 622	 (laboratory tests), x care plan goals are "The care plan is no A review of the facil Letter Policy" did no required documents upon a resident tran On 5/4/18 at 10:12 at (administrative staff aware of the finding provided. 3. The facility staff 44's care plan goals receiving provider for hospital on 2/14/18 Resident #44 was at 1/25/17 with the dia atrial fibrillation, dep dysphagia. The mo Data Set) was an at ARD (Assessment I) The resident was co make daily life deciss A review of the clinic #44 was sent to the 3/25/18. Further rev documented eviden documentation inclu 	r sheet, medication list, labs -rays." When asked if the also provided, RN #1 stated, ot sent." ity policy, "Discharge/Transfer ot document directions for the s to be sent to the hospital asfer to the hospital. a.m., the Administrator member) ASM #1, was made s. No further information was failed to ensure Resident # a were provided to the or facility-initiated transfers to and 3/25/18. dmitted to the facility on gnoses of but not limited to oression, anxiety disorder, and est recent MDS (Minimum nnual assessment with an Reference Date) of 3/14/18. ognitively intact in ability to	F€	522				
	On 5/04/18 at 8:57	AM, in an interview with RN						

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DEPART	MENT OF HEALTH	AND HUMAN SERVICES			Ч		APPROVED
CENTER	S FOR MEDICARE	& MEDICAID SERVICES	r		0		0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		495401	B. WING	i		05/	04/2018
NAME OF F	ROVIDER OR SUPPLIER		·	s	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	04/2010
TYLER'S	RETREAT AT IRON E	BRIDGE			2001 IRON BRIDGE RD CHESTER, VA 23831		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 622	stated, "we send a information, transfer x-rays." When aske also provided, she s sent." A review of the facili Letter Policy" did no required documents upon a resident tran On 5/4/18 at 10:12 at (administrative staff aware of the finding provided. 4. The facility staff #21's care plan goa receiving provider for hospital on 4/23/18. Resident #21 was a 08/07/17 with recen with diagnoses that to: dementia, pneum pressure and atrial theartbeat) (1). The most recent MI assessment, a quar with an assessment coded the resident at (brief interview for m she has no cognitive making.	se, the unit manager) she face sheet, insurance r sheet, medication list, labs, ed if the care plan goals are stated, "The care plan is not ity policy, "Discharge/Transfer of document directions for the s to be sent to the hospital hafer to the hospital. a.m., the Administrator member) ASM #1, was made s. No further information was failed to ensure Resident Is were provided to the for a facility-initiated transfer to included but were not limited nonia, diabetes, high blood fibrillation (an irregular DS (minimum data set) terly Medicare assessment, t reference date of 02/19/18, as scoring a "13" on the BIMS nental status) score, indicating e impairment of daily decision	F6	522			
	The "Nurse Practitic	oner Progress Note" dated					

		AND HUMAN SERVICES			FORM	D: 05/10/2018 MAPPROVEL D. 0938-039		
	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DA	(X3) DATE SURVEY COMPLETED		
		495401	B. WING		05	5/04/2018		
NAME OF	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP C		04/2010		
TYLER'S	S RETREAT AT IRON E	BRIDGE		12001 IRON BRIDGE RD CHESTER, VA 23831				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	· · · · · · · · · · · · · · · · · · ·	SHOULD BE	(X5) COMPLETION DATE		
F 622	04/23/18 at 11:28 a (heart rate) irregula Hypotensive (low bl Lethargic-send to E (immediately) via 9 Treatment plan di assigned nurse-dau Representative] ma by charge nurse". On 05/03/18 at 2:34 conducted with LPN regarding the proce residents are sent of stated call the doctor with the resident, ar resident to the hosp doctor's order. Who be documented in the stated that she wou nursing note. LPN document the symp exhibiting and that the medical doctor were #4 stated that she wou physician gave an o the hospital and the medical services) al When asked if she documents/papers the time of the trans nursing does not typ information. When sent with residents of stated that nurses w background, assess face sheet, medicat directives, and any f	.m., documented in part, "HR r between 33-130's. ood pressure) of 86/48. R (emergency room) stat for possible atrial fibrillation scussed with patient and ughter [Responsible ide aware of hospital transport for possible atrial fibrillation scussed with patient and ughter [Responsible ide aware of hospital transport for possible aware of hospital transport for possible ide aware of hospital transport for possible for possible and transfer the out to the hospital. LPN #4 for, update what is going on and then would transfer the out to the hospital. LPN #4 for update what is going on and then would transfer the out to the neceived a en asked if a transfer would he clinical record, LPN #4 Id document the transfer in a #4 stated that she would toms the resident was he responsible party and the e aware of the situation. LPN yould also document that the order to send the resident to time EMS (emergency prived to pick up the resident.	F 6					

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If continuation sheet Page 15 of 112

CENTERS FOR MEDICARE & MEDICALD SERVICES OMB NO. 0938-0391 XINTERS FOR MEDICARE & MEDICALD SERVICES (X) MUTTRE CONSTRUCTION AND PLAN OF CORRECTION (X) PROVEMENSUPPLERCUL MAKE OF PROVIDER OR SUPPLIER (X) DRUCE SERVICES TYLERS RETREAT AT IRON BRIDGE ISTREET ADDRESS. CITY.STRE. 200 CORE (X4) ID SUMARY STATEMENT OF DEFICIENCIES (PACH DEFICIENCY MAST BE PRECEDED BY PLUE ISTREET ADDRESS. CITY.STRE. 200 CORE YEAH DEFICIENCY MAST BE PRECEDED BY PLUE D PREFIX REGULATORY OR LSC DEMTRYING INFORMATION F 622 Continued From page 15 with residents to the hospital, LPN #4 stated that they do not send care plan goals were sent with a resident upon transfer to the hospital. RM #1 was asked if Care plan goals and be avare of the baove findings on 05/04/18 at 9:57 a.m No further information was obtained prior to exit. (1) This information was obtained prior to exit. (1) This information was obtained from the following website: https://medlineplus.gov/atriafibrillation.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 10/20/18. Resident #47 was admitted to the facility on 07/09/20/14 with recent readmission on 01/04/18, with diagnoses that included bu twere not limited to: demenye			AND HUMAN SERVICES			P		: 05/10/2018 APPROVED	
AND PLAN OF CORRECTION INFIDENTIFICATION NUMBER: A BUILING INFIDENTIFICATION NUMBER: A BUILING INFIDENTIFICATION NUMBER: 05/04/2018 NAME OF PROVIDER OR SUPPLIER 495401 B. WING 05/04/2018 05/04/2018 INAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 12001 IRON BRIDGE RD 05/04/2018 IVAID SUMMARY STATEMENT OF OFFICENCIES INFIDE RD CHESTER, VA 23331 05/04/2018 IVAID SUMMARY STATEMENT OF OFFICENCIES INFIDE RD CHESTER, VA 23331 05/04/2018 05/04/2018 IVAID SUMMARY STATEMENT OF OFFICENCIES INFIDE RD INFIDE RD CHESTER, VA 23331 05/04/2018 05/04/2018 IVAID SUMMARY STATEMENT OF OFFICENCIES INFIDE RD INFIDE RD 05/04/2018 05/04/2018 IVAID SUMMARY STATEMENT OF DEFICENCIES INFIDE RD INFIDE RD 05/04/2018 05/04/2018 IVAID SUMMARY STATEMENT OF DEFICENCIES INFIDE RD INFIDE RD 05/04/2018 05/04/2018 IVAID SUMMARY STATEMENT OF DEFICIENCY INFIDE RD INFIDE RD 05/04/2018 05/04/2018 IVAID SUMARY STATEMENT OF DEFICIENCY I				r		0			
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE TYLER'S RETREAT AT IRON BRIDGE STREET ADDRESS, CITY, STATE, ZIP CODE (X4) ID PREEM SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ASTREMENT OF DEFICIENCIES) (EACH CORRECTIVE ASTREMENT OF DEFICIENCIES) (EACH CORRECTIVE ASTREMENT OF DEFICIENCIES) (EACH CORRECTIVE ASTRONOPRATE DEFICIENCY) ID PREFIX TAG D PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ASTRONOPRATE DEFICIENCY) COMMENTION (EACH CORRECTIVE ASTRONOPRATE DEFICIENCY) F 622 Continued From page 15 with residents to the hospital, LPN #4 stated that they do not send the care plan. F 622 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. F 622 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 #4/7'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									
MAKE OF PROVIDER OR SUPPLER STREET ADDRESS, CUTY, STATE, ZIP CODE TYLERS RETREAT AT IRON BRIDGE 12001 IRON BRIDGE RD (X4) ID PREFEX TAG EMMARY STATEMENT OF DEFICIENCIES (EACH OPERICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PD PREFEX REGULATORY OR LSC IDENTIFYING INFORMATION) PD PREFEX TAG PROVIDER OF OWNERCTION SHOLLD BY CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMBRIDGE RD CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 622 Continued From page 15 with residents to the hospital, LPN #4 stated that they do not send the care plan. F 622 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. F 622 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. I) 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 10/2/18. 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, and stage kidney disease requiring			495401	B. WING	i		05/	04/2018	
ITTLER'S KETREAT AT IKON SRUGGE CHESTER, VA 23831 (X4) ID PREFIX TAG ISUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ATTON SPECTORED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D D PREFIX TAG D PROVINCE ATTON FOR CORRECTION (EACH CORRECTIVE ATTON OF CORRECTION CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) 0(9) CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY 0(9	NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULTORY OR LSC DENTIFYING INFORMATION) PREFX TAG CEACH DEFICIENCY INST BE PRECEDED BY FULL REGULTORY OR LSC DENTIFYING INFORMATION) CACH DEFICIENCY Count of the construction of the cons	TYLER'S	RETREAT AT IRON E	RIDGE						
 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 	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLETION	
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		with residents to the they do not send the During an interview #1, on 05/04/18 at 8 care plan goals were transfer to the hospi send care plans or o of information sent w to the hospital. ASM #1 (Administra administrator, was n findings on 05/04/18 No further information following website: https://medlineplus.g 5. The facility staff f #47's care plan goal receiving provider for hospital on 1/02/18. Resident #47 was are 07/09/2014 with rece with diagnoses that is to: dementia, end sta hemodialysis (dialys waste from the blood do their job (1)), high vascular disease (na blood vessels that sta	e hospital, LPN #4 stated that e care plan. with RN (registered nurse) :57 a.m., RN #1 was asked if e sent with a resident upon tal. RN #1 stated they do not care plan goals in the packet with a resident upon transfer tive Staff Member), the nade aware of the above at 9:57 a.m. on was obtained prior to exit. was obtained from the gov/atrialfibrillation.html ailed to ensure Resident s were provided to the or a facility-initiated transfer to dmitted to the facility on ent readmission on 01/04/18, included but were not limited age kidney disease requiring is uses a machine to remove d when kidneys can no longer n blood pressure, peripheral arrowing and hardening of the	Fθ	522				

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			P		: 05/10/2018
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			0		APPROVED. 0938-0391
1	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495401	B. WING				
NAME OF F	PROVIDER OR SUPPLIER		·	s	TREET ADDRESS, CITY, STATE, ZIP CODE	05/	04/2018
TYLER'S	RETREAT AT IRON E	RIDGE		1	2001 IRON BRIDGE RD		
				C	CHESTER, VA 23831		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 622	assessment, an anr with an assessment coded the resident a (brief interview for m she has severe cog decision making. The nursing note, d documented in part, elevated Temp (tem order of Tylenol (fev given per MD (medi after an hour Temp sent to ER (emerge (evaluation)". An MD order dated "Transfer to ER for of On 05/03/18 at 2:34 conducted with LPN regarding the proces residents are sent o stated call the doctor with the resident, an resident to the hosp doctor's order. Whe be documented in th stated that she woul nursing note. LPN # document the symp exhibiting and that th medical doctor were #4 stated that she w physician gave an o	nual Medicare assessment, t reference date of 03/19/18, as scoring a "6" on the BIMS nental status) score, indicating nitive impairment of daily ated 01/02/18 at 2:50 a.m., , "Resident noted with perature) of 101.4, standing rer reducing medication (3)) cal doctor). Temp rechecked elevated to 102.4Resident ncy room) for further Eval 01/02/18, documented evaluation". • p.m., an interview was I (licensed practical nurse) #4, ss staff follows when ut to the hospital. LPN #4 or, update what is going on ad then would transfer the ital after she received a en asked if a transfer would he clinical record, LPN #4 Id document the transfer in a #4 stated that she would toms the resident was he responsible party and the e aware of the situation. LPN yould also document that the rder to send the resident to	F 6	22			
	medical services) ar When asked if she o	time EMS (emergency rived to pick up the resident. documented what were sent with the resident at			· ·		

Event ID: 3FC711

Facility ID: VA0402

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		AND HUMAN SERVICES			P		D: 05/10/2018
		& MEDICAID SERVICES			0	MB NC	APPROVED 0. 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			IPLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		495401	B. WING	≩		05	/04/2018
NAME OF	PROVIDER OR SUPPLIER			Γ	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00	104/2010
TYLER'S	S RETREAT AT IRON E	BRIDGE			12001 IRON BRIDGE RD CHESTER, VA 23831		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 622	the time of the trans nursing does not typ information. When sent with residents of stated that nurses w background, assess face sheet, medicat directives, and any I pertinent. When ask with residents to the they do not send the During an interview of #1, on 05/04/18 at 8 care plan goals were transfer to the hospi send care plans or co of information sent w to the hospital. ASM #1 (Administra administrator, was m findings on 05/04/18 No further information following website: https://medlineplus.g 00707.htm (2) This information following website: https://medlineplus.g	sfer, LPN #4 stated that bically document this asked what documents were during a transfer, LPN #4 vill send the SBAR (situation, sment, recommendation) note, ion listing, advanced aboratory tests that are ted if the care plan was sent hospital, LPN #4 stated that e care plan. with RN (registered nurse) :57 a.m., RN #1 was asked if e sent with a resident upon tal. RN #1 stated they do not care plan goals in the packet with a resident upon transfer tive Staff Member), the nade aware of the above at 9:57 a.m. on was obtained prior to exit. was obtained from the gov/ency/patientinstructions/0 was obtained from the gov/ency/article/000170.htm was obtained from the	F	62:			

Facility ID: VA0402

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DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES			P		D: 05/11/2018	
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			0	FORM APPROVED OMB NO. 0938-0391		
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				X3) DAT	E SURVEY PLETED	
		495401	B. WING			05/04/2018		
NAME OF P	ROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE	0	104/2010	
TYLER'S	RETREAT AT IRON BRID	GE		1:	2001 IRON BRIDGE RD CHESTER, VA 23831			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		Ľ			· T	
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	2	(X5) COMPLETION DATE	
F 623	Continued From page	- 18	F	623				
F 623 SS=D	Notice Requirements	Before Transfer/Discharge		623	 No correction to be made for resident #323. Any resident who is transferred to the 			
	§483.15(c)(3) Notice to Before a facility transf	ers or discharges a			hospital is at risk for the deficient practic 3. a. Director of Nursing or designee will inservice license nursing staff on the nee	1		
	resident, the facility m (i) Notify the resident a	and the resident's			notify the responsible party and documen notification in the medical records related	nt		
	representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The				resident transferred to the hospital.	uw		
					3. b. Administrator will inservice Social			
	facility must send a co				Workers on requirements for notification	1 of		
	representative of the C				ombudsman.			
	Long-Term Care Omb				4. a. Unit Manger or designee will audit	all		
	(ii) Record the reasons				transfers to the hospital for 2 months to			
	discharge in the reside				ensure responsible party is notified of			
		graph (c)(2) of this section;			hospital transfer.			
	and				b. Administrator will audit all transfers to the hospital to ensure ombudsman was	0		
	paragraph (c)(5) of this	e the items described in section.			notified. c. Unit Manager and Administrator or			
	§483.15(c)(4) Timing c	of the notice			designee will report the results of the auc	dits		
		in paragraphs (c)(4)(ii) and			to the QAPI committee monthly for 2			
	(c)(8) of this section, th				months.			
	discharge required und	der this section must be			d. Audit results / trends will be reviewed			
		least 30 days before the			QAPI meeting to ensure that Action Plar			
	resident is transferred				are effective. Additional action plans wi	ill		
		de as soon as practicable			be done as needed.			
	before transfer or disch	harge when- duals in the facility would					6/4/2018	
		paragraph (c)(1)(i)(C) of					l	
	this section;							
	(B) The health of indivi	duals in the facility would						
	be endangered, under	paragraph (c)(1)(i)(D) of						
	this section;							
	(C) The resident's heal	th improves sufficiently to						
	allow a more immediate under paragraph (c)(1)	e transfer or discharge,						
	(D) An immediate trans							
		ner er dioenalge le						

Facility ID: VA0402

If continuation sheet Page 19 of 112

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 495401 05/04/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 12001 IRON BRIDGE RD **TYLER'S RETREAT AT IRON BRIDGE** CHESTER, VA 23831 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 623 Continued From page 19 F 623 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 III Individuals Act.

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: VA0402

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DEPART	MENT OF HEALTH	AND HUMAN SERVICES					05/10/2018 APPROVED
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES					0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G		E SURVEY PLETED
		495401	B. WING	;		05/	04/2018
NAME OF I	PROVIDER OR SUPPLIER	<u></u>		Γ	STREET ADDRESS, CITY, STATE, ZIP CODE		
TYLER'S	RETREAT AT IRON E	BRIDGE			12001 IRON BRIDGE RD		
					CHESTER, VA 23831		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 623	Continued From pa	ge 20	F	623	3		
	effecting the transfer must update the rec as practicable once becomes available.	the notice changes prior to er or discharge, the facility cipients of the notice as soon the updated information					
	In the case of facility the administrator of written notification p to the State Survey State Long-Term Ca the facility, and the well as the plan for relocation of the res 483.70(I).	e in advance of facility closure y closure, the individual who is the facility must provide orior to the impending closure Agency, the Office of the are Ombudsman, residents of resident representatives, as the transfer and adequate sidents, as required at §					
	by: Based on staff inter review, and clinical determined that fac written notification to and the long term ca	rview, facility document record review, it was ility staff failed to provide o the resident representative are ombudsman for a sfer for one of 36 residents in					
	notification to Resid	ombudsman for a transfer to					
	The findings include	e:					
	8/24/17 and readmi	admitted to the facility on tted on 4/14/18 with ided but were not limited to					

Facility ID: VA0402

If continuation sheet Page 21 of 112

CENTERS FOR MEDICARE & STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION	1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			OWR NC) 0938-0391	
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	(AZ) WOL	TIPLE CONSTRUCTION		MB NO. 0938-0391 (X3) DATE SURVEY	
		A. BUILDI	ING		MPLETED	
	495401	B. WING	,	05	/04/2018	
NAME OF PROVIDER OR SUPPLIER		ľ	STREET ADDRESS, CITY, STATE, ZIP CODE		104/2010	
TYLER'S RETREAT AT IRON BRI	IDGE		12001 IRON BRIDGE RD CHESTER, VA 23831			
PREFIX (EACH DEFICIENCY MU	MENT OF DEFICIENCIES UST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG		ULD BE	(X5) COMPLETION DATE	
 stenosis, left femur and Resident #323's most data set) assessment with an Af date) of 4/30/18. Resid being cognitively intact decisions scoring 14 o BIMS (Brief Interview ff Review of Resident #3 revealed that he had be hospital on 4/14/18. Th documented at 3:00 p. blood) observed to rolle cast (L) (left) arm. No se distress, no c/o (compl primary care clinician: doctor) on 4/14/18 at 3 Other Send (sic) to ER eval (Evaluation)." The next note docume p.m., revealed that Resident Hospital) for eval. (Evaluation)." The next note docume p.m., revealed that Resident Hospital) for eval. (Evaluation)." The next note docume p.m., Resident documented, "Resident Hospital) for eval. (Evaluation)." The next note docume p.m., Resident denies pain on noted. Left via ambular 3:50pm (p.m.). Return orders). Abrasion noted and drsg (dressing) put (emergency room) nursi (responsible party) awa Further review of Resident failed to evidence that the set failed to evidence that the failed to evidence that the set failed to evidence that the failed to evidence that	larged prostate, and aortic of left distal radius fracture. recent MDS (minimum was a 14 day scheduled RD (assessment reference ident #323 was coded as at in the ability to make daily but of possible 15 on the for Mental Status) exam. 323's nursing notes been transferred to the The following note was .m., "Bleeding (new led gauze portion of soft ssx (sign/symptoms) of blaints) of pain. Reported to (Name of MD (medical 3:20 PM. Order obtained: R (emergency room) for ented on 4/14/18 at 10:41 esident #323 arrived back to ay. The following was nt sent to (Name of aluation). Resident noted .UE (left upper extremity). or discomfort. No distress ince via stretcher @ (at) with N.N.O's (no new ed under cast. Area clean ut into place by ER rse. No distress noted. RP	F 6:	23			

Facility ID: VA0402

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PRINTED: 05/10/201	18
FORM APPROVE	D
OMB NO. 0938-039)1

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

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495401	B. WING			05/	04/2018
	PROVIDER OR SUPPLIER	BRIDGE		1:	TREET ADDRESS, CITY, STATE, ZIP CODE 2001 IRON BRIDGE RD HESTER, VA 23831		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 623	#323's transfer, and received a copy of the On 5/03/18 at 9:17 conducted with RN manager. RN #3 si initiated transfer, nu notification to the re- that the family is alw also stated that the ombudsman. RN # if another department On 5/03/18 at 2:34 conducted with LPN Resident #323's nu staff follows when r hospital. LPN #4 si what was going on the resident out after order. When asked be documented in the stated that she wou nursing note. LPN document the symple exhibiting and that medical doctor was #4 stated that she wo the hospital and the medical services) at When asked if nurs party with written no transfer, LPN #4 st verbally. When asl ombudsman of a fa #4 stated that the no	nge 22 d that the ombudsman this written notification. a.m., an interview was (registered nurse) #3, the unit tated that during a facility- urses did not send written esponsible party. RN #3 stated ways notified verbally. RN #3 nurses did not notify the 43 stated that she was not sure ent notified the ombudsman. p.m., an interview was N (licensed practical nurse) #4, rse, regarding the process esidents are sent out to the tated call the doctor, explain with the patient and then send er she received a doctor's d if a resident transfer would the clinical record, LPN #4 uld document the transfer in a #4 stated that she would otoms the resident was the responsible party and the a ware of the situation. LPN would also document that the order to send the resident to e time EMS (emergency urrived to pick up the resident. ses provide the responsible otification of a facility- initiated ated that nurses tell the family ked if nurses notify the acility- initiated transfer, LPN nurses did not do that. p.m., an interview was	F	523			

Facility ID: VA0402

If continuation sheet Page 23 of 112

		ID HUMAN SERVICES MEDICAID SERVICES				PRINTED: 05 FORMAPF OMB NO: 093	ROVED
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE SURV COMPLETED	EY
		495401	B. WING		_	05/04/20)18
NAME OF P				TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
TYLER'S	RETREAT AT IRON BRID	GE		2001 IRON BRIDGE RD CHESTER, VA 23831			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)	СОМ	(X5) IPLETION DATE
F 623	conducted with OSM social worker. OSM # was supposed to send notification for a facilit stated that she sent th end of each month of transferred to the hos she had been doing th the new regulation ha she had been doing th the new regulation ha she had notified the o #323's transfer to the #9 stated that she wor On 5/03/18 at 5:39 p.r conducted with OSM a did not notify the omb transfer because he c same day. OSM #9 s understanding that I h send the notification." On 5/04/18 at 10:30 a staff member) #1, the aware of the above co The facility policy titled Letter Policy," docume "Social service or desi original discharge/tran resident or guardian/s emergency transfers,"	(other staff member) #9, the #9 stated that social work d the ombudsman written y-initiated transfer. OSM #9 he ombudsman a list at the residents who had been pital. When asked how long his, OSM #9 stated, "Since d come out." When asked if mbudsman of Resident hospital on 4/14/18, OSM uld have to check. m., further interview was #9. OSM #9 stated that she udsman of Resident #323's ame back to the facility the tated, "It was my ad a 48 hour window to .m., ASM (administrative administrator was made incerns. d, "Discharge/Transfer ents in part the following: gnee will assure the sfer letter is given to ponsor if applicable2. For one list can be sent to the id of the month."	F 623				
F 624 SS=D		was presented prior to exit. Orderly Transfer/Dschrg	F 624	#323.2. Any resident transmission	b be made for resider ansferred to the hosp		
	3-100. ro(o)(r) oneniai			at risk for the defie			

Facility ID: VA0402

If continuation sheet Page 24 of 112

		ID HUMAN SERVICES MEDICAID SERVICES				FO	ED: 05/11/2018 RM APPROVED NO. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTIC		(X3) DA	TE SURVEY MPLETED
		495401	B. WING				E/04/2049
NAME OF PI			I	STREET ADDRES	SS, CITY, STATE, ZIP CODE		5/04/2018
TYLER'S I	RETREAT AT IRON BRID	GE		12001 IRON BRI CHESTER, VA			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EAC	ROVIDER'S PLAN OF COR CH CORRECTIVE ACTION S S-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 624	discharge. A facility must provide preparation and orien safe and orderly trans facility. This orientation form and manner that understand. This REQUIREMENT by: Based on staff intervit facility document revise review, it was determit ensure preparation and prior to transfer to the residents in the surve The facility staff failed #323 was properly ori hospital transfer that of The findings include: Resident #323 was and 8/24/17 and readmitted diagnoses that include muscle weakness, en stenosis, left femur and Resident #323's most data set) assessment assessment with an A date) of 4/30/18. Res being cognitively intac decisions scoring 14 of	e and document sufficient tation to residents to ensure sfer or discharge from the on must be provided in a t the resident can " is not met as evidenced iew, resident interview, ew and clinical record ined the facility staff failed to nd orientation of the resident hospital for one of 36 y sample, Resident #323. I to document that Resident ented and prepared for a boccurred on 4/14/18.	F	inservice and orient 4. a. Unit all transfe is prepare b. Unit M results of monthly f c. Audit re QAPI med	ector of Nursing or de license nursing staff ting residents prior to t Managers or design ers for 2 months to en ed and oriented prior langers or designee v the audits to the QA for 2 months. esults / trends will be eting to ensure that A ive. Additional actio	on preparing o the transfer. nee will audit nsure residents to transfer. will report the PI committee e reviewed at Action Plans	6/4/2018
	Review of Resident #3 revealed that he had t hospital on 4/14/18. T	been transferred to the					
ORM CMS-256	7(02-99) Previous Versions Obso	blete Event ID: 3FC71	1	Facility ID: VA0402	1	f continuation shee	et Page 25 of 112

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM A	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495401	B. WING	;		05/0	4/2018
NAME OF I	PROVIDER OR SUPPLIER			I	STREET ADDRESS, CITY, STATE, ZIP CODE 12001 IRON BRIDGE RD		
TYLER'S	RETREAT AT IRON E	BRIDGE		1	CHESTER, VA 23831		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 624	documented at 3:00 blood) observed to cast (L) (left) arm. N distress, no c/o (co primary care clinicia doctor) on 4/14/18 Other Send (sic) to eval (evaluation)." The next note docu p.m., revealed that the facility the same documented, "Resi Hospital) for eval. (with blood to cast of Resident denies par noted. Left via amb 3:50pm (p.m.). Ret orders). Abrasion m and drsg (dressing) (emergency room) (responsible party) Review of the clinic documentation the prepared for the fac hospital on 4/14/18 On 5/03/18 at 9:17 conducted with RN manager. RN #4 s document that a re prepared for a facil On 5/03/18 at 11:5 conducted with Re	 D.p.m., "Bleeding (new rolled gauze portion of soft No ssx (sign/symptoms) of mplaints) of pain. Reported to an: (Name of MD (medical at 3:20 PM. Order obtained: ER (emergency room) for Immented on 4/14/18 at 10:41 Resident #323 arrived back to e day. The following was dent sent to (Name of Evaluation). Resident noted on LUE (left upper extremity). In or discomfort. No distress pulance via stretcher @ (at) urn with N.N.O's (no new noted under cast. Area clean) put into place by ER nurse. No distress noted. RP aware." cal record failed to reveal any resident was oriented and cility-initiated transfer to the following staff do not sident was oriented and lity- initiated transfer. 7 a.m., an interview was sident #323. Resident #323 d not remember being 		624	4		

Facility ID: VA0402

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STATEMEN	T OF DEFICIENCIES	& MEDICAID SERVICES	(72) 141 1		OMB N	RM APPROV 10. 0938-0
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		DATE SURVEY
		495401	B. WING			
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z		05/04/2018
TYLER'	S RETREAT AT IRON I	BRIDGE		12001 IRON BRIDGE RD CHESTER, VA 23831		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF		
PRÉFIX TAG	REGULATORY OR L	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
F 624	Continued From pa	ge 26	F 6	24		
	On 5/03/18 at 2:34	p.m., an interview was				
	conducted with LPN	(licensed practical nurse) #4				
	Resident #323's nui	rse, regarding the process				
	bospital I BN #4 -+	esidents are sent out to the				
	What was doing on y	ated call the doctor, explain with the patient and then send				
	the resident out after	r she received a doctor's				
	order. When asked	if a transfer would be				
	documented in the c	clinical record, LPN #4 stated				
	that she would docu	ment the transfer in a nursing				
	note or an SBAR (si	tuation, background.				
	assessment and rec	commendation) note. LPN #4				
	stated that she would the resident was ever	d document the symptoms				
	the resident was ext responsible party an	d the medical doctor was				
	aware of the situatio	n. LPN #4 stated that she				
·	would also documer	It that the physician gave an				
	order to send the res	sident to the hospital and the		i		
	time EMS (emergen	cy medical services) arrived				
	to pick up the reside	nt. When asked if she would				
	document that the re	esident was oriented and				
	there was an option	sfer, LPN #4 stated that				
	the resident was all	on the SBAR note asking if rt and oriented but that option				
	did not mean the res	ident was oriented and				
	prepared for a transf	er.				
	On 5/04/18 at 10:30	a.m., ASM (administrative				
	staff member) #1, the	e administrator was made				
	aware of the above of	concerns.				
	The facility policy title	ed, "Discharge/Transfer				
	Letter Policy," did not	t address the above		F 656		
	prior to exit.	r information was presented				
1	•	Comprehensive Care Plan	EGE	1. No correction to be ma	ade for	
SS=E	CFR(s): 483.21(b)(1)		F 65	^o resident #70, 25, 36 or 30)	
	· · · · · · · · · · · · · · · · · · ·			2. All residents are at risk	c of the	
				deficient practice.	- or me	
I CHE DEP	7(02-99) Previous Versions O			······································		

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FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB_NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** A. BUILDING COMPLETED 495401 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 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 656 Continued From page 27 3. a. Director of Nursing or designee F 656 §483.21(b) Comprehensive Care Plans will inservice Nursing Department §483.21(b)(1) The facility must develop and Staff on following care plan implement a comprehensive person-centered interventions such as tube feeding care plan for each resident, consistent with the orders, protective sleeves, resident rights set forth at §483.10(c)(2) and administrating Coumadin, §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's completion of pain assessments prior medical, nursing, and mental and psychosocial to and after administration of pain needs that are identified in the comprehensive medication. assessment. The comprehensive care plan must 4. a. Unit Managers or designee will describe the following -(i) The services that are to be furnished to attain audit residents with tube feeding or maintain the resident's highest practicable orders to ensure feedings are given physical, mental, and psychosocial well-being as as ordered. required under §483.24, §483.25 or §483.40; and b. Unit Managers or designee will (ii) Any services that would otherwise be required audit by direct observation residents under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights with an order for protective sleeves 5 under §483.10, including the right to refuse x a week for 1 month and then treatment under §483.10(c)(6). random 3 x a week for 1 month. (iii) Any specialized services or specialized c. Unit Manager or designee will rehabilitative services the nursing facility will audit MAR for residents receiving provide as a result of PASARR recommendations. If a facility disagrees with the Coumadin 5 x a week for 2 months findings of the PASARR, it must indicate its to ensure medication is administered rationale in the resident's medical record. on time. (iv)In consultation with the resident and the d. Unit Manager or designee will resident's representative(s)-(A) The resident's goals for admission and audit weekly for 2 months for desired outcomes. documentation of pain assessment (B) The resident's preference and potential for before and after administration of future discharge. Facilities must document pain medication. whether the resident's desire to return to the e. Unit Managers will report the community was assessed and any referrals to results of the audits to the QAPI local contact agencies and/or other appropriate entities, for this purpose. committee monthly for 2 months. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: VA0402

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		AND HUMAN SERVICES			F	PRINTED FORM): 05/10/2018 1 APPROVED
						MB NC	0. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495401	B. WING	i		05	/04/2018
NAME OF	PROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE		10 112010
TYLER'S	RETREAT AT IRON E	BRIDGE			2001 IRON BRIDGE RD CHESTER, VA 23831		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ÍD PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 656	Continued From page	ge 28	Fe	656	69 v. a		6 4 18
	requirements set for section.	rth in paragraph (c) of this			f. Audit results / trends will be reviewed at QAPI meeting to en	CUIRA	0
		IT is not met as evidenced			that Action Plans are effective.	isuic	
	by:				Additional action plans will be	done	
	interview, facility do	ion, staff interview, resident cument review and clinical			as needed.	- access (*******	Т
	record review, it was	s determined that the facility op and implement the					
	comprehensive care	e plan for four of 36 residents					
	in the survey sample 30.	e, Resident #70, 50, 36 and					
	1. The facility staff facomprehensive care	ailed to follow the a plan to provide tube					
	feedings as ordered #70.	by the physician for Resident					
	2. The facility staff fa	ailed to follow the					
	comprehensive care sleeves as ordered l #25.	e plan to apply protective by the physician for Resident					
		ailed to implement the plan for Resident #36 in cation, Coumadin.		1 (1)(1)			
	#30's comprehensive	ailed to implement Resident e care plan to complete a					
	pain assessment privadministration of PR medications.	or to and after the N (as needed) pain					
	The findings include:	:					
	1. The facility staff fa comprehensive care feedings as ordered #70.	iled to follow the plan to provide tube by the physician for Resident					

l

Facility ID: VA0402

If continuation sheet Page 29 of 112

		AND HUMAN SERVICES & MEDICAID SERVICES	,			FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495401	B. WING			05/0	04/2018
NAME OF F	PROVIDER OR SUPPLIER	. <u> </u>			STREET ADDRESS, CITY, STATE, ZIP CODE		
TYLER'S	RETREAT AT IRON E	BRIDGE			12001 IRON BRIDGE RD CHESTER, VA 23831		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 656	Continued From pa	ge 29	F€	656	3		
	12/2/17 with diagno limited to: irregular	admitted to the facility on ses that included but were not heartbeat, dementia, high difficulty swallowing.					
	quarterly assessme reference date) of 4 having scored a set (brief interview for r resident was severe resident was coded staff for all activities eating, which the re	DS (minimum data set), a ent, with an ARD (assessment 1/13/18 coded the resident as ven out of 15 on the BIMS mental status) indicating the ely impaired cognitively. The as requiring assistance from s of daily living except for esident could perform after the e resident was coded as be.					
	p.m. of Resident #7 in a wheelchair. The in front of the reside less than 25% of gr 25% of the dessert any of the mashed	a made on 5/03/18 at 12:33 70. The resident was sitting up e lunch tray was on the table ent. The resident had eaten round beef and approximately . The resident had not eaten potatoes or vegetables. The ney don't taste like potatoes. I					
	of OSM (other staff	s made on 5/3/18 at 1:19 p.m. member) #11, a dietary aide lent's tray and putting it in the					
	OSM #11 took the this writer in attend take Resident #70's how much the resid	s made on 5/3/18 at 1:30 p.m. food cart to the kitchen with ance. OSM #11 was asked to s tray out of the cart and see dent had eaten. When asked dent ate, OSM #11 stated, "Not					

Facility ID: VA0402

If continuation sheet Page 30 of 112

		AND HUMAN SERVICES				FORM	: 05/10/2018 APPROVED
STATEMENT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		U PLE CONSTRUCTION G	(X3) DAT	. 0938-0391 E SURVEY IPLETED
		495401	B. WING	G		05/	/04/2018
NAME OF I	PROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	04/2010
TYLER'S	RETREAT AT IRON E	BRIDGE			12001 IRON BRIDGE RD CHESTER, VA 23831		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ı. IX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 656	Continued From pay very much. A couple Review of the reside 12/12/17 and revise "Focus. PEG (1) on (by mouth) < (less the Provide PEG feedin ordered." Review of the May 2 documented, "IF BY MEAL LESS THAN (milliliter) DIABETIS Review of the May 2 administration record at any meal is <60% 250 ML (milliliters) v replacement." Reviet 12:00 noon docume circle around them it was not given. An interview was coop.m. with LPN (licen When asked why re- #1 stated, "Why? To To make sure it's in When asked who us stated, "We all use t An interview was coop.m. with CNA (certific resident's aide. Whe much a resident ate,	ge 30 e bites of meat and pumpkin." ent's care plan initiated on d on 4/17/18 documented, ly for water flushes, bolus if po han) 50%. Interventions. gs and water flushes as 2018 physician's orders MOUTH INTAKE AT ANY 60% BOLUS 250 ML OURCE" 2018 MAR (medication d) documented, "If PO intake o Bolus DiabetiSource AC ia PEG tube as meal w of the MAR for 5/3/18 at nted the nurse's initials with a ndicating the tube feeding nducted on 5/3/18 at 3:22 sed practical nurse) #1. sidents had care plans, LPN review what we need to do. line with their scope of care." sed the care plans, LPN #1	F		DEFICIENCY)		
	"A hundred percent."	aten that day, CNA #1 stated, ' When asked if she had s tray up, CNA #1 stated she					

Event ID: 3FC711

Facility ID: VA0402

If continuation sheet Page 31 of 112

DEPAF CENTE	RTMENT OF HEALTH	AND HUMAN SERVICES			F	RINTE	D: 05/10/20	018
ISTATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL	JLTI DIN	IPLE CONSTRUCTION	MB NC (X3) DA	0. 0938-03 TE SURVEY MPLETED	ED 191
		495401	B. WING	G				
	PROVIDER OR SUPPLIER			Τ	STREET ADDRESS, CITY, STATE, ZIP CODE	05	/04/2018	
TYLER'	S RETREAT AT IRON B				12001 IRON BRIDGE RD CHESTER, VA 23831			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ΊX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE	Ă
	had not. The above with CNA #1. CNA # eats everything." On 5/3/18 at 6:45 p.r member) #1, the adr director of nursing with director of nursing with director of nursing with findings. On 5/3/18 at 8:20 a.r OSM (other staff men records staff, for the food portions. No pol An interview was con #2, the director of nur residents had care pl plans, why. So that with while they are here." Them, ASM #2 stated asked if staff were ex plan, ASM #2 stated, An interview was conference asked if staff were ex plan, ASM #2 stated, An interview was conference asked if staff were ex plan, ASM #2 stated, An interview was conference asked what circle MAR meant, LPN #3, the When asked what circle MAR meant, LPN #3 st When asked how much consumed at lunch on she had been told that hadn't eaten 60 perces Review of the facility's documented, "POLICY care will be establishe	observations were shared 1 stated, "Well she usually m. ASM (administrative staff ninistrator and ASM #2, the ere made aware of the n., a request was made to mber) #1, the medical facility's policy on monitoring icy was received. ducted on 5/4/18 with ASM rsing. When asked why ans, ASM #2 stated, "Care re know their plan of care When asked who used , "Every one of us." When pected to follow the care "Yes." ducted on 5/4/18 at 9:15 resident's nurse on 5/3/18. cled nurses' initials on the stated it meant that it wasn't by the nurses are made of food the resident had ated, "The CNAs tell us." ch Resident #70 had n 5/3/18, LPN #3 stated that t morning that the resident	F	656				

Facility ID: VA0402

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		AND HUMAN SERVICES		l		D: 05/10/2018 MAPPROVED
	T OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	T	(OMB NC	<u>D. 0938-0391</u>
AND PLAN	DF CORRECTION	IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	JLTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED	
		495401	B. WING	3	05	5/04/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 03	104/2016
TYLER'S	RETREAT AT IRON E	BRIDGE		12001 IRON BRIDGE RD CHESTER, VA 23831		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	IX (EACH CORRECTIVE ACTION SHOUL	DBE	(X5) COMPLETION DATE
	regulatory requireme basis. In states whe applies, this will be of assessment. Goals objective. PROCED familiar with each re approaches must be care staff must alwa follow their Resident implement any part of Charge Nurse or ME can be documented necessary." No further information According to Fundar Williams and Wilkins documented, "A writh communication tool a members that helps careThe nursing ca information about the and goals. It contain achieving the goals of and is used to direct revise and update th there are changes in with new orders" (1 (1) Fundamentals of & Wilkins 2007 Lippin pages 65-77. Basic Nursing, Esser (Potter and Perry, 20 reference for care pla a written guideline for	ents and on an as needed re pre-admission screening coordinated with the facility must be measurable and URE: D) All staff must be sident's Care Plan and all e implemented. Z) All direct ys know, understand and t's Care Plan. If unable to of the plan, notify your DS Coordinator, so that this or the Care Plan changed if on was provided prior to exit. mentals of Nursing Lippincott s 2007 pages 65-77 ten care plan serves as a among health care team ensure continuity of are plan is a vital source of e patient's problems, needs, as detailed instructions for established for the patient careexpect to review, e care plan regularly, when condition, treatments, and	F6	656		

Facility ID: VA0402

If continuation sheet Page 33 of 112

RTMENT OF HEALTH	AND HUMAN SERVICES			F		D: 05/10/2018
RS FOR MEDICARE	& MEDICAID SERVICES				FOR	M APPROVED
IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			IPLE CONSTRUCTION	(X3) DA	D. 0938-0391 TE SURVEY MPLETED
	495401	B. WING	G			
PROVIDER OR SUPPLIER			Т	STREET ADDRESS, CITY, STATE, ZIP CODE	05	/04/2018
S RETREAT AT IRON B	RIDGE			12001 IRON BRIDGE RD	,	
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECTION	D BE	(X5) COMPLETION DATE
criteria to be used in care. The written can nursing care prioritie professionals. The coordinates resource care. A correctly for easy to continue car If the patient's status nursing diagnosis an no longer appropriate plan. An out of date compromises the qu 1. PEG Percutanee (PEG) is the preferren nutritional support in gastrointestinal syste enteral nutrition. This from: https://www.ncbi.nlm 69302/ 2. The facility staff fai comprehensive care sleeves as ordered b #25. Resident #25 was ad	a the evaluation of nursing are plan communicates as to other health care care plan also identifies and es used to deliver nursing mulated care plan makes it e from one nurse to another. a has changed and the of related interventions are e, modify the nursing care or incorrect care plan ality of nursing care." Ous endoscopic gastrostomy ed route of feeding and patients with a functional em who require long-term a information was obtained .nih.gov/pmc/articles/PMC40	Fe	65		·	
8/13/14 and readmitte that included but were pressure, heart failure chronic pain. The most recent MDS annual assessment, v reference date) of 2/2	ed on 3/4/15 with diagnoses e not limited to: high blood e, arthritis, lung disease and S (minimum data set), an with an ARD (assessment 2/18, coded the resident as	t		·		
	ERS FOR MEDICARE IT OF DEFICIENCIES OF CORRECTION PROVIDER OR SUPPLIER S RETREAT AT IRON E SUMMARY STA (EACH DEFICIENCY REGULATORY OR LS Continued From page criteria to be used in care. The written canursing care priorities professionals. The of coordinates resource care. A correctly for easy to continue care If the patient's status nursing diagnosis an no longer appropriat plan. An out of date compromises the quint 1. PEG Percutane (PEG) is the preferred nutritional support in gastrointestinal syste enteral nutrition. This from: https://www.ncbi.nlm 69302/ 2. The facility staff fai comprehensive care sleeves as ordered b #25. Resident #25 was ad 8/13/14 and readmitted that included but were pressure, heart failure chronic pain. The most recent MDS annual assessment, we reference date) of 2/2	OF CORRECTION IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: 495401 PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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/PMC40 69302/ 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	ERS FOR MEDICARE & MEDICAID SERVICES IT OF DEFICIENCIES OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) ML A BUIL 495401 B. WING PROVIDER OR SUPPLIER SRETREAT AT IRON BRIDGE ID REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREF TAC 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 musing 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/PMC40 69302/ 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 efference date) of 2/22/18, coded the resident as	ERS FOR MEDICARE & MEDICAID SERVICES IT OF DEFICIENCIES OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULT A. BUILDIN 495401 B. WING_ PROVIDER OR SUPPLIER SRETREAT AT IRON BRIDGE ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID 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 nuritional 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/PMC40 69302/ 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.	ERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDERSUPPLIERCLA DEPTIFICATION NUMBER (X2) MULTIPLE CONSTRUCTION A BUILDING 495401 8. WING PROVIDER OR SUPPLIER 3 STREET ADDRESS, CITY, STATE, ZIP CODE 12001 IRON BRIDGE 3 STREET ADDRESS, CITY, STATE, ZIP CODE RETREAT AT IRON BRIDGE 12001 IRON BRIDGE RD CHESTER, VA 23831 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REQUARCY OR US CIDENTIFYING INFORMATION) ID PREFX 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. F 656 1. PEG - Percutaneous endoscopic gastrostomy (PEG) is the prefered 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/PMC40 69302/ 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 81/3/14 and readmitted to: high blood pressure, heart failure, arthritis, lung disease and chronic pain. The most recent MDS (minimum da	ERS_FOR MEDICARE & MEDICAID SERVICES OP OF OFERENCES OWB NC OF OF OFERENCES (M) PROVIDERSUPPLERQLA DENTIFICATION NUMBER (22) MULTIPLE CONSTRUCTION (33) DA A BUILDING 495401 8. WING (20) PROVIDER OR SUPPLER STREET ADDRESS, CITY, STATE, ZIP CODE (20) STREET AT IRON BRIDGE STREET ADDRESS, CITY, STATE, ZIP CODE (20) SUMMARY STATEMENT OF DEFICIENCIES OF OPPOVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHULD BE CROSS-REPERPECTED TO THE PROSTORING) (20) REGULATORY OR LSC IDENTIFYING INFORMATION) PREPX TAG CORRECTIVE ACTION SHULD BE CROSS-REPERPECTED TO THE APPROPRIATE DEFICIENCY WIST BE PRESCRIPTION TAG Continued From page 33 criteria to be used in the evaluation of nursing care. A correctly formulated care plan makes it easy to continue care from one nurse to another. If the patients status has changed and the nursing diagnosis and related interventions are no longer appropriate, modify the nursing care." F 656 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/PMC40 69302/ 2. The facility staff failed to follow the comprehensive care plan to apply protective sieves as ardified to the facility on X1/31/4 and readmitted on 34/15 with diagnoses that included but were not limited to: high blood pressure, heart failure, arthritis, lung disease and chronic pain.

Facility ID: VA0402

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 05/10/2018 APPROVED
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			UI PLE CONSTRUCTION G	MB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
		495401	B. WING			05/	04/2018
NAME OF F	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		0 112010
TYLER'S	RETREAT AT IRON E	BRIDGE			12001 IRON BRIDGE RD CHESTER, VA 23831		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 656	was severely impair was coded as requir all activities of daily An observation was of Resident #25. Th back in bed with her wearing a hospital g There was a white b An observation was of Resident #25. Th with her eyes closed gown and her arms bandage on the right An observation was of Resident #25. Th and was wearing a s was a white bandag forearm otherwise, h An observation was of Resident #25 was resident had geri sle Review of the reside initiated on 2/10/18 s impaired mobility, in 4/20/18 skin tear to Geri sleeves (protect	status) indicating the resident red cognitively. The resident ring assistance from staff for living. made on 5/2/18 at 8:20 a.m., e resident was lying on her reyes closed. She was yown and her arms were bare. bandage on the right forearm. made on 5/3/18 at 8:18 a.m. e resident was lying in bed d. She was wearing a hospital were bare. There was a white the forearm. made on 5/3/18 at 12:10 p.m. e resident was lying in bed short-sleeved blouse. There is on the resident's right her arms were not covered. made on 5/3/18 at 12:29 p.m. s up in a wheelchair, the eves on her arms. ent's comprehensive care plan and revised on 4/29/18 s. (Name of Resident #25) is skin integrity r/t (related to) continence and obesity. (R) (right) arm. Interventions. ctive sleeves)."	F	556			

Facility ID: VA0402

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STATEMEN	OF DEFICIENCIES	E & MEDICAID SERVICES	(201101-			MAPPROVE D. 0938-039
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION G		TE SURVEY MPLETED
		495401	B. WING		0.5	04/2049
NAME OF	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP C	ODE	5/04/2018
TYLER'S	RETREAT AT IRON	BRIDGE		12001 IRON BRIDGE RD CHESTER, VA 23831		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CO	PRECTION	
PREFIX TAG	(EACH DEFICIENC REGULATORY OR I	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 656	Continued From pa	age 35	F 656	3		
	Review of the May	2018 MAR (medication				
	administration reco	rd) documented, "GERI				
	SLEEVES EVERY	SHIFT TO BILATERAL ARMS				
	nurse's initials were	N." On 5/1/18 and 5/2/18, the circled on the 7:00 a.m. to				
	3:00 p.m. shift indic	ating the geri sleeves were				
	not on. There was	no documentation on the 3:00				
	shifts.	or 11:00 p.m. to 7:00 a.m.				
	An interview was co	onducted on 5/3/18 at 12:19				
	p.m. with LPN #3, t	he resident's nurse. When				
	asked who put the	geri sleeves on the residents,				
	the morning when t	e CNA usually puts them on in hey do their care." When				
	asked why resident	s had care plans, LPN #3				
	stated, "So we can	keep up with how they're				
	doing, so we can be	etter care for them." When				
	"All of us should " M	e care plans, LPN #3 stated, /hen asked who developed				
	and revised the car	e plan, LPN #3 stated,				
	"They're supposed t	to be developed on admission				
	or at least within 24	hours. The care plan is based hat the come in with." When				
	asked why Residen	t #25 had geri sleeves, LPN				
	#3 stated, "Because	she has a skin tear."				
	An interview was co	nducted on 5/3/18 at 3:32				
	p.m. with CNA #1, the second	ne resident's aide, regarding				
	CNA #1 stated "We	he resident's geri sleeves. had to order some. I found				
	them in the drawer a	and then I put them on."				
	When asked if Resi	dent #25 had the geri sleeves				
		CNA #1 stated she had not.				
	On 5/3/18 at 6:45 p.	m. ASM (administrative staff				
	member) #1, the ad	ministrator and ASM #2, the vere made aware of the				
	7(02-99) Previous Versions (L		

DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES			P	RINTE	D: 05/10/2018
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			0	FORI MB NC	MAPPROVED 0. 0938-0391
STATEMEN AND PLAN (T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		495401	B. WING	}			
NAME OF	PROVIDER OR SUPPLIER		1	Γ	STREET ADDRESS, CITY, STATE, ZIP CODE	05	/04/2018
TYLER'S	RETREAT AT IRON E	BRIDGE			12001 IRON BRIDGE RD		
(X4) ID		TEMENT OF DEFICIENCIES			CHESTER, VA 23831		
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BF	(X5) COMPLETION DATE
F 656	Continued From pag findings.	ge 36	Fe	656	6		
	 #2, the director of nuresidents had care pplans, why. So that while they are here.' them, ASM #2 stated asked if staff were eplan, AM #2 stated, No further information 3. The facility staff facomprehensive care regards to her medice *Coumadin (Warfaring treatment of venous extension, pulmonar for Patients -Advise pthe prescribed dosage) 	on was provided prior to exit. ailed to implement the plan for Resident #36 in cation, Coumadin*. n) is used in prophylaxis and thrombosis and its y embolism (PE). Instructions patients to: Strictly adhere to					
	11/14/17 with diagno not limited to: high bl	ses that included but were ood pressure, osteoporosis, y of pulmonary embolus			, ,		
	assessment, a quarte assessment reference resident as scoring a interview for mental s was capable of makin decisions. Resident #	S (minimum data set) erly assessment, with an ce date of 3/4/18, coded the 15 on the BIMS (brief status) score, indicating she ng her cognitive daily #36 was coded as requiring of her activities of daily					

Event ID: 3FC711

Facility ID: VA0402

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

STATEMEN	OF DEFICIENCIES		Tara		<u>_OMB N(</u>	<u> </u>	
AND PLAN (OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495401	B. WING		0!	5/04/2018	
	PROVIDER OR SUPPLIER	BRIDGE		STREET ADDRESS, CITY, STATE, ZIP CODE 12001 IRON BRIDGE RD CHESTER, VA 23831		5/04/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 656	living.	ge 37 care plan dated, 4/26/18, "Focus: Resident is at risk	F 6	56			
	for bleeding/bruising tests) R/T (related to The "Interventions" medication as order	g/abnormal labs (laboratory b) anticoagulant medication." documented in part, "Provide ed."					
	revealed and order t 10 mg (milligrams) p @ (at) 5 p.m. on Mo	cian's orders dated 4/26/18, hat documented, "Coumadin oo (by mouth) qd (every day) nday thru Sat (Saturday). o @ 5 p.m. on Sunday."					
	5/2/18 at 10:54 a.m.	nducted with Resident #36 on Resident #36 stated they t staffed and they don't get ations on time.					
	5/3/18 starting at 4:3 for the hall on which There was no nurse This surveyor stayed nurse (RN [registere- came to the medicat pushed the cart down administer medicatio	ide of the nursing unit on 0 p.m. The medication cart Resident #36 was observed. around the medication cart. I at the nursing station. The d nurse) #3, unit manager) ion cart at 5:32 p.m. She in the hallway and started to ons. At 5:33 p.m., Resident bing to the dining room.				η.	
·	(medication administ was requested from a member) #6, regiona The MAR documente mg tablet ; take 1 tab evening." It was not c	n. a copy of the MAR ration record) for May 2018, ASM (administrative staff Il director of clinical services. ed, "Warfarin (Coumadin) 10 (tablet) by mouth every documented as having been 18 at the scheduled time of					

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Facility ID: VA0402

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PRINTED: 05/10/2018 FORM APPROVED

		AND HUMAN SERVICES				PRINTE	D: 05/10/2018 M APPROVED		
		& MEDICAID SERVICES					OMB NO. 0938-0391		
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		IPLE CONSTRUCTION		TE SURVEY		
		495401	B. WING	3_		05	5/04/2018		
NAME OF	PROVIDER OR SUPPLIER			Τ	STREET ADDRESS, CITY, STATE, ZIP COD				
TYLER'S	RETREAT AT IRON E	BRIDGE			12001 IRON BRIDGE RD CHESTER, VA 23831				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	'IX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
F 656	5:00 p.m. On 5/3/18 at 6:39 p.	ge 38 m., a copy of the MAR stration record) for May 2018	F	65	56				
	was requested. The (Coumadin) 10 mg t mouth every evening	MAR documented, "Warfarin ablet; take 1 tab (tablet) by g." It was not documented as stered on 5/3/18 at the							
J.	On 5/4/18 at 8:40 a. this surveyor that sh until 8:04 p.m.	m., Resident #36 informed e didn't get her Coumadin							
	nurse) #1 on 5/4/18 purpose of the care care for the patient." should be followed, I When asked who ha	nducted with RN (registered at 9:17 a.m., regarding the plan. RN #1 stated, "It's to When asked if the care plan RN #1 stated, "Absolutely." is access to the care plan, es and the resident or family."							
	administrator, ASM # ASM #4, the regional	staff member) #1, the #2, the director of nursing and I director of clinical services, the above concern on 5/4/18							
	following website: https://dailymed.nlm.	was obtained from the nih.gov/dailymed/drugInfo.cf 902e-c26c-23ca-d5accc4151							
	4. The facility staff fa #30's comprehensive pain assessment prio administration of PR medications.	iled to implement Resident e care plan to complete a or to and after the N (as needed) pain							

Facility ID: VA0402

If continuation sheet Page 39 of 112

DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES		,		PRINTE	D: 05/10/2018
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				FOF	MAPPROVED
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONST		(X3) D	O. 0938-0391 ATE SURVEY OMPLETED
		495401	B. WING	3			
NAME OF	PROVIDER OR SUPPLIER			STREET AD	DDRESS, CITY, STATE, ZIP C		5/04/2018
TYLER'	S RETREAT AT IRON E	BRIDGE		12001 IRO	N BRIDGE RD R, VA 23831		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES					
PRÉFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX (E CRO	PROVIDER'S PLAN OF COR EACH CORRECTIVE ACTION OSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 656	Continued From page	ge 39	Fe	56			
	 8/24/17 and readmit diagnoses that inclu type two diabetes, n unspecified dementi disturbance. Reside (minimum data set a assessment with an date) of 3/1/18. Res being cognitively inta decisions scoring 12 BIMS (Brief Interview Review of Resident i (physician order sum documented the follo 1) "Hydrocodone- A 7.5-325 mg (milligran every 6 hours for pai on 2/21/18. 2) "MAPAP (Tylenol) (650 mg) by mouth e mild pain/temperatur GM daily. Check dail initiated on 11/28/17. Review of Resident # (medication administ she received Norco o times: 4/4/18 at 12:1 4/7/18 at 0600 a.m., a p.m. 	430's April 2018 MAR ration record) revealed that on the following dates and 5 a.m., and 6:00 a.m., and 4/9/18 at 12 a.m. and 6 sident #30's April 2018 MAR					
	revealed that she rec following dates and ti	eived Tylenol 650 mg on the mes: 4/6/18 at 6:00 p.m.,					
RM CMS-256	7(02-99) Previous Versions Ol	bsolete Event ID: 3FC711		Facility ID: VA04	lo2 If cont	inuation sheet P	age 40 of 112

FO 7(02-99) Previous Versions Obsolete

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DEPAR	MENT OF HEALTH	AND HUMAN SERVICES					D: 05/10/2018
		& MEDICAID SERVICES					MAPPROVED D. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) Mul A. Build		LE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		495401	B. WING	i		04	5/04/2018
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		0/04/2010
TYLER'S	RETREAT AT IRON E	BRIDGE			2001 IRON BRIDGE RD CHESTER, VA 23831		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 656	4/19/18 at 1:00 a.m 4/23/18 at 1:00 a.m 4/23/18 at 12:00 a.m There was no evide a pain assessment of administration of No 2018. There was no assessment after th administered in Aprit that non-pharmacole attempted prior to th (as needed) pain me sheet for April was no record. Review of Resident revealed that she re following dates and times administered w There was no evider a pain assessment w administration of Tyl was no evidence of after the Tylenol was was no evidence that interventions were a administration of PR flow sheet for May w Review of Resident a 11/28/17, documente "Potential for pain/di- mobility, neuropathy, resolved within 1 hour review. Interventiona	 4/22/18 at 12:00 a.m., n., and 4/30/18 at 2:00 a.m. nce in the clinical record that was completed prior to the proo and Tylenol in April of pevidence of a follow up pain e Norco and Tylenol was There was no evidence ogical pain interventions were the administration of the PRN edications. The pain flow missing from the clinical #30's May 2018 MAR ceived Tylenol 650 mg on the times: 5/1/18 and 5/3/18, were illegible. nce in the clinical record that was completed prior to the enol in May of 2018. There a follow up pain assessment s administered in May. There at non-pharmacological pain ttempted prior to the two completely blank. #30's pain care plan dated ed in part, the following: scomfort related to impaired , gout; Goal: Pain will be ur of intervention through next s: Pain assessment per rn (as needed), Administer 	F 6	556	*		
		per MD (medical doctor)					

Event ID: 3FC711

Facility ID: VA0402

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DEPAR	MENT OF HEALTH	AND HUMAN SERVICES			F		: 05/10/2018 APPROVED	
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			C		. 0938-0391	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DAT	(X3) DATE SURVEY COMPLETED	
		495401	B. WING	÷		05/	04/2018	
NAME OF I	PROVIDER OR SUPPLIER			Γ	STREET ADDRESS, CITY, STATE, ZIP CODE	1		
TYLER'S	RETREAT AT IRON B	RIDGE			12001 IRON BRIDGE RD			
				L	CHESTER, VA 23831			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE	(X5) COMPLETION DATE	
F 656	Continued From page	ge 41	Fe	656	5			
	interview was condu When asked if facili giving her pain med that facility staff will location. Resident # come back and do a pain. Resident #30 should do this. On 5/03/18 at 5:35 p conducted with LPN When asked the pur #1 stated that the pur #1 stated that the pur serve as a guide to the When asked who has LPN #1 stated that a to the care plan. When ot follow the care p the care plan is not p current status." On 5/04/18 at 9:30 a conducted with ASM member) #2, the DC When asked about to administering a pr stated that staff shou assessment that inclocation, and intensit that this information the pain log (pain flo could determine whe pain flow sheet was the unit manager con that the pain flow should be the staff should be the should be the should be the unit manager conthat the pain flow should be the s	eximately 5:30 p.m., an acted with Resident #30. ty staff assess her pain before ication, Resident #30 stated ask her pain level and the 30 stated that staff never a follow up assessment on her stated that she thought staff o.m., an interview was (licensed practical nurse) #1. rpose of the care plan, LPN upose of the care plan was to take care of the residents. ad access to the care plan, all licensed staff had access teen asked if was ever ok to lan, LPN #1 stated, "Only if reflecting the resident's a.m., an interview was (administrative staff DN (Director of Nursing). he process staff follows prior in pain medication, ASM #2 uld be conducted a pain ludes the duration of pain, by of pain. ASM #2 stated should be documented on w sheet). When asked if she ere Resident #30's April 2018 located, ASM #2 stated that uld not find it. ASM #2 stated that she could not						

Event ID: 3FC711

Facility ID: VA0402

If continuation sheet Page 42 of 112

PRINTED: 05/10/2018

DEPAF		ND HUMAN SERVICES			PRI	NTED: 05/11/2018
	RS FOR MEDICARE &					
STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3)	NO. 0938-0391 DATE SURVEY COMPLETED
	24-19-12-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1	495401	B. WING			
NAME OF	PROVIDER OR SUPPLIER		I	STREET ADDRESS, CITY, STATE		05/04/2018
TYLER'S	RETREAT AT IRON BRID	GE		12001 IRON BRIDGE RD	=, ZIP CODE	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		CHESTER, VA 23831		
PREFIX	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIN CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD BE ID TO THE APPROPRIATE ICIENCY)	(X5) COMPLETION DATE
	determine if nursing st and forgot to documer ASM #2 stated that sh stated, "They probably documentation of the a if Resident #30's care stated, "We don't have followed." On 5/03/18 at 10:39 a. staff member) #1, the a aware of the above con No further information of Care Plan Timing and H CFR(s): 483.21(b)(2)(i) §483.21(b) Comprehen §483.21(b)(2) A compre- be- (i) Developed within 7 of the comprehensive ass (ii) Prepared by an inter includes but is not limited (A) The attending physic (B) A registered nurse of resident. (C) A nurse aide with re- resident. (D) A member of food and (E) To the extent practic the resident and the resident An explanation must be	taff did the pain assessment th, or if it was not done. the could not say. ASM #2 or missed the actual assessment." When asked plan was followed, ASM #2 the anything saying it was m., ASM (administrative administrator was made merrs. was presented prior to exit. Revision -(iii) usive Care Plans thensive care plan must lays after completion of essment. disciplinary team, that ad to cian. with responsibility for the sponsibility for the and nutrition services staff. able, the participation of ident's representative(s).	F 6	056	re plan was updated on 2/9/18. plan was revised ogram. risk for the deficient e license nursing staff wing care plan ng or designee will and care plan is g or designee will audi g plans on care plan to red 3 x weekly for 2 or designee will e audits to the QAPI	t
	and their resident repres not practicable for the de resident's care plan. (F) Other appropriate sta	sentative is determined evelopment of the		d. Audit results / trend QAPI meeting to ensu are effective. Addition be done as needed.	ls will be reviewed at are that Action Plans	
	02-99) Previous Versions Obsolete					6/4/18

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 05/10/2018 APPROVED
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			O IPLE CONSTRUCTION IG	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
		495401	B. WING	€		05	/04/2018
NAME OF I	PROVIDER OR SUPPLIER			Γ	STREET ADDRESS, CITY, STATE, ZIP CODE		04/2010
TYLER'S	RETREAT AT IRON E	BRIDGE			12001 IRON BRIDGE RD CHESTER, VA 23831		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 657	disciplines as detern or as requested by f (iii)Reviewed and re- team after each ass comprehensive and assessments. This REQUIREMEN by: Based on staff inter- facility document rev- review, it was detern failed to review and care plan for two of sample, Resident #6 1. The facility staff fa comprehensive care Resident #62. 2. The facility staff fa comprehensive care initially on a toileting non-complaint with h The findings include 1. The facility staff fa comprehensive care Resident #62. The facility staff fa comprehensive care initially on a toileting non-complaint with h The findings include 1. The facility staff fa comprehensive care Resident #62. Resident #62 was ac 9/13/17 with diagnos limited to: repeated f pressure and demer	mined by the resident's needs the resident. vised by the interdisciplinary ressment, including both the quarterly review IT is not met as evidenced view, resident interview, view and clinical record mined that the facility staff revise the comprehensive 36 residents in the survey 52 and #19. ailed to review and revise the e plan after the 2/9/18 fall for failed to revise Resident #19's e plan to reflect she was program and was her toileting program. ailed to review and revise the plan after the 2/9/18 fall for dmitted to the facility on ses that included but were not falls, diabetes, high blood	F	65	7		

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DEPAR	MENT OF HEALTH	P		: 05/10/2018			
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			C		APPROVED . 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DAT	E SURVEY IPLETED
		495401	B. WING	;		05/	04/2018
NAME OF I	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u>.</u>	
TYLER'S	RETREAT AT IRON E	BRIDGE			2001 IRON BRIDGE RD		
(24.0.15			1		CHESTER, VA 23831		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) - COMPLETION DATE
F 657	Continued From page	ae 44	F	657			
		scored a four out of 15 on the		501			
		w for mental status) indicating					
		verely impaired cognitively. oded as requiring assistance					
	from staff for all acti	vities of daily living with the					
	exception of eating perform after the tra	which the resident could					
	perform after the tra	iy was set up.					
	Review of the 2/9/18	3 nurse's note documented,					
		sident observed on floor in the bell within reach but not on.					
	No injures noted, As	ssisted off floor by staff. t he was attempting to do."					
	9/14/17 and revised "Focus. Risk for Fall documented evidence	ent's care plan initiated on on 3/30/18 documented, ls." There was no ce that the comprehensive reviewed or revised following					
	fall investigation was (administrative staff administrator. On 5/	m. a request for the 2/9/18 s requested from ASM member) #1, the 3/18 at 4:45 p.m., ASM #1 t locate the fall investigation.					
	p.m., with LPN (licer resident's nurse. Wh care plans, LPN #1 s we need to do. To m scope of care." Whe plan, LPN #1 stated, asked when the care #1 stated, "If there w	nducted on 5/3/18 at 3:22 nsed practical nurse) #1, the nen asked why residents had stated, "Why? To review what take sure it's in line with their en asked who used the care , "We all use them." When e plan would be revised, LPN vas a change." When asked if anged, LPN #1 stated it					

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PRINTED: 05/10/2018

PRINTED: 05/10/2018 FORM APPROVED OMB NO. 0938-0391

DEPARTMENT	OF HEALTH AN	D HUMAN	SERVICES
CENTERS FOR	MEDICARE & I	MEDICAID	SERVICES

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		495401	B. WING			05/	04/2018
	PROVIDER OR SUPPLIER	BRIDGE		1	STREET ADDRESS, CITY, STATE, ZIP CODE 2001 IRON BRIDGE RD CHESTER, VA 23831		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF COR PREFIX (EACH CORRECTIVE ACTION I TAG CROSS-REFERENCED TO THE A DEFICIENCY)		IOULD BE COMPLÉTIC	
F 657	On 5/3/18 at 6:45 p and ASM #2, the di aware of the finding Review of the facilit documented, "POL care will be establis updated in accorda regulatory requirem basis. In states who applies, this will be assessment. Goals objective. PROCED familiar with each r approaches must b significant changes The Care Plan must days of new full MD to review the 24- H changes or change of daily living) statu coordinator will ado status to the existin Z) All direct care st understand and fol If unable to implem your Charge Nurse	ASM #1, the administrator rector of nursing were made gs. by's policy titled, "Care Plan" ICY: interdisciplinary plan of shed for every resident and nce with state and federal nents and on an as needed ere pre-admission screening coordinated with the facility must be measurable and DURE: D) All staff must be esident's Care Plan and all be implemented. G) In cases of in the resident's condition, at be updated within seven (7) DS. V) The MDS Coordinator is our Report daily for significant is in resident's ADSL (activities s. The Care Planning d minor changes in resident's ng Care Plans on daily basis. aff must always know, low their Resident's Care Plan. tent any part of the plan, notify or MDS Coordinator, so that ented or the Care Plan	F	657			
	(administrative stat nursing. When ask plans, ASM #2 stat we know their plan When asked who u "Every one of us."	onducted on 5/4/18 with ASM f member) #2, the director of ed why residents had care red, "Care plans, why. So that of care while they are here." used them, ASM #2 stated, When asked if the care plan a change in a resident's					

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Facility ID: VA0402

		AND HUMAN SERVICES		PRINTER	D: 05/10/2018				
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES					APPROVED 0. 0938-0391		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			IPLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED		
		495401	B. WING	÷		0.5	05/04/2018		
NAME OF I	PROVIDER OR SUPPLIER		1	Г	STREET ADDRESS, CITY, STATE, ZIP CODE		04/2018		
TYLER'S	RETREAT AT IRON E	BRIDGE			12001 IRON BRIDGE RD CHESTER, VA 23831				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC	ULD BE	(X5) COMPLETION DATE		
	Continued From par condition ASM #2 st No further information According to Funda Williams and Wilkin documented, "A write communication tool members that helps careThe nursing of information about the and goals. It contain achieving the goals and is used to direct revise and update the there are changes in with new orders" ((1) Fundamentals of & Wilkins 2007 Lipp pages 65-77. 2. The facility staff f comprehensive care initially on a toileting non-complaint with the Resident #19 was act 4/20/16 and readmitt diagnoses that include muscle weakness, ty anxiety disorder, and	ge 46 tated, "Sure." on was provided prior to exit. mentals of Nursing Lippincott s 2007 pages 65-77 ten care plan serves as a among health care team ensure continuity of are plan is a vital source of e patient's problems, needs, ns detailed instructions for established for the patient careexpect to review, he care plan regularly, when n condition, treatments, and 1) Nursing Lippincott Williams incott Company Philadelphia ailed to revise Resident #19's plan to reflect she was program and was her toileting program. dmitted to the facility on ted on 8/15/17 with ded but were not limited to /pe two diabetes mellitus, d status post stroke.	F		DEFICIENCY)				
	set) assessment was an ARD (assessmen Resident #19 was co impaired of cognitive	recent MDS (minimum data s a quarterly assessment with it reference date) of 2/20/18. oded as being moderately function scoring 08 out of 15 iterview for Mental Status)							

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Facility ID: VA0402

DEPA	RTMENT OF HEALTH	AND HUMAN SERVICES				PRINTE	D: 05/10/2018
CENT	ERS FOR MEDICARE	& MEDICAID SERVICES				FOR	MAPPROVED
STATEME	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		CONSTRUCTION	OMB NC (X3) DA	D. 0938-0391 TE SURVEY MPLETED
		495401	B. WING	G			
NAME O	F PROVIDER OR SUPPLIER					05	/04/2018
					EET ADDRESS, CITY, STATE, ZIP CODE		
ILEK	'S RETREAT AT IRON E	BRIDGE					
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES			ESTER, VA 23831		
PRÉFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREF TAG	FIX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 657	Continued From page	20.47					
	e en andea i rom pau		Fe	657			
	frequently incenting	9 was coded as being					
	requiring limited ass	nt of bowel and bladder and istance from one staff					
	member for toileting	istance from one staff					
	in the teneting	•					
	Review of Resident	#19's POS (physician order					
	sneet) dated 4/30/18	, documented the following					
	order: "loileting proc	Iram every 3 hours from 9					
	AM to 10 PM." This of	order was initiated on					
	3/26/18.						
	Deview of Devia			WWWWWWWWWWW			
	Review of Resident #	19's March 2018 restorative					
	staff wore implement	documented evidence that		-			
	stall were implement	ting the toileting program.					
	Resident #19's April ; program was missing record.	2018 restorative ambulation g from Resident #19's clinical					
•	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 f	or toileting was blank.					
	Review of Resident #	19's comprehensive care			•		
	plan dated 8/16/17 ar	nd revised 4/30/18, failed to					
	evidence that she wa	s on a toileting program.		:			
	On 5/3/18 at 9:40 a.m	n., an interview was		:			
	conducted with CNA	(certified nursing assistant) #					
	3, Resident #19's CN	A. When asked if Resident					
	#19 was on any speci	al toileting program, CNA #3					
	supposed to take her	CNA #3 stated, "We are					
	asked if nursing staff	every 3 hours." When document when they take					
	her to the bathroom	CNA #3 stated that they					
	documented on the re	estorative ambulation log.				-	
	CNA #3 presented to	this writer Resident #19's					
	May 2018 restorative	log. The log was					
	completely blank. Wh	en asked why the log was					
	67(02-99) Previous Versions Ob			Facility ID	F VA0402		
				. somy it	CVA0402 If continuation	1 sheet Par	70 18 of 110

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		(X1) PROVIDED/CURDUED/COM			UND N	O. 0938-039
AND PLA	N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION	(X3) D	ATE SURVEY
		495401	B. WING			
NAME (F PROVIDER OR SUPPLIER				0	5/04/2018
TYLEF	'S RETREAT AT IRON	BRIDGE		STREET ADDRESS, CITY, STATE, ZIP CODE 12001 IRON BRIDGE RD CHESTER, VA 23831	:	*
(X4) ID		ATEMENT OF DEFICIENCIES	ID			
PREFI) TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		NUDDE	(X5) COMPLETION DATE
F 65	7 Continued From		1			
	o ornandou i forn pa		Fe	57		
	DIARK, CNA #3 state	ed that Resident #19 always				
	#3 stated that the r	bathroom when asked. CNA esident will say she does not				
	have to go and that	she can take herself. When				
	asked if she docum	ented this refusal, CNA #3				
	stated, "No." CNA #	3 stated that it was blank for				
	I that day 5/3/18 beca	ause she had not had a				
	chance to see the re	esident yet.				
	On 5/2/19 at 10:04					
	Conducted with Res	o.m., an interview was ident #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 r	need staff coming in here to				
	telling me when to g	o to the bathroom."				
	On 5/2/19 at 2:24 m					
	On 5/3/18 at 2:34 p.	m., an interview was (licensed practical nurse) #4,				
	Resident #19's nurse	e. When asked about				
	Resident #19's bowe	el and bladder status, LPN #4				
	stated that Resident	#19 was incontinent though				
	the resident thought	she was very continent I PN				
	#4 stated that Reside	ent #19 needs a lot of				
	stated that Desident	omes to toileting. LPN #4				
	her toileting program	#19 was non-complaint with . When asked if Resident				
	#19's non-compliance	e with her toileting schedule				
	was documented any	where, LPN #4 stated it may		1		
	have been in a nursir	ng note. When asked if she		Ì		
	would expect to see t	he toileting program and				
	Resident #19's non-c	ompliance on the care plan				
	LPN #4 stated that sh	ne would expect that				
	#4 stated that Reside	ated on the care plan. LPN nt #19 was just recently				
	placed back on a toile	eting schedule.				
	Review of Resident #	19's nursing notes failed to				
	evidence any docume	entation that she was				
	non-complaint with he	r toiloting a			ł	1

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STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	IPLE CONSTRUCTION	<u>OMB NC</u> (X3) DA	M APPROV D. 0938-03 TE SURVEY
		DENTINOATION NOWBER.	A. BUILDIN	NG	со	MPLETED
		495401	B. WING		05	/04/2018
	PROVIDER OR SUPPLIER	BRIDGE		STREET ADDRESS, CITY, STATE, ZIP CODE 12001 IRON BRIDGE RD CHESTER, VA 23831		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION	D BE	(X5) COMPLETIC DATE
F 657	Continued From page	ge 49	F 65	7		
	ASM #2 stated the to the care plan, becau reflect the resident's also stated that she plan document her n program. ASM #2 sta IDT (interdisciplinary review or revise the o anyone caring for the care plan. ASM #2 s	ON (Director of Nursing). Dileting program should be on set the care plan was to current condition. ASM #2 would expect to see the care on-compliance with the ated that all members of the team could develop and care plan. ASM #2 stated that e resident had access to the tated that the unit manager ne April 2018 restorative				
	On 5/4/18 at 10:39 a. staff member) #1, the aware of the above c	m., ASM (administrative administrator was made oncerns.				
	No further information	n was presented prior to exit.				
	Williams and Wilkins documented, "A writte communication tool a members that helps e careThe nursing car	en care plan serves as a mong health care team insure continuity of re plan is a vital source of				
i a a r t	nformation about the and goals. It contains achieving the goals es and is used to direct c evise and update the here are changes in c	patient's problems, needs, detailed instructions for stablished for the patient areexpect to review, care plan regularly, when condition, treatments, and		F-658 1. Physician order obtained for oxygen for resident # 50. Pain medication order was clarified for		
F 658 S	vith new orders" Services Provided Me CFR(s): 483.21(b)(3)(i	et Professional Standards)	F 658	resident # 30. Resident #36 medication order was corrected of 4-18.		

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TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES	1			(3) DATE S COMPL		
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _		COMPL	EILU	
		495401	B. WING			05/04	/2018	
NAME OF I	PROVIDER OR SUPPLIER		T	ST	REET ADDRESS, CITY, STATE, ZIP CODE			
TYLER'S	RETREAT AT IRON I	BRIDGE		12001 IRON BRIDGE RD CHESTER, VA 23831				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		(X5) OMPLETIO DATE	
			F 6	58	2.a. 100% audit of residents	at		
F 658	Continued From pa	ige 50	ГО	50	receiving Oxygen to identify any risk for this deficient practice.	ai		
	§483.21(b)(3) Com	prehensive Care Plans			b. Residents with pain medication	n		
	The services provid	led or arranged by the facility,			orders are at risk for this deficient			
		comprehensive care plan,			practice.			
	must- (i) Meet profession:	al standards of quality.			c. Residents with orders for Blood	d		
	This REQUIREMEN	NT is not met as evidenced			Sugar monitoring are at risk for the	his		
	by:				deficient practice.			
	Based on observat	tion, staff interview, facility nd clinical record review, it			d. All residents are at risk for issu	ues		
	was determined the	e facility staff failed to follow			related to hand washing with			
	professional standa	ards of practice for four of 36			medication pass.			
	residents in the sur	vey sample, Resident #50,			e. All residents are at risk for this	5		
	#70, #36 and #30.				deficient practice during			
	1. The facility staff	failed to obtain a physician's			recapitulation of physician orders	1		
	order for oxygen fo	r Resident #50.			3. Director of Nursing or designe	1		
		failed to wook their bonds after			will in service licensed nursing st			
	2. The facility start	failed to wash their hands after to Resident #70 and before			regarding obtaining oxygen order	rs,		
	taking a blood suga	ar reading from Resident #62.			hand washing protocols with			
	-				medication pass and obtaining a blood sugar, and reviewing month	hlv		
	3. The facility staff	failed to follow professional ce for the recapitulation of			orders.	iny		
	Resident #36's phy	sician orders.			4. a. Unit Manager or designee w	vill		
					audit 3 medication passes weekly	1		
	4. The facility staff	failed to clarify Resident #30's			months to ensure handwashing is			
	medication orders				done per protocol.			
					b. Director of Nursing or designe			
	The findings includ	e:			will audit new medication orders	1		
	1 The facility staff	failed to obtain a physician's			ensure orders are clear and oxyg	1		
	order for oxygen fo	r Resident #50.			ordered if appropriate x 2 months	-		
					c. Unit Manager or designee will			
	Resident #50 was a	admitted to the facility on itted on 4/20/18 with			audit obtaining blood sugars 3x			
	diagnoses that include	uded but were not limited to:			weekly x 2 months to ensure prop	per		
	pneumonia, acute i	respiratory failure, high blood			hand washing technique is used.			

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AND PLAI	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			F	TED: 05/10/20 ORM APPROV
		IDENTIFICATION NUMBER:	A. BUILDI	TIPLE CONSTRUCTION	(X:	NO. 0938-03
NAME OF	PROVIDER OR SUPPLIEF	495401	B. WING			COMPLETED
				STREET ADDRESS, CITY, STATE, ZIP CODE		05/04/2018
	S RETREAT AT IRON	BRIDGE		12001 IRON BRIDGE RD		
(X4) ID PREFIX	SUMMARY ST	ATEMENT OF DEFICIENCIES		CHESTER, VA 23831		
TAG	REGULATORY OR I	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)		(X5) COMPLETIO DATE
F 658	Continued From pa	ige 51				
	pressure and chron	lic pain syndrome	F 658	d. Unit Managers or designee	will	
				audit 100% of physician order ensure orders are transcribe co x5 week x 2months	s to	
	review.	num data set available for		x5 week x 2months.	rrectly	
	Review of the 3/12/1	8 nurse's admission		e. Unit Managers will report the results of the aveluation of the second s		
1						1
		ned that the resident was nes three, indicating the e was, where he was and			-	
1	what year it was.	e was, where he was and				
	An observation			To vie wed at () A Dr mast		6/4/18
		nade on 5/2/18 at 8:40 a.m. resident was sitting on the				0/4/18
S	ide of the bed. There	Was an oxygen		Additional action plans will be as needed.	done	
1 -				as needed.		
na	asal cannula (soft pl	astic president took his				
DE	edside railing and pu	t it on.				
Ar	observation was ma	ade on 5/3/18 at 8:20 a.m.				
			"With other states and state			
		nd was set at two liters per nula was hanging over the				
Re	view of the resident's	care plan initiated on				
		resp (respiratory) failure. roxygen as ordered."				
orde	new of the April and Mers did not oviden	May 2018 physician's				
1.	in the not evidence a	an order for oxygen.				
Revi	ew of the nurse's no	tes dated 4/21/18 at				
	8 a.m. documented, al Cannula."	"Method: Oxygen via				
Nasa						

Event ID: 3FC711 .

Facility ID: VA0402

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					FOD): 05/10/2018
CENTERS FOR MEDICARE & M		-		C	MB NC	APPROVED 0.0938-0391
STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		PLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
	495401	B. WING	ə		0.5	04/2040
NAME OF PROVIDER OR SUPPLIER			Γ	STREET ADDRESS, CITY, STATE, ZIP CODE	1 05	/04/2018
TYLER'S RETREAT AT IRON BRID	GE			12001 IRON BRIDGE RD CHESTER, VA 23831		
PREFIX (EACH DEFICIENCY MUS	ENT OF DEFICIENCIES BT BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
p.m., with LPN (licensed resident's nurse. When a considered a medication When asked if staff were oxygen without an order When asked about Resi #3 stated, "He doesn't ha so someone put him on LPN #3 stated, "He typic When asked if there sho resident's oxygen, LPN # On 5/3/18 at 6:45 p.m. A member) #1, the adminis director of nursing were findings.	otes dated 4/22/18 at d, "Method: Oxygen via acted on 5/03/18 at 12:19 d practical nurse) #3, the asked if oxygen was n, LPN #3 stated it was. e allowed to administer r, LPN #3 stated, "No." ident #50's oxygen, LPN have an order for oxygen it maybe for comfort." cally is not wearing it." buld be an order for the #3 stated, "Yes." ASM (administrative staff strator and ASM #2, the made aware of the a request for the facility's y was requested from er) #1, the medical cted on 5/04/18 at 8:30 irector of nursing. When hsidered a medication, hen asked if staff could ut an order, ASM #2 vays call the doctor and ASM #3, the regional	F	658	· · · · · · · · · · · · · · · · · · ·		

	RS FOR MEDICAR	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	()(7) 1 1 1 1 -		OMB NO	M APPROV D. 0938-03
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		ATE SURVEY
		495401	B. WING		0	5/04/2018
NAME OF	PROVIDER OR SUPPLIEF	2		STREET ADDRESS, CITY, STATE, ZIP	CODE	J/04/2010
TYLER'S	S RETREAT AT IRON	BRIDGE		12001 IRON BRIDGE RD CHESTER, VA 23831		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	RRECTION	
PREFIX TAG	(EACH DEFICIENC REGULATORY OR	EY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE	(X5) COMPLETI DATE
F 658			F 65	8		
	No further informa	tion was obtained prior to exit.				
	According to Fund Potter, 6th edition.	amentals of Nursing, Perry and page 1122, Oxygen should be				
	treated as a drug.	It has dangerous side effects.				
	such as atelectasis	s or oxygen toxicity. As with				
	should be continue	ge or concentration of oxygen usly monitored. The nurse				
	should routinely ch	eck the physician's orders to				
	verify that the clien	t is receiving the prescribed on. The six rights of				
	medication adminis	stration also pertain to oxygen				
	administration."	, , ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
	giving medications	failed to wash their hands after to Resident #70 and before				
		ar reading from Resident #62.				
	12/2/17 with diagno limited to: irregular	admitted to the facility on pses that included but were not heartbeat, dementia, high				
	blood pressure and	difficulty swallowing.				
	The most recent M	DS (minimum data set), a				
	reference date) of 4	ent, with an ARD (assessment //13/18 coded the resident as				
	having scored a ser	ven out of 15 on the BIMS				
	(brief interview for r	nental status) indicating the ely impaired cognitively. The				
	resident was coded	as requiring assistance from				
	staff for all activities	of daily living except for				
	tray was set up. The	sident could perform after the eresident was coded as				
	having a feeding tul	De.				
	9/13/17 with diagno	dmitted to the facility on ses that included but were not				
	innited to: repeated	falls, diabetes, high blood			venuer in de	

CENTERS FOR MEDICARE & MEDICAID SERVICES CM PROVERSUPPLIERLANDING (X) MULTIPLE CONSTRUCTION (X) MULTIPLE CONSTRUCTION A BULDNO 495401 (X) MULTIPLE CONSTRUCTION (X) MULTIPLE CONSTRUCTION (X) MULTIPLE CONSTRUCTION NAME OF PROVIDER OR SUPPLIER 495401 (X) MULTIPLE CONSTRUCTION (X) MULTIPLE CONSTRUCTION (X) MULTIPLE CONSTRUCTION TYLERS RETREAT AT IRON BRIDGE SUMMARY STATEMENT OF DEFICIENCIES (X) MULTIPLE CONSTRUCTION (X) MULTIPLE CONSTRUCTION (X) MULTIPLE CONSTRUCTION CM10 SUMMARY STATEMENT OF DEFICIENCIES (X) MULTIPLE CONSTRUCTION (X) MULTIPLE CONSTRUCTION (X) MULTIPLE CONSTRUCTION CM10 SUMMARY STATEMENT OF DEFICIENCIES (X) MULTIPLE CONSTRUCTION AND CORRECTION (X) MULTIPLE CONSTRUCTION (X) MULTIPLE CONSTRUCTION CM10 SUMMARY STATEMENT OF DEFICIENCIES (X) MULTIPLE CONSTRUCTION AND CORRECTION (X) MULTIPLE CONSTRUCTION (X) MULTIPLE CONSTRUCTION F658 Continued From page 54 (X) MULTIPLE CONSTRUCTION AND CORRECTION AND CORRECTIVE ACTION SHOULD BE (X) MULTIPLE CONSTRUCTION AND CORRECTIVE ACTION SHOULD BE (X) MULTIPLE CONSTRUCTION F658 Continued From page 54 (X) MULTIPLE CONSTRUCTIVE ACTION SHOULD BE (X) MULTIPLE CONSTRUCTIVE ACTION SHOULD BE (X) MULTIPLE CONSTRUCTION F658	DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES				PRINTE	D: 05/10/2018	
AND PLAN OP CORRECTION (A) Includes SUPPLIER (A) UNLIPLE CONSTRUCTION (A) UNLIPLE CONSTRUCTION MAME OF PROVIDER OR SUPPLIER 495401 a wina (C) ONE RIDGE (C) ONE RIDGE CONSTRUCTION TYLER'S RETREAT AT IRON BRIDGE STREET ADDRESS, CITY, STATE, 2UP CODE (C) OS (C) OLD REDGE CODE 05/04/2018 (PA) (D) REDGE VIER SUMMARY STATEMENT OF DEFICIENCES (C) OLD REDGE CODE PROVIDER'S FLAN OF CORRECTION (PA) (D) REDGE VIER SUMMARY STATEMENT OF DEFICIENCES (C) OLD REDGE CODE PROVIDER'S FLAN OF CORRECTION (PA) (D) REDGE VIERY FOR NUMBER PERFECTION INFORMATION PROVIDER'S FLAN OF CORRECTION OF CORRECTION (C) OLD REDGE CODE (PA) (D) REDGE VIERY FOR NUMBER PERFECTION OF DEFICIENCES (C) OLD REDGE CODE (C) OLD REDGE CODE (PA) (D) REDGE VIERY FOR NUMBER PERFECTION INFORMATION PROVIDER'S FLAN OF CORRECTION OF DEFICIENCES (C) OLD REDGE CODE (PA) (D) REDGE VIERY FOR NUMBER PERFECTION INFORMATION PROVIDER'S FLAN OF CORRECTION TO THE ADDRESS (C) TO THE APPROPRIATE (C) OLD REDGE CODE (PA) (D) REDGE CODE F 658 F 658 F 658 F 658 (PA) (D) REDGE CODE STOME CODE F 658 F 658 F 658 C CONTINUE REDGE CODE (PA) (R) REDGE CODE STOME CODE F 658 F 658	CENTE	RS FOR MEDICARE	& MEDICAID SERVICES						
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AVID TUREYS RETREAT AT IRON BRIDGE STREET AND ROUGES. CITY. STREET 20 CODE CMUD SUMMAY STATEMENT OF DEFICIENCIES D PRETX TAG SUMMAY STATEMENT OF DEFICIENCIES D PRETX TAG CAND DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PRETX REGULATORY OR LSC IDENTIFYING INFORMATION INFORM			495401	B. WING	G				
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(04)10 TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST EREPRECEDED BY FULL PEGUAL DEFICIENCY Image: Comparison of the compariso	TYLER'S	RETREAT AT IRON E	BRIDGE			12001 IRON BRIDGE RD			
PREEX IEAD DEFICIENCY MIG REPRECEDED BY FULL PREEX FEAD CORPERTING INFORMATION CONTINUED THE APPROPRIATE	(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	10	L	-			
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 56 on the BIMS (brief interview for mental status) indicating the resident was severely impaired cognitively. The resident was severely impaired cognitively. 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 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 tak 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 cart, removed her gloves, wiped off the monitor and put it back into the cart.		(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREF	IX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	DBE	COMPLETION	
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. An observation 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 mith the exceptions in appleauce into the resident's room and administered the medications by mouth to the resident #70. The nurse took the medications in appleauce into the resident a cup of water after giving 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 versident is blood sugar. The lancet did not pierce the resident's skin so LPN #1 then we taking the cart keys out and obtained another lancet and returned to the resident's hood sugar. LPN #1 then obtained another lancet and returned to the cart, removed her gloves, wiped off the monitor and put it back into the cart.	F 658	Continued From page	ge 54	E	65	0			
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 ecoded 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 santitze 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 from the cart. LPN #1 then obtained another lancet and returned to the resident's norm. LPN #1 then obtained another lancet and returned to the resident's norm. LPN #1 then obtained another lancet and returned to the cart, removed her gloves, wiped off the monitor and put it back into the cart.				r (000	0			
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		off the monitor and pu	ut it back into the cart.						
a mail with the conducted on oron at 5.50									

Event ID: 3FC711

Facility ID: VA0402

If continuation sheet Page 55 of 112

		AND HUMAN SERVICES				FORM	: 05/10/2018 APPROVED . 0938-0391	
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		LE CONSTRUCTION	(X3) DA1	TE SURVEY MPLETED	
		495401	B. WING	;		05/04/2018		
NAME OF	PROVIDER OR SUPPLIER			5	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00		
TYLER'S	S RETREAT AT IRON I	BRIDGE			2001 IRON BRIDGE RD CHESTER, VA 23831			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 658	 p.m. with LPN #1, r their hands. LPN # and I didn't do it be and #62)." When as their gloved hands stated, "I should ha issue. It's contamin On 5/3/18 at 6:45 p member) #1, the ac director of nursing v findings. An interview was co a.m. with ASM #2. V their hands, ASM # in-between activitie should do after they their pockets, ASM their gloves off even Review of the facilit Washing" document is the most importation the spread of infect replace the need for rubbing or hand wa Perform hand-hygie direct contact with r gloves c. Before ha (regardless of whet resident care." 	egarding when staff washed 1 stated, "Between patients tween (names of Resident #70 sked what staff did if they put into their pockets, LPN #1 ve re-gloved. It's a safety ation." .m. ASM (administrative staff dministrator and ASM #2, the were made aware of the onducted on 5/4/18 at 8:30 When asked when staff wash 2 stated, "Before, after and s." When asked what staff y put their gloved hands in #2 stated, "They should take ty time." y's policy titled, "Hand ted, "POLICY: Hand washing nt component for preventing ion. Use of gloves does not r hand cleaning by either hand shing. PROCEDURE: 3. ene: a. Before and after having esidents b. After removing ndling an invasive device her or not gloves are used) for	F	658				
	3. The facility staff f	on was provided prior to exit. ailed to follow professional a for the recapitulation of						

Facility ID: VA0402

If continuation sheet Page 56 of 112

	H AND HUMAN SERVICES				FORM	: 05/10/2018 APPROVED . 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION	(X3) DAT	E SURVEY
	495401	B. WING			0.5	/04/2018
NAME OF PROVIDER OR SUPPLIE	R	ľ	ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 001	04/2010
TYLER'S RETREAT AT IRON	I BRIDGE	,		2001 IRON BRIDGE RD HESTER, VA 23831		
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 658 Continued From	page 56	F 6	58			
11/14/17 with diag not limited to: hig	admitted to the facility on gnoses that included but were n blood pressure, osteoporosis, story of pulmonary embolus					
assessment, a qu assessment refer resident as scorir interview for men was capable of m decisions. Reside	MDS (minimum data set) arterly assessment, with an ence date of 3/4/18, coded the g a 15 on the BIMS (brief tal status) score, indicating she aking her cognitive daily nt #36 was coded as requiring ost of her activities of daily					
revealed docume (milligrams) po (b	rsician's orders dated 4/26/18, nted, "Coumadin* 10 mg y mouth) qd (every day) @ (at) y thru Sat (Saturday). Coumadin n. on Sunday."					
treatment of veno extension, pulmor for Patients -Advis	arin) is used in prophylaxis and us thrombosis and its nary embolism (PE). Instructions se patients to: Strictly adhere to sage schedule. (1)					
administration rec	April 2018 MAR (medication ord) documented, "Coumadin Monday thru Sat. Coumadin 15 ry) Sunday."					
	May 2018 MAR documented, tablet; take 1 tab (tablet) by ing."					
On 5/4/18 at 8:45	a.m., with RN (registered					

If continuation sheet Page 57 of 112

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	05/10/2018 APPROVED 0938-0391
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495401	B. WING) 		05/	04/2018
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	<u></u>	
TYLER'S	RETREAT AT IRON E	BRIDGE			12001 IRON BRIDGE RD CHESTER, VA 23831		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 658	nurse) #1, the unit r orders for Resident reviewed with RN # administration record The May MAR was stated, "This is a tra- who is responsible of the end of the mont stated, "It's usually (manager) and myse nurses on the unit." The facility policy, "F of Computerized Ph documented in part, facility staff, medical separated by room a according to resider Corrections, addition computerized medic a licensed nurse, fac an authorized desig should accompany to computerized medic including demograp interchange informa POS (physician orde appropriate Medicatt documentation is re members who make POS should sign an the written correction record by facility sta further changes in p the ten-current med computerized medic the new month. On designated date Fac	nanager. The physician #36's Coumadin were 1. The April MAR (medication 'd) was reviewed with RN #1. reviewed with RN #1. RN #1 inscription error." When asked for comparing the orders at h for the next month, RN #1 RN #3 - the other unit eff. We get help from different That's a transcription error." Recapitulation/Reconciliation armacy Records" "2. Once received by the I record documents should be number and collated ht room number and name. 3. hs, and changes to the cal record should be made by cility medical records staff or nee. The original order date written entries to the cal record. Changes, hic, clinical and therapeutic tion, should be made on the er summary) and to the ion Record Form when such quired. Facility staff e hand-written changes to the d date all entries. 4. Once ns are made to the medical ff, facility should maintain any hysician/prescriber orders in	F	658			

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Event ID: 3FC711

Facility ID: VA0402

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		AND HUMAN SERVICES				PRINTED FORM): 05/10/2018 1 APPROVED	
		& MEDICAID SERVICES					. 0938-0391	
	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE		IPLE CONSTRUCTION		TE SURVEY MPLETED	
		495401	B. WING)		05/04/2018		
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
TYLER'S	RETREAT AT IRON E	BRIDGE			12001 IRON BRIDGE RD CHESTER, VA 23831			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 658	individual and perm first business day of agreed upon with pl the corrected copy of pharmacy for immed medical records corr changes, correction to the medical recorr the attending physic is signed, no change POS above the atter line." ASM (administrative administrator, ASM ASM #4, the regional were made aware of at 10:40 a.m. No further information following website: https://dailymed.nlm m?setid=d91934a0- b6& 4. The facility staff fa medication orders for Resident #30 was an 8/24/17 and readmitt diagnoses that inclu- type two diabetes, n- unspecified dementi disturbance. Resider	anent medical record. On the f the month or on a date narmacy, Facility should return of the computerized POS to diate correction in pharmacy's nputer system. 5. Written s and additions may be made d until the time it is signed by ian. Once the medical record es should be made to the nding physician signature e staff member) #1, the #2, the director of nursing and al director of clinical services, f the above concern on 5/4/18 on was provided prior to exit. was obtained from the .nih.gov/dailymed/drugInfo.cf 902e-c26c-23ca-d5accc4151 ailed to clarify Resident #30's	F	65				

Event ID: 3FC711

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Facility ID: VA0402

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 05 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SI COMPLE	SURVEY
495401 B. WING 05/04/	1/2018
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 SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE contractive actine contractive actine should be contr	(X5) COMPLETION DATE
 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 000 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., 4/12/18 at 1:00 a.m., 4/22/18 at 1:2:00 a.m., 4/23/18 at 1:00 a.m., and 4/30/18 at 2:00 a.m., 4/23/18 at 1:2:00 a.m., and 4/30/18 at 2:00 a.m., 4/23/18 at 1:2:00 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. 	

Facility ID: VA0402

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	MENT OF HEALTH	AND HUMAN SERVICES				FORM /	05/10/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE		PLE CONSTRUCTION G	(X3) DATE COMF	SURVEY PLETED
		495401	B. WING			05/0	04/2018
NAME OF F	ROVIDER OR SUPPLIER	L			STREET ADDRESS, CITY, STATE, ZIP CODE 12001 IRON BRIDGE RD		
TYLER'S	RETREAT AT IRON I	BRIDGE		1	CHESTER, VA 23831		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	۶IX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 658	a resident has with pain medication or instructions for who administered, LPN usually had a pain #4 stated that if the scale attached to in Tylenol first (the le if the Tylenol was in this also depended When asked if nur determine which p administered at the stated no. LPN #4 been clarified. LP instructions to give may have a differe #4 stated that mile on a scale from 1- On 5/4/18 at 9:30 conducted with AS member) #2, the I When asked about a resident has two pain medication of be administered, medication orders ASM #2 stated the pain scale then the nurses to decide #2 stated the ord given for mild pain meant, ASM #2 stated the pain flow she	t the process staff follows when two different PRN (as needed) ders (Norco and Tylenol) and en each medication should be #4 stated that pain orders scale attached to them. LPN e order did not have a pain t, she would administer the ast strong) and then the Norco neffective. LPN #4 stated that d on the resident's pain level. rese were legally able to bain, medication should be eir own discretion, LPN #4 4 stated the orders should have N #4 stated the Tylenol had e for mild pain, but that nurses ent perception of mild pain. LPN d pain to her was a pain of five	t	65			Page 61 of 11

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Facaity ID: VA0402

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION	(X3) DATI	E SURVEY PLETED
		495401	B. WING		05/	04/2018
NAME OF F	PROVIDER OR SUPPLIER		• _	STREET ADDRESS, CITY, STATE, ZIP CODE		
TYLER'S	RETREAT AT IRON E	BRIDGE		12001 IRON BRIDGE RD CHESTER, VA 23831		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		D BE	(X5) COMPLETION DATE
F 658 F 684 SS=D	Continued From pa less than five on a s On 5/4/18 at 10:39 staff member) #1, th aware of the above that the facility used reference. No furth prior to exit. In "Complete Guide edition, 2008; Lippin page 318. "If you be in error, you must re receive clarification. Quality of Care CFR(s): 483.25 § 483.25 Quality of Quality of care is a applies to all treatm facility residents. Ba assessment of a rest that residents receive accordance with pro practice, the compro- care plan, and the re This REQUIREMEN by: Based on observat interview, facility do record review, it was	ge 61 scale from 1-10. a.m., ASM (administrative he administrator was made concerns. ASM #1 stated 1 Lippincott as a professional er information was presented to Documentation," 2nd noott Williams and Wilkins; elieve a practitioner's order is efuse to carry it out until you " care fundamental principle that ent and care provided to ased on the comprehensive sident, the facility must ensure ve treatment and care in ofessional standards of ehensive person-centered esidents' choices. IT is not met as evidenced ion, resident interview, staff cument review and clinical s determined that the facility	F 68	DEFICIENCY)	octor wa continue lin at or lt on of es for r	
	staff failed to provid accordance with pro practice, the compre- care plan and the re	e care and treatments in ofessional standards of ehensive person-centered esident's choices for three of survey sample, Residents #		 b. Residents with medications via peg tube are at risk for the deficient practice. c. Residents with orders for an coverings are at risk for the depractice. 	m	

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Facility ID: VA0402

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PRINTED: 05/10/2018

DEPA	DEPARTMENT OF HEALTH AND HUMAN SERVICES								
		& MEDICAID SERVICES			0		APPROVED . 0938-0391		
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		PLE CONSTRUCTION 3	(X3) DAT	E SURVEY MPLETED		
		495401	B. WING	Э		05/	/04/2018		
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE				
TYLER	S RETREAT AT IRON E	RIDGE			12001 IRON BRIDGE RD				
			I		CHESTER, VA 23831				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE RIATE	(X5) COMPLETION DATE		
					3.a. Director of Nursing or desi	gnee			
F 684			F 6	684	will inservice license nursing st	aff on			
	1. The facility staff fa	ailed to administer Resident			administering Coumadin and				
	#30 S Courriadin per	the physician order.			obtaining orders for administration	ting _			
	2. The facility staff fa	ailed to administer			medications via feeding tubes.				
	medications via the	feeding tube as ordered by			b. Director of Nursing or design	nee			
	the physician for Re	sident #70.			will in-service C.N.A's on appl	ying			
	3. The facility staff fa	ailed to apply protective arm			arm coverings. 4.a. Director of Nursing or design				
	covers as ordered by	y the physician for Resident	esident will audit Coumadin orders 5 x a						
	#25.				week for 2 months to ensure		6/4/18		
					medication is administered at				
	The findings include:	:			designated times.				
	1 The facility staff fo	iled to educidize Decident			b. Unit Manager or designee wil	1			
	#36's Coumadin* per	iled to administer Resident r the physician order.			audit medications administer via feeding tubes at designated time	L			
	*Coumadin (Warfarir	n) is used in prophylaxis and			weekly for 2 months.	5 5 A			
	treatment of venous				c. Unit Manager or designee wil	1			
		y embolism (PE). Instructions patients to: Strictly adhere to			audit resident with orders for arr	n			
	the prescribed dosag				coverings 3 x weekly for 2 mont	hs to			
	-				ensure they are applied.				
		mitted to the facility on ses that included but were			d. Unit Manager or designee will				
	not limited to: high bl	ood pressure, osteoporosis,			report the results of the audits to	the			
	gallstones and histor	of pulmonary embolus			QAPI committee monthly for 2 months.				
	(clot).	×							
	The most recent MDS	5 (minimum data set)			e. Audit results / trends will be				
	assessment, a quarte	erly assessment, with an			reviewed at QAPI meeting to ens that Action Plans are effective.	ure			
		e date of 3/4/18, coded the 15 on the BIMS (brief			Additional action plans are effective.				
	interview for mental s	tatus) score, indicating she			Additional action plans will be do as needed.	ne			
	was capable of makir	ng her cognitive daily							
		36 was coded as requiring							
	living.	of her activities of daily							
	-								

Facility ID: VA0402

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PRINTED: 05/10/2018

		AND HUMAN SERVICES				FORM	: 05/10/2018 APPROVED 0. 0938-0391
STATEMENT	S FOR MEDICARE OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •			(X3) DA	TE SURVEY MPLETED
	N.	495401	B. WING				/04/2018
NAME OF F	ROVIDER OR SUPPLIER	I		1	TREET ADDRESS, CITY, STATE,	ZIP CODE	
TYLER'S	RETREAT AT IRON	BRIDGE			CHESTER, VA 23831		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	'IX	PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLETION DATE
F 684	5/2/18 at 10:54 a.r (the facility) are sh their evening medi Review of the phys	onducted with Resident #36 on n. Resident #36 stated they ort staffed and they don't get cations on time. sician's orders dated 4/26/18,	F	684			
	revealed the follow "Coumadin 10 mg (every day) @ (at) (Saturday). Couma Sunday."	<i>v</i> ing order that documented, (milligrams) po (by mouth) qd 5 p.m., on Monday thru Sat adin 15 mg po @ 5 p.m., on					
	documented in pa for bleeding/bruisi tests) R/T (related	ve care plan dated, 4/26/18, rt, "Focus: Resident is at risk ng/abnormal labs (laboratory to) anticoagulant medication." " documented in part, "Provide ered."					
	5/3/18 starting at for the hall on whi There was no nur The nurse came to p.m. She pushed started to adminis	made of the nursing unit on 4:30 p.m. The medication cart ch Resident #36 was observed. se around the medication cart. to the medication cart at 5:32 the cart down the hallway and ster medications. At 5:33 p.m., s observed going to the dining					
	room on 5/3/18, f The resident did medication. At 6: dining room and towards her room	th Resident #36 in the dining rom 5:32 p.m. until 6:33 p.m. not receive her Coumadin 38 p.m., Resident #36 left the walked down the hallway n. She stopped and spoke with egistered nurse] #3.					
	On 5/3/18 at 6:39 (medication adm -2567(02-99) Previous Versi	9 p.m. a copy of the MAR inistration record) for May 2018, page Obsolete Event ID:3FC			Facility ID: VA0402	If continuation she	et Page 64 of 11

		AND HUMAN SERVICES				F	ORM AP	5/10/2018 PROVED 938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		PLE CONSTRUCTION	(X	3) DATE S COMPLE	
		495401	B. WING	3			05/04	/2018
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZI	P CODE		
TYLER'S	RETREAT AT IRON I	BRIDGE		1	12001 IRON BRIDGE RD CHESTER, VA 23831			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	٦X	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BI		(X5) OMPLETION DATE
F 684	was requested from member) #6, region The MAR documen mg tablet ; take 1 t evening." It was no administered on 5/ 5:00 p.m. On 5/4/18 at 8:40 at this surveyor that s until 8:04 p.m. An interview was c nurse) #5 on 5/4/12 administering med stated, "It can be g hour afterward." W medication not give #5 stated, "You are asked if Coumadin time every day, RN at the same time e levels (in the blood therapeutic." An interview was givin evening shift, RN the shift." When a resident medicatio "Yes." RN #3 was the medication can station at 5:30 p.m cart to the floor an returned and start insulin's before the	age 64 n ASM (administrative staff nal director of clinical services. hted, "Warfarin (Coumadin) 10 ab (tablet) by mouth every it documented as having been 3/18 at the scheduled time of a.m., Resident #36 informed she didn't get her Coumadin conducted with RN (registered 8 at 8:41 a.m., regarding ications as ordered. RN #5 given an hour before and an /hen asked what staff does if en during this time frame, RN e out of compliance." When n should be given the same N #5 stated, "It should be given every day. You want to keep the d) at the same level, conducted with RN # 3, a unit 8 at 8:44 a.m. When asked g medications on 5/3/18 on the #3 stated, "I was covering for sked if she administered all ons on time, RN #3 stated, informed of the observation of rt still sitting at the nurse's n. RN #3 stated, "I pulled my d then got called away. I then ed doing the blood sugars and e residents ate dinner. conducted with administrative		68	¥4			
FORM CMS-	2567(02-99) Previous Versio		11		Facility ID: VA0402	If continuatio	n sheet Pa	ige 65 of 11

DEPART		AND HUMAN SERVICES & MEDICAID SERVICES				FORM OMB NO.	05/10/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DAT COM	E SURVEY PLETED
		495401	B. WING			05/	04/2018
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE 01 IRON BRIDGE RD		
TYLER'S	RETREAT AT IRON I	BRIDGE		СН	ESTER, VA 23831		(X5)
(X4) ID PREFIX TAG		TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	COMPLETION DATE
F 684	staff member (ASM on 5/4/18 at 8:53 a medications should ordered." When as time, when should should be given or afterwards. When be given, ASM #2 give it in the eveni p.m." When asked when should it be "Between 4:00 p.r observation was s The facility policy, Medication Admin "5. During medica should take all me policy and applica limited to the follo medications withi policy." ASM #1, the adm of nursing and As clinical services, concern on 5/4/1 No further inform (1) This informat following website https://dailymed. m?setid=d91934 b6&	 <i>A</i>) #2, the director of nursing, I.m., regarding when d be given. ASM #2 stated, "As sked if the order is for a specific it be given, ASM #2 stated it the hour before or one hour asked when Coumadin should stated, "The preference is to a petween 5:00 p.m. and 6:00 d if it is ordered for 5:00 p.m. given, ASM #2 stated, n. and 6:00 p.m. The above thared with ASM #2. "General Dose Preparation and istration" documented in part, and 6:00 p.m. The above thared with ASM #2. "General Dose Preparation and istration" documented in part, and by facility staff easures required by facility able law, including, but not wing: 5.4 Administer an timeframes specified by facilitation was provided prior to exit. Son was obtained from the above 8 at 10:40 a.m. ation was provided prior to exit. Son was obtained from the above and a sordered by facility and the fact the feeding tube as ordered by resident #70. 	y sf i1	684	Facility ID: VA0402 If cor	ntinuation sho	eet Page 66 of 7

		AND HUMAN SERVICES				FORM A	05/10/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION	(X3) DATE SURVE COMPLETED	
		495401	B. WING			05/0	04/2018
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
TYLER'S	RETREAT AT IRON	BRIDGE			HESTER, VA 23831		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 684	Continued From pa	age 66	F	684			
	12/2/17 with diagned limited to: irregular blood pressure and The most recent M quarterly assessm reference date) of having scored a set (brief interview for resident was seve resident was code staff for all activitie eating which the re- tray was set up. Th having a feeding to An observation wa of LPN (licensed p Resident #70's roo- with medications in the mouth. An observation wa of LPN (licensed p medications to Re- medications in ap room and adminis to the resident.	admitted to the facility on oses that included but were not heart beat, dementia, high d difficulty swallowing. IDS (minimum data set), a ent, with an ARD (assessment 4/13/18 coded the resident as even out of 15 on the BIMS mental status) indicating the rely impaired cognitively. The d as requiring assistance from as of daily living except for esident could perform after the he resident was coded as ube. as made on 5/3/18 at 8:45 a.m. oractical nurse) #3 entering om with a cup of applesauce n it. LPN #3 gave the e applesauce to the resident by as made on 5/3/18 at 5:23 p.m. oractical nurse) #1 giving esident #70. The nurse took the plesauce into the resident's stered the medications by mouth e plan initiated on 12/5/17 and					
	revised on 12/5/1 documentation sp	7 did not evidence becifically regarding giving the ligh the feeding tube.					
	Review of the Ma documented, "LE	y 2018 physician's orders VOTHYROXINE SODIUM					

Facility ID: VA0402

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DEPARTMENT OF HEALT				FORM	: 05/10/2018 APPROVED . 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		E SURVEY IPLETED
	495401	B. WING			/04/2018
NAME OF PROVIDER OR SUPPLIE	र		STREET ADDRESS, CITY, STATE, ZIF 12001 IRON BRIDGE RD	CODE	
TYLER'S RETREAT AT IRON			CHESTER, VA 23831		(VE)
(FACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC)	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
 (3)VIA PEG TU PEG TUBE; FOL VALSARTAN (5) (6)VIA PEG TUBE (1) Review of the Ma administration red "LEVOTHYROXI (2)TUBE; OME ASPIRING ORAN ACID VIA PEG T TUBE; CARVED CARBIDOPA-LE medications were administered dur An interview was a.m. with LPN #3 took her medicat them by mouth" ordered to be giv PEG." When ask medications by r be given via the We need to follo had followed the An interview was p.m. with Reside took her medicat took them in app how long she ha mouth, Residen 	TUBE; OMEPRAZOLE BE; ASPIRING ORANGEVIA IC ACID (4) VIA PEG TUBE; VIA PEG TUBE; CARVEDILOL BE; CARBIDOPA-LEVODOPA 7)." y 2018 medication cord documented, NE SODIUMVIA PEG PRAZOLEVIA PEG TUBE; NGEVIA PEG TUBE; NGEVIA PEG TUBE; VODOPA VIA PEG TUBE;" The e documented as being	o h by			

Facility ID: VA0402

If continuation g

		AND HUMAN SERVICES				FORM	05/10/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATI COM	E SURVEY PLETED
		495401	B. WING				04/2018
NAME OF F	PROVIDER OR SUPPLIER	1			STREET ADDRESS, CITY, STATE, ZIP CODE 12001 IRON BRIDGE RD	<u>.</u>	
TYLER'S	RETREAT AT IRON	BRIDGE		1	CHESTER, VA 23831		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	٦X	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 684	 When asked what documented, LPN an order to give the On 5/3/18 at 6:45 pmember) #1, the adirector of nursing findings. An interview was of a.m. with ASM #2, asked if staff show when they were or stated, "No they slorder or get it clarit. No further information of the state of the major hormore, and the major hormore gland. This informore, https://pubchem.rt thyroxine_sodium 2. PEG Percuta (PEG) is the preferent nutritional support gastrointestinal spectral nutrition. from: https://www.ncbi.69302/ 3. Omeprazoleshort-term treatm adults. Most patients m weeks of therapy 	the physician's orders #1 stated, "I thought there was em either way." o.m. ASM (administrative staff dministrator and ASM #2, the were made aware of the conducted on 5/4/18 at 8:30 director of nursing. When Id give medications by mouth dered via PEG tube, ASM #2 houldn't they should follow the ified." ation was provided prior to exit. sodium Levothyroxine Sodium one derived from the thyroid vation was obtained from: action.nih.gov/compound/Levo		684			
	from:				Facility ID: VA0402 If col	ntinuation shee	et Page 69 of 11

Facility ID: VA0402

If continuation sheet Page 69 of 112

		AND HUMAN SERVICES			0		APPROVED 0938-0391
		& MEDICAID SERVICES		T 101		(X3) DATE	
STATEMENT AND PLAN OF	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,				LETED
		495401	B. WING			05/0	4/2018
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
	RETREAT AT IRON E	RIDGE			2001 IRON BRIDGE RD		
ITLER 5	RETREAT AT INONE				CHESTER, VA 23831		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 684	 m?setid=A1B077E 419D 4. Folic acid Folin the body make hear information was ob https://medlineplus 5. Valsartan Vals indicated for the tra lower blood pressured cardiovascular ever myocardial infarction 6. Carvedilol Car management of est be used alone or in antihypertensive a diuretics. This info https://dailymed.nl m?setid=7d485d3 6a 7. Carbidopa-levor levodopa extender in the treatment of Parkinson's disear postencephalitic p parkinsonism whit nervous system b and/or manganess was obtained from https://dailymed.nl 	n.nih.gov/dailymed/drugInfo.cf 6-B070-43F2-A98E-380CC635 c acid is a B vitamin. It helps althy new cells. This batterined from: .gov/folicacid.html artan Tablets, USP are eatment of hypertension, to ire. Lowering blood pressure fatal and nonfatal ents, primarily strokes and ons. rvedilol is indicated for the ssential (hypertension). It can n combination with other gents, especially thiazide-type rmation was obtained from: m.nih.gov/dailymed/drugInfo.cf 8-5d43-4a54-bc63-82734035c6 dopa Carbidopa and d release tablets are indicated f the symptoms of idiopathic se (paralysis agitans), parkinsonism, and symptomatic ch may follow injury to the y carbon monoxide intoxication e intoxication. This information		684			
							2000 70 of 112

Facility ID: VA0402

If continuation sheet Page 70 of 112

PRINTED: 05/10/2018

		AND HUMAN SERVICES					APPROVED
		& MEDICAID SERVICES				T	0938-0391 E SURVEY
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		PLE CONSTRUCTION		PLETED
		495401	B. WING			05/	04/2018
NAME OF F	ROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE		
TYLER'S	RETREAT AT IRON E	BRIDGE			12001 IRON BRIDGE RD CHESTER, VA 23831		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	'IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 684	 The facility staff covers as ordered #25. Resident #25 was a 8/13/14 and readm that included but w pressure, heart fail chronic pain. The most recent M annual assessmen reference date) of having scored a fiv interview for menta was severely impa was coded as requ all activities of daily. An observation wa of Resident #25. T back in bed with he wearing a hospital There was a white An observation wa of Resident #25. T with her eyes close gown and her arm bandage on the rig An observation wa of Resident #25. T with her eyes close gown and her arm bandage on the rig An observation wa p.m., of Resident # bed and was wear There was a white 	failed to apply protective arm by the physician for Resident admitted to the facility on itted on 3/4/15 with diagnoses ere not limited to: high blood ure, arthritis, lung disease and DS (minimum data set), an it, with an ARD (assessment 2/22/18, coded the resident as e out of 15 on the BIMS (brief al status) indicating the resident ired cognitively. The resident iring assistance from staff for y living. s made on 5/2/18 at 8:20 a.m., he resident was lying on her er eyes closed. She was gown and her arms were bare. bandage on the right forearm. as made on 5/3/18 at 8:18 a.m., he resident was lying in bed ed. She was wearing a hospital s were bare. There was a white		684			
	An observation wa p.m., of Resident	as made on 5/3/18 at 12:29 #25 was up in a wheelchair,					+ Page 71 of 112

Event ID: 3FC711

Facility ID: VA0402

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PRINTED: 05/10/2018

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES							ED: 05/10/2018 RM APPROVED NO. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUC A. BUILDING				(X3) DATE SURVEY COMPLETED	
		495401	B. WING			05/04/2018		
NAME OF PROVIDER OR SUPPLIER				1	STREET ADDRESS, CITY, STATE, ZIP C	ODE		
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 PREF TAG		PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 684	Continued From page 71 and she had geri sleeves on her arms.		F	684				
	2/10/18 and revised "Focus. (Name of F impaired skin integr mobility, incontinen	ent's care plan initiated on d on 4/29/18 documented, Resident #25) is at risk for rity r/t (related to) impaired ce and obesity. 4/20/18 skin rm. Interventions. Geri sleeves)."						
	Review of the May 2018 physician's orders documented, "04/20/18: GERI SLEEVES EVERY SHIFT TO BILATERAL ARMS FOR PREVENTION."							
	"GERI SLEEVES E ARMS FOR PREV 5/2/18, the nurse's 7:00 a.m. to 3:00 p sleeves were not o	the 3:00 p.m. to 11:00 p.m. or						
	p.m. with LPN #3, t asked who put the LPN #3 stated, "Th the morning when asked why Resider	onducted on 5/3/18 at 12:19 the resident's nurse. When geri sleeves on the residents, the CNA usually puts them on in they do their care." When the #25 had geri sleeves tated, "Because she has a skin						
	p.m. with CNA #1, asked when the re- on, CNA #1 stated, found them in the o	onducted on 5/3/18 at 3:32 the resident's aide. When sident's geri sleeves were put , "We had to order some. I drawer and then I put them on." resident had the sleeves on		F	acility ID: VA0402 If c	continuation sh	eet Page 72 of 112	

ALEMEN	T OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	000.000		OMB N	RM APPRO
D PLAN (OF CORRECTION	IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DAT	E SURVEY
		495401	B. WING			
AME OF	PROVIDER OR SUPPLIER			STREET ADDRESS OFFICE	05	6/04/2018
YLER'S	RETREAT AT IRON BR	IDGE		STREET ADDRESS, CITY, STATE, ZIP CODE 12001 IRON BRIDGE RD		
		DGE				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		CHESTER, VA 23831		
PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRE X (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)		(X5) COMPLETI DATE
F 684	Continued From pag	ie 72				
	the day before, CNA	#1 stated she had not.	Fe	84		
	On 5/3/18 at 6:45 p.r and ASM #2, the dire aware of the findings	n. ASM #1, the administrator actor of nursing were made				
	0-					
	An interview was cor	ducted on 5/4/18 with ASM				
	#2, the director of nu	rsing. When asked if she				
	expected staff to follo ASM #2 stated, she o	w the physician's orders				
	No further information	n was provided prior to exit.				
689	Free of Accident Haza	ards/Supervision/Devices	F 68			
SS=D	CFR(s): 483.25(d)(1)	(2)	1 00	to be made i	or resident	
	\$400 OF(N A			#25. Shower pad was immediated from the unit.	itely removed	
	§483.25(d) Accidents			2.a. Residents who are transfer	rad using a	
	The facility must ensu	re that -		Hoyer Lift are at risk for the d	ficient	
	as free of accident has	ident environment remains		practice.	lineiem	
	do nee of accident na.	zards as is possible; and		b. All residents are at risk for i	ssues with	
	§483.25(d)(2)Each red	sident receives adequate		shower pad.		
	supervision and assist	ance devices to prevent		3. a. Director of Rehab will ins	ervice	
	accidents.	and devices to prevent		Nursing Department Staff on p	roper use of	
		is not met as evidenced		Hoyer Lift to include having ty	vo people	
	by:			during transfers.		
	Based on observation	, staff interview, facility		b. New shower pad obtained ar	d placed on	
	document review and o	clinical record review, it		stretcher.		
V	was determined the fac	cility staff failed to provide		4.a. Director of Nursing or desi	gnee will	
8	an environment free of	accidents and hazards for		audit use of Hoyer Lift 3x a we months.	ek for 2	
	one of 36 residents in t	he survey sample,		b. Director of Nursing or design	10.0	
	Resident #25; and for o stretchers.	one of one shower		report the results of the audits to	the OADI	
3				committee monthly.		
1	. The facility staff faile	d to use two staff while		c. Audit results / trends will be	reviewed at	
u	ising the Hoyer lift for I	Resident #25.		QAPI meeting to ensure that Ac	tion Plans	
				are effective. Additional action	plans will	
2	. The facility staff faile	d to provide an		be done as needed.		
e	nvironment free of acc	idente and hannul	ł			

Facility ID: VA0402

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DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES			P	RINTE	D: 05/10/20	18	
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			C	FORI MB NO	MAPPROVE D. 0938-039	:D	
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			IPLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED	<u>'</u>	
		495401	B. WING	÷			104/0040		
NAME OF	PROVIDER OR SUPPLIER			Γ	STREET ADDRESS, CITY, STATE, ZIP CODE	0:	5/04/2018	\neg	
TYLER'S	RETREAT AT IRON E	BRIDGE	12001 IRON BRIDGE RD CHESTER, VA 23831						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	_	
F 689	Continued From pagone of one-shower		Fe	689	9				
	The findings include	:							
	1. The facility staff fa using the Hoyer lift f	ailed to use two staff while or Resident #25.							
	8/13/14 and readmit that included but we	dmitted to the facility on ted on 3/4/15 with diagnoses re not limited to: high blood re, arthritis, lung disease and							
	annual assessment, reference date) of 2/ having scored a five interview for mental was severely impaire was coded as requiri all activities of daily li	S (minimum data set), an with an ARD (assessment 22/18 coded the resident as out of 15 on the BIMS (brief status) indicating the resident ed cognitively. The resident ing assistance from staff for iving. The resident was wo or more staff for transfers							
	p.m., of CNA (certifie	made on 5/3/18 at 12:10 d nursing assistant) #1 5's room alone. The CNA							
	of Resident #25 bein wheelchair out of the observation of the res Hoyer lift (a mechanic	made on 5/3/18 at 12:29 p.m. g pushed by CNA #1 in her resident's room. An sident's room was made. A cal lift) was next to the was no one else in the							
/	A review of the reside	ent's care plan initiated on							

		AND HUMAN SERVICES			P		: 05/10/2018 APPROVED	
	OF DEFICIENCIES	& MEDICAID SERVICES					<u>. 0938-0391</u>	-
	OF DEFICIENCIES	IDENTIFICATION NUMBER:			PLE CONSTRUCTION G		E SURVEY	
		495401	B. WING	i		05/	/04/2018	
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		0.02010	1
TYLER'S	RETREAT AT IRON E	BRIDGE			12001 IRON BRIDGE RD			
					CHESTER, VA 23831			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 689	Continued From page	ae 74	Fe	580	٥			
	•	on 2/25/18 documented,	10	103	5			
	"Focus. Risk for fall	s related to impaired						
		ons. 2 person assist with ADLs						
	education for transfe	ring) and bed mobility. Staff ers "						
			÷					
		nducted on 5/3/18 at 3:32						
		Vhen asked how the resident						
		any staff were needed to get			· · · ·			
	a resident out of bee	d with a Hoyer lift, CNA #1						
		h asked why two staff were						
		ated, "In case anything ked who got the resident out						
	of bed that day, CN	A #1 stated, "The hospice						
		hen asked again, who got the		7				
		ed that day, CNA #1 stated, "I she got the resident out of						
		lift by herself, CNA #1 stated,						
		asked if that was correct,						
	CNA #1 stated, "1 co	ouldn't find anyone else."						
	On 5/3/18 at 6:45 p.	m. ASM (administrative staff						
		ministrator and ASM #2, the						
	director of nursing w findings.	vere made aware of the						
	indingo.							
		nducted on 5/4/18 at 8:30						
		Vhen asked how many staff using a Hoyer lift, ASM #2						
		st." When asked why, ASM #2						
	stated, "It's for safet							
		y's policy titled, "HOW TO						
	TRANSFER WITH	THE HOYER LIFT"						
		yer lift, or mechanical lift as it						
		regiver's co-worker when he immobile patient from one						
		Press the button that will						

Facility ID: VA0402

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DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES				PRINTEI	D: 05/10/2018	
CENTE	CENTERS FOR MEDICARE & MEDICAID SERVICES					FORM APPROVED OMB NO. 0938-0391		
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION	(X3) DA	TE SURVEY	
		495401	B. WINC	э_				
NAME OF	PROVIDER OR SUPPLIER		L	Т	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	5/04/2018	
TYLER'S	RETREAT AT IRON E	BRIDGE			12001 IRON BRIDGE RD CHESTER, VA 23831			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	٦X	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
	engage the lift and s maintaining control of The Hoyer Lift MUS people. " No further informatic 2. The facility staff fa environment free of one of one-shower s Observation was ma of a resident in the s unit. The resident w being assisted by a s On 5/4/18 at 10:20 a 100/200 unit was obs member (OSM [othe shower stretcher was holes in the cushion Of the 13 holes, only have any tears in the drain holes had crack ranging from approxi approximately eight in inside of the stretche	slowly lift the patient, of both the sling and the lift. T always be used with two on was obtained prior to exit. ailed to provide an accidents and hazards on accidents an	F	68	39			
	was safe and sanitary want to take a showe An interview was con nurse) #4 on 5/4/18 a shown the shower str on the 100/200 hall. V concern that the stret rears in it, RN #4 state	ed if the shower stretcher y, OSM #4 stated, "I wouldn't er on it." ducted with RN (registered at 10:32 a.m. RN #4 was retcher in the shower room When asked why it was a cher cushion had rips and ed, "Germs in there. Also, such fragile skin, it would						

Facility ID: VA0402

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	RS FOR MEDICARE &		1		OMB N	<u>O. 0938-039</u>
	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		E SURVEY
		495401	B. WING			
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	05	/04/2018
TYLER'S	RETREAT AT IRON BRID	GE		12001 IRON BRIDGE RD CHESTER, VA 23831		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID			
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 689	Continued From page	76	F 6	89		
	asked who maintains #1 stated, "Maintenan needed and the nurse nursing assistants) ob them." When asked if rips and tears in the cu stretcher, ASM #1 stat it would be a concern, infection control conce A request was made for maintaining the showe On 5/4/18 at 11:11 a.m director of clinical serv the facility staff did not maintaining the showe	ember) #1, the 18 at 10:40 a.m. When the shower stretchers, ASM ce repairs anything that is s and CNAs (certified serve them when they use it was acceptable to have ushion of the shower ted, "No." When asked why ASM #1 stated, "It's an ern and it's a safety hazard. or the facility policy on er stretchers. ASM #4, the regional ices informed this surveyor have a policy on r stretchers. ASM #4 that the cushion has been				
F 697 SS=D	No further information Pain Management CFR(s): 483.25(k)	was provided prior to exit.	F 69	7 1. No correction to be made for	resident # 30.	
	provided to residents w consistent with profess the comprehensive per and the residents' goals	e that pain management is who require such services, ional standards of practice, son-centered care plan, s and preferences. is not met as evidenced rview, staff interview, v and clinical record		 Residents with complaints of for this deficient practice. Director of Nursing or design licensed nursing staff on assessi and after administering pain me pharmacological interventions. 	pain are at risk nee will inservice ng pain prior to	

Event ID: 3FC711

Facility ID: VA0402

If continuation sheet Page 77 of 112

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 05/11/2018 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB_NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED 495401 B. WING NAME OF PROVIDER OR SUPPLIER 05/04/2018 STREET ADDRESS, CITY, STATE, ZIP CODE TYLER'S RETREAT AT IRON BRIDGE 12001 IRON BRIDGE RD CHESTER, VA 23831 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) COMPLETION TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 697 Continued From page 77 F 697 4. a. Unit Manager or designee will audit 5 failed to ensure a comprehensive pain residents weekly x 2 months to ensure that pain management program for one of 36 residents in assessments were done prior to and after pain the survey sample, Resident #30. medication was administered and that non-The facility staff could not provide evidence that pharmacological interventions were tried and pain was assessed prior to the administration of documented. as needed (PRN) pain medication to Resident b. Unit Managers will report the results of the #30, on several occasions in April of 2018 and on audits to the QAPI committee monthly for 2 two occasions in May of 2018. The facility staff months. could also not evidence that non-pharmacological c. Audit results / trends will be reviewed at QAPI interventions were attempted prior the meeting to ensure that Action Plans are effective. administration of prn pain medications. Additional action plans will be done as needed. 6/4/18The 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

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

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DEPAR	IMENT OF HEALTH	AND HUMAN SERVICES			PI		: 05/10/2018	
		& MEDICAID SERVICES			O		APPROVED	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	(X3) DA1	TE SURVEY MPLETED	
	, ,	495401	B. WING			05	/04/2018	
NAME OF I	PROVIDER OR SUPPLIER		<u> </u>	;	STREET ADDRESS, CITY, STATE, ZIP CODE	0.0	04/2010	-
TYLER'S	RETREAT AT IRON E	RIDGE			12001 IRON BRIDGE RD CHESTER, VA 23831			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	<u>I</u>		-		1	4
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 697	Continued From an	70		_]
1 097			F 6	697	7			
	for mild pain/temper	outh every 4 hours as needed rature. MAX (maximum)						
		GM daily. Check daily total."						
	This order was initia	ated on 11/28/17.						
	Review of Resident	#30's April 2018 MAR						
	(medication adminis	stration record) revealed that						
		on the following dates and 15 a.m., and 6:00 a.m.,						
		and 4/9/18 at 12 a.m. and 6						
	p.m.							
	revealed that she re following dates and 4/19/18 at 1:00 a.m.	esident #30's April 2018 MAR ceived Tylenol 650 mg on the times: 4/6/18 at 6:00 p.m., , 4/22/18 at 12:00 a.m., n., and 4/30/18 at 2:00 a.m.						
	a pain assessment v administration of No 2018. There was no assessment after the administered in April that non-pharmacolo attempted prior to th	nce in the clinical record that was completed prior to the rco and Tylenol in April of evidence of a follow up pain e Norco and Tylenol was . There was no evidence ogical pain interventions were e administration of PRN pain						
	missing from the clir	in flow sheet for April was nical record.						
	revealed that she red (milligram) on the fol	#30's May 2018 MAR ceived Tylenol 650 mg llowing dates and times: mes administered were						
	a pain assessment v administration of Tyle	nce in the clinical record that vas completed prior to the enol in May of 2018. There a follow up pain assessment						

Facility ID: VA0402

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		AND HUMAN SERVICES			P		APPROVED
CENTER	S FOR MEDICARE	& MEDICAID SERVICES			0	<u>MB NO.</u>	0938-0391
STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED
		495401	B. WING			05/(04/2018
NAME OF F	PROVIDER OR SUPPLIER		l	S	STREET ADDRESS, CITY, STATE, ZIP CODE	£	
	DETREAT AT IDON D			1	2001 IRON BRIDGE RD		
I YLER'S	RETREAT AT IRON E	SRIDGE		C	CHESTER, VA 23831		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 697	was no evidence the interventions were administration of Pl flow sheet for May Review of Resident 11/28/17, documen "Potential for pain/or mobility, neuropath resolved within 1 ho review. Interventio facility routine and	is administered in May. There at non-pharmacological pain attempted prior to the RN pain medications. The pain was completely blank. t #30's pain care plan dated ted in part, the following: discomfort related to impaired y, gout; Goal: Pain will be our of intervention through next ns: Pain assessment per prn (as needed), Administer per MD (medical doctor)	Fθ	397			
· ·	conducted with LPI regarding the proce administering a pro- LPN #4 stated she assessment and fir non-pharmacologic prior to the adminis LPN #4 stated, "Yo as ROM (range of stated that if those would move on to p if pain would be as non-pharmacologic administering pain that it should be. L assess for pain loc effectiveness of he this information wo in the clinical recor should be on the p that a pain assess	p.m., an interview was N (licensed practical nurse) #4, ess staff follows prior to a (as needed) pain medication. would conduct a pain st attempt cal pain relief interventions stration of pain medications. u want to try something as far motion), repositioning." LPN #4 interventions did not work she prn medications. When asked sessed prior to attempting cal interventions and medications, LPN #4 stated .PN #4 stated that she would ation, intensity of pain, and the rr interventions. When asked if puld be documented anywhere d, LPN #4 stated, "Yes, it ain flow sheet." LPN #4 stated ment might also be jursing note. LPN #4 could not				\$	

Facility ID: VA0402

If continuation sheet Page 80 of 112

DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES			P	RINTED	: 05/10/2018	
		& MEDICAID SERVICES			C	FORM APPROVED OMB NO. 0938-0391		
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		PLE CONSTRUCTION	(X3) DAT	E SURVEY	
		495401	B. WING	<u>،</u>		05/	04/2018	
NAME OF I	PROVIDER OR SUPPLIER		A	Γ	STREET ADDRESS, CITY, STATE, ZIP CODE		0.112010	
TYLER'S	RETREAT AT IRON E	BRIDGE			12001 IRON BRIDGE RD CHESTER, VA 23831			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	I IX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
	On 5/03/18 at appro- interview was condu When asked if facili giving her pain medi that facility staff will location. Resident # come back and do a pain. Resident #30 should do this. Resigets her pain medica Resident #30 stated non-pharmacologica medications are add On 5/04/18 at 9:30 a conducted with ASM member) #2, the DO regarding the proce- administering a pro- stated that staff sho assessment that inco- location, and intensi information should to log (pain flow sheet) non-pharmacologica attempted prior to the medications, ASM # ASM #2 stated this is documented on the progress note. Whe determine where Re- flow sheet was local unit manager could that the pain flow sh record and should h	nt #30-pain medication. Desimately 5:30 p.m., an Jucted with Resident #30. ty staff assess her pain before lication, Resident #30 stated ask her pain level and the 30 stated that staff never a follow up assessment on her stated that she thought staff lident #30 stated that she just ation when she requests it. I that staff do not attempt al interventions before pain ministered. a.m., an interview was 1 (administrative staff DN (Director of Nursing), ss staff follows prior to pain medication, ASM #2 uld conducted a pain ludes the duration of pain, ty of pain. ASM #2 stated this be documented on the pain 0. When asked if al interventions should be he administration of pain 2 stated that they should. Information should also be pain flow sheet or in the en asked if she could esident #30's April 2018 pain ted, ASM #2 stated that the not find it. ASM #2 stated et was part of the clinical ave been in Resident #30's	F	697				
	should do this. Res gets her pain medic Resident #30 stated non-pharmacologica medications are adr On 5/04/18 at 9:30 a conducted with ASM member) #2, the DO regarding the proce administering a prn stated that staff sho assessment that inc location, and intensi information should b log (pain flow sheet) non-pharmacologica attempted prior to the medications, ASM # ASM #2 stated this is documented on the progress note. Whe determine where Res flow sheet was locat unit manager could that the pain flow sh record and should h chart. ASM #2 state	ident #30 stated that she just ation when she requests it. I that staff do not attempt al interventions before pain ministered. a.m., an interview was (administrative staff DN (Director of Nursing), ss staff follows prior to pain medication, ASM #2 uld conducted a pain cludes the duration of pain, ty of pain. ASM #2 stated this be documented on the pain budes the duration of pain cludes the the should also be pain flow sheet or in the cen asked if she could could be pain flow sheet or in the cen asked if she could could be pain flow sheet or in the cen asked if she could could be pain flow sheet or in the cen asked if she could could be pain flow sheet or in the cen asked if she could could be pain flow sheet or in the cen asked if she could could be pain flow sheet or in the cen asked if she could could be pain flow sheet or in the cen asked if she could could be pain flow sheet or in the cen asked if she could could be pain flow sheet or in the cen asked if she could could be pain flow sheet or in the cen asked if she could be pain flow sheet or in the cen asked if she could be pain flow sheet or in the cen asked if she could be pain flow sheet or in the cen asked if she could be pain flow sheet or in the cen asked if she could be pain flow sheet or in the clinic sheet or in the cen askeet of the clinic sheet or in the cen askeet of the clinic sheet or in the cen askeet of the clinic sheet or in the cen askeet or in the cen a						

Facility ID: VA0402

If continuation sheet Page 81 of 112

		AND HUMAN SERVICES			F): 05/10/2018 APPROVED
		& MEDICAID SERVICES			C		0938-0391
	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:				IPLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		495401	B. WING	≩		05	/04/2018
NAME OF	PROVIDER OR SUPPLIER			Γ	STREET ADDRESS, CITY, STATE, ZIP CODE	· · · · · · · · · · · · · · · · · · ·	
		200			12001 IRON BRIDGE RD		
ITLERS	RETREAT AT IRON E	SRIDGE			CHESTER, VA 23831		
(X4) ID	SI IMMADY STA			L	·		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 697	Continued From pa	ge 81	F	69)7		
	-	was not done. ASM #2	. `				
		d not say. ASM #2 stated,					
	"They probably miss	sed the actual documentation					
	of the assessment."						
	On E14/40 -1 40.00						
	On 5/4/18 at 10:39 a	a.m., ASM (administrative					
	aware of the above	ne administrator was made					
	aware of the above	concerns.					
	Pain Protocol," docu	led, "Pain Management and umented in part, the following:					
	"3. Non-pharmacolo	gical intervention will be					
	attempted prior to th	ne administration of PRN pain					
		it is determined the resident's					
	pain will need pharm	nacological interventions: a.					
		dministration of medications					
		e Medication Administration					
	be located on the M	onse of the medication(s) will edication Administration					
		rmation on the pain flow					
	record will identify a	. Location of pain- Ask the					
	resident to point to the	he side(s) of pain. b. Pain					
	intensity- Provide the	e resident with the 10 point					
	Pain Intensity Scale	and ask the resident to			· ·		
	choose the best des	cription of his/her pain					
	experience. c. Pain	quality- Encourage the					
		ctives to describe the quality					
		aching, shooting, burning,					
		and unbearable). d. onset					
		Ask the resident about the					
	Addrewating factors	eriods of relief (if any). e. Ask the resident if there are					
		or activities that help reduce					
The second se		anying symptoms- Ask the					
	resident if there are				r		
		nausea, vomiting, and					
	sensitivity to light an						
		erventions will be attempted					
	prior to the administr						

If continuation sheet Page 82 of 112

ATEMEN	T OF DEFICIENCIES	MEDICAID SERVICES				RM APPROV 10. 0938-03
ID PLAN (OF CORRECTION	IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		495401	B. WING			
IAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI		5/04/2018
YLER'S	RETREAT AT IRON BRID	GE		12001 IRON BRIDGE RD		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	<u> </u>	CHESTER, VA 23831		
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE	(X5) COMPLETION DATE
F 697	Continued From page	82				
		esident will be reassessed	F 6	97		
	for pain a regular inter notified of ineffective p needed."	vals. The physician will be				
	No further information	was presented prior to exit.				
	combination is used to moderately severe pai This information was o Institutes of Health.	n. btained from the National ih.gov/pubmedhealth/PMH				
		nor aches, pains, and also				
	Institutes of Health.	btained from The National				
	T0008785/?report=deta					
F 761 SS=D	Label/Store Drugs and CFR(s): 483.45(g)(h)(1)	Biologicals)(2)	F 76	1		
	§483.45(g) Labeling of Drugs and biologicals u labeled in accordance v professional principles, appropriate accessory a instructions, and the exp applicable.	ised in the facility must be with currently accepted and include the and cautionary		 Flu vaccine vials were ima The nurse who left the medic was spoken with after the ex All residents are at risk for practice. Director of Nursing or des licensed nursing staff on stor include monitoring expiratio. 	cation cart unlocked it conference. r this deficient signee will inservice rage of biologicals to	
	§483.45(h) Storage of D	rugs and Biologicals		of medication carts when not		-
	§483.45(h)(1) In accord Federal laws, the facility biologicals in locked con temperature controls, ar	r must store all drugs and npartments under proper				

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		D HUMAN SERVICES MEDICAID SERVICES					APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	
		495401	B. WING			05/	04/2018
NAME OF P				S	TREET ADDRESS, CITY, STATE, ZIP CODE		
TVIEDIO		CE.		12	2001 IRON BRIDGE RD		
ITLERS	RETREAT AT IRON BRID	GE		С	HESTER, VA 23831		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR(DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 761	1 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 guantity stored is minimal and a missing dose can			761	 4. a.Unit Managers will audit the n rooms 2x weekly x 2 months to enare stored properly including check expiration dates. b.Unit Managers or designee will a medication carts via direct observation ensure they are locked x 2 months. c. Unit Managers will report the reaudits to the QAPI committee monthing of the provide the store of the providethe store of the providet	sure biologic cing for nudit tion M-F to sults of the	als
	by: Based on observatio document review, it w staff failed to ensure expired in one of two	is not met as evidenced n, staff interview, and facility vas determined the facility medications were not medication rooms, and n a safe manner for one of			months. d. Audit results / trends will be rev meeting to ensure that Action Plan <u>Additional action plans will be don</u>	s are effectiv	ve.
	vaccines, that were a expired in one of two	led to lock the medication					
		iled to ensure influenza available for use, were not medication rooms.					
	infection by the influe works by causing you protection (antibodie	vaccine is used to prevent enza virus. The vaccine ur body to produce your own s) against the disease. It's . There are many types of					

Facility ID: VA0402

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		LE CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		495401	B. WING	i		05/0	04/2018
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
TYLER'S	RETREAT AT IRON E	BRIDGE			12001 IRON BRIDGE RD CHESTER, VA 23831		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 761	any given year. The every year. It is ned influenza vaccine e and the protection of (1) Observation was m medication room or unit dose syringes of found in the units re syringes were expired found in the units re syringes were expired An interview was co practical nurse) #1 asked if you can giv LPN #1 stated, "I w they are expired." V for checking medic expired, LPN #1 stated, "I w they are expired." V for checking medic expired, LPN #1 stated things we should ta responsible becaus When the syringes shown to LPN #1, s An interview was co nurse) #1 on 5/2/18 whose responsibilit refrigerators to ens #1 stated, "Myself a effort to get rid of th resident dies." The influenza were sho The facility policy, ' Medication Adminis	at not all will cause problems in e influenza vaccine is made eessary to receive your very year as different viruses only lasts for less than a year." ade of the unit 100/200 n 5/2/18 at 3:15 p.m. Sixteen of influenza vaccine were erigerator. All sixteen of the red on 4/2018. onducted with LPN (licensed on 5/17/18 at 3:17 p.m. When ve a medication that is expired, ras told you cannot give them if When asked who's responsible ations to ensure they are not ated, "If we (the nurses) see ske it out. All nurses are se we all give medications." of influenza vaccines were she just shook her head. onducted with RN (registered 8 at 3:20 p.m. When asked by it is to check the drugs in the ure they are not expired, RN and the nurses. It's a group nings when it's expired or the expired unit dose syringes of wn to RN #1. 'General Dose Preparation and stration" documented in part, nouldCheck the expiration		761			

Facility ID: VA0402

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		AND HUMAN SERVICES			PF		05/10/2018 APPROVED
[& MEDICAID SERVICES	1		0	MB NO. 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED
		495401	B. WING			05/	04/2018
NAME OF I	PROVIDER OR SUPPLIER		·T	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
TYLER'S	RETREAT AT IRON B	BRIDGE			2001 IRON BRIDGE RD CHESTER, VA 23831		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 761	member) #5, vice pr ASM #4, corporate in these findings on 5/ No further information 2. The facility staff factor on the Sherwood An observation was The medication card between two rooms nurse) #1 was in a r sight of the cart. The Approximately 30 to came out of the resist the cart up the hall the An interview was co p.m. with LPN #1, we when leaving the med LPN #1 stated, "It we locked it." When as! "Safety issues." On 5/3/18 at 6:45 p. member) #1, the ad director of nursing we	SM (administrative staff resident of operations, and nurse were made aware of 4/18 at 11:29 a.m. on was provided prior to exit. ailed to lock the medication	F 7	761			
	a.m. with ASM #2. V when leaving the me ASM #2 stated, "The	nducted on 5/4/18 at 8:30 Vhen asked what staff did edication cart out of sight, ey're supposed to lock it." .M #2 stated, "For safety					
	Review of the facility	y's policy titled, "General Dose					

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DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES						D: 05/11/2018
	S FOR MEDICARE &	MEDICAID SERVICES						M APPROVED 0. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION		(X3) DAT	E SURVEY PLETED
		495401	B. WING				05	/04/2018
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
TYLER'S	RETREAT AT IRON BRID	GE			2001 IRON BRIDGE RD CHESTER, VA 23831			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIA IEFICIENCY)		(X5) COMPLETION DATE
F 761 F 804 SS=B	Preparation and Medi documented, "7. Facil medication carts are a sight or unattended." No further information (1) This information wa following website: https://www.ncbi.nlm.r 0046150/	cation Administration" ity should ensure that was locked when out of was obtained prior to exit. as obtained from the hih.gov/pubmedhealth/PMH		761	1. No correction to	be made since no re	esident	
	§483.60(d)(1) Food pro- conserve nutritive value §483.60(d)(2) Food an attractive, and at a safe temperature. This REQUIREMENT by: Based on observation document review it was staff failed to ensure for two dining areas, the re- The facility staff failed to temperature in the rest The findings include: Observation was made	e and the facility provides- epared by methods that e, flavor, and appearance; d drink that is palatable, e and appetizing is not met as evidenced , staff interview, and facility s determined the facility od was palatable in one of estorative dining area. o serve food at a palatable orative dining area.		 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. 				o ble 3x a
		35 a.m. The temperatures food being served. The						

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DEPART	FORM APPROVED				
		MEDICAID SERVICES	7		OMB NO. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495401	B. WNG		05/04/2018
NAME OF P		<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CODE	
TYLER'S I	RETREAT AT IRON BRID	GE		12001 IRON BRIDGE RD CHESTER, VA 23831	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E COMPLETION
F 804	Continued From page	9 87	F 80)4	
		iree meat was recorded at			
	180 degrees. The temperature of the peas was recorded at 180 degrees.				
	The food trays were s	served to the residents in the			
	restorative dining area	a at 12:22 p.m. The last			
		sistance from the staff for			
	eating was at 12:37 p				
	-	ted at 12:40 p.m. with two			
		tary manager, other staff The test tray consisted of			
		ound ham, puree peas,			
	puree meat, puree bre	ead, mashed potatoes, peas	*****		
		pkin mousse. The recorded			
		ree meat was recorded at corded temperature of the			
		. Both surveyors and OSM			
		It was agreed that the peas			
	and ground meat was palatability. When ask	ked 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, "Fo	ood Temperatures"			
	documented in part, "				
	palatable when served of delivery."	d, which is defined as point			
	Administrative staff m	ember (ASM) #1, the			
		2, the director of nursing,			
		ional director of clinical aware of the above concern			
	on 5/3/18 at 6:50 p.m.				
	No further information	was provided prior to exit.			
F 842			F 84	$2^{ }_{1. \text{ No correction to be made for resident}}$	7
SS=E	CFR(s): 483.20(f)(5),	483.70(i)(1)-(5)		44,26,46,30 or 19.	s /,

Facility ID: VA0402

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DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES				ED: 05/11/2018
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				RM APPROVED 0. 0938-0391
6	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		495401	B. WNG		0	5/04/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		
TYLER'S	RETREAT AT IRON BRID	GE		12001 IRON BRIDGE RD		
				CHESTER, VA 23831		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COL (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	Continued From page §483.20(f)(5) Residen (i) A facility may not re- resident-identifiable to accordance with a cor- agrees not to use or d except to the extent the to do so. §483.70(i) Medical rec §483.70(i) (1) In accord professional standards must maintain medica- that are- (i) Complete; (ii) Accurately docume (iii) Readily accessible (iv) Systematically org- §483.70(i)(2) The facili all information container regardless of the form records, except when a (i) To the individual, or representative where p (ii) Required by Law; (iii) For treatment, payr operations, as permitter with 45 CFR 164.506; (iv) For public health a- neglect, or domestic vi activities, judicial and a law enforcement purpor purposes, research purpor purposes, research purpor medical examiners, fur	88 t-identifiable information. elease information that is the public. ease information that is an agent only in thract under which the agent isclose the information e facility itself is permitted ords. dance with accepted and practices, the facility records on each resident it records on each resident nted; ; and anized ty must keep confidential ed in the resident's records, or storage method of the release is- their resident permitted by applicable law; ment, or health care ed by and in compliance ctivities, reporting of abuse, olence, health oversight administrative proceedings, uses, organ donation rposes, or to coroners, neral directors, and to avert	F 8	DEFICIENCY) 2. 100% audit of current resi	dent orders to deficient practic signee will inserv aining a diagnost nedication order et and restorative ord. t new orders for se M-F x 2 month will audit 5 pain hs to ensure they S will audit 5 months to ensure d. the results of the e monthly for 2 be reviewed at Q n Plans are effect	vice is or s, log hs. v are API ive.
	medical examiners, fur a serious threat to hea	neral directors, and to avert th or safety as permitted				

Facility ID: VA0402

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PRINTED: 05/10/2018 FORM APPROVED OMB NO. 0938-0391

DEPARTMENT	OF HEALTH AN	D HUMAN	SERVICES
CENTERS FOR	MEDICARE &	MEDICAID	SERVICES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		495401	B. WING			05/04/2018	
	PROVIDER OR SUPPLIER	BRIDGE		1	TREET ADDRESS, CITY, STATE, ZIP CODE 2001 IRON BRIDGE RD CHESTER, VA 23831		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 842	by and in compliand §483.70(i)(3) The farecord information a unauthorized use. §483.70(i)(4) Medic for- (i) The period of tim (ii) Five years from there is no requiren (iii) For a minor, 3 y legal age under Sta §483.70(i)(5) The n (i) Sufficient informat (ii) A record of the n (iii) The comprehen provided; (iv) The results of a and resident review determinations con (v) Physician's, num professional's prog (vi) Laboratory, rad services reports as This REQUIREMEN by: Based on staff inte and facility document that the facility staff and accurate clinica residents in the sur #44, #26, #46, #30	ce with 45 CFR 164.512. acility must safeguard medical against loss, destruction, or cal records must be retained the required by State law; or the date of discharge when ment in State law; or rears after a resident reaches the law. medical record must contain- ation to identify the resident; esident's assessments; usive plan of care and services any preadmission screening v evaluations and ducted by the State; se's, and other licensed ress notes; and iology and other diagnostic required under §483.50. NT is not met as evidenced erview, clinical record review, ent review, it was determined failed to ensure a complete al record for five of 36 vey sample; Residents #7,	F	342			

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DEPART	MENT OF HEALTH	AND HUMAN SERVICES			P		: 05/10/2018 APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	r		0		0938-0391
1	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G		E SURVEY IPLETED
		495401	B. WING	i		05/	04/2018
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
TYLER'S	RETREAT AT IRON E	BRIDGE			12001 IRON BRIDGE RD		
	4		1		CHESTER, VA 23831		·
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 842	Continued From pa	ae 90	F٤	342	2		
	2. The facility staff	failed to document in the eason Resident #44 was					
		failed to document in the eason Resident #26 was ent.					
		failed to document in the eason Resident #46 was ent.					
		ailed to ensure Resident #30's sheet was in the clinical					
		ailed to ensure Resident #19's /e log for toileting was on the					
	The findings include	ə:					
		t to document in the clinical Resident #7 was prescribed a				r	
	10/6/16 with the dia high blood pressure depression, history osteoarthritis, and a recent MDS (Minim assessment with an Reference Date) of coded as cognitively daily life decisions. requiring extensive						

Facility ID: VA0402

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

OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 495401 B. WING 05/04/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 12001 IRON BRIDGE RD TYLER'S RETREAT AT IRON BRIDGE CHESTER, VA 23831 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) F 842 Continued From page 91 F 842 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 scables 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

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Event ID: 3FC711

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PRINTED: 05/10/2018 FORM APPROVED OMB NO. 0938-0391

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

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		495401	B. WING			/04/2018		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 12001 IRON BRIDGE RD CHESTER, VA 23831					
(X4) ID PREFIX TAG	SUMMARY ST	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAT	N OF CORRECTION E ACTION SHOULD BE TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE		
F 842	"Nurses need to in interventions, clier referrals in the me [1] Permethrin is u	hat happened to a client." dicate all assessments, nt responses, instructions, and dical record". used to treat scabies.	F 8	42				
	clinical record, the prescribed a treat Resident #44 was 1/25/17 with the d atrial fibrillation, d dysphagia. The n Data Set) was an ARD (Assessmen The resident was ability to make da was coded as reconstruction	admitted to the facility on iagnoses of but not limited to epression, anxiety disorder, and nost recent MDS (Minimum annual assessment with an it Reference Date) of 3/14/18. coded as cognitively intact in ily life decisions. The resident juiring extensive care for toileting, dressing, and sion for eating; and as continer						
	physician's teleph "Permethrin crea leave on 8-14 hou did not document cream.	inical record revealed a none order dated 3/19/18 for m [1] 5% - Apply to entire body, urs, then shower off." The order t the reason for the Permethrin	r					
, ,	reveal any evider reason for the Pe	nce of a note documenting a ermethrin cream and failed to		Facility ID: VA0402	If continuation she	t Dana 02 of		

DEPART		FORM APPROVED OMB NO. 0938-0391					
STATEMENT	OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495401	B. WING	i		05/0	4/2018
NAME OF F	ROVIDER OR SUPPLIER	L		5	STREET ADDRESS, CITY, STATE, ZIP CODE		
	RETREAT AT IRON				12001 IRON BRIDGE RD		
ITLERS	RETREAT AT IKON				CHESTER, VA 23831		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 842	evidence any indica	ation the resident had any requiring the use of the	F٤	842	2		
	#1 (Registered Nur stated that there was scabies on the unit treated prophylactic documenting in a c was provided, RN	p.m., in an interview with RN rse, the unit manager), she as one identified case of and everyone else was cally. When asked about clinical record why a treatment #1 stated the record should going on with a patient and the					
	Records" failed to i ensuring complete provided to a resid On 5/4/18 at 10:12	a.m., the Administrator was findings. No further					
	clinical record, the prescribed a treatr Resident #26 was 3/14/16 with the di depression, history hypothyroidism, st dementia, mood d dysphagia. The m Data Set) with an Date) of 2/23/18.	f failed to document in the reason Resident #26 was nent. admitted to the facility on agnoses of but not limited to y of falls, aphasia, insomnia, roke, high blood pressure, isorder, psychotic disorder, and nost recent MDS (Minimum ARD (Assessment Reference The resident was coded as ed in ability to make daily life					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	05/10/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	-	495401	B. WING	<u> </u>		05/0	04/2018
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 2001 IRON BRIDGE RD		
TYLER'S	RETREAT AT IRON E	BRIDGE		1	HESTER, VA 23831		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 842	limited assistance f supervision for dress independent for hyg continent of bowel a A review of the clini physician's telephon "Permethrin cream leave on 8-14 hours did not document the cream. Further review of the reveal any evidence reason for the Permevidence any indica signs or symptoms Permethrin cream. On 5/3/18 at 12:30 #1 (Registered Nur- stated that there was scabies on the unit treated prophylactic documenting in a c was provided, RN # reflect everything g reason why. A review of the faci Records" failed to i ensuring complete provided to a reside	ident was coded as requiring or bathing and transfers; asing and eating; was giene and toileting; and as and bladder. cal record revealed a ne order dated 3/19/18 for [1] 5% - Apply to entire body, s, then shower off." The order ne reason for the Permethrin e clinical record failed to a fa note documenting a nethrin cream and failed to ation the resident had any requiring the use of the p.m., in an interview with RN se, the unit manager), she as one identified case of and everyone else was cally. When asked about linical record why a treatment #1 stated the record should oing on with a patient and the lity policy, "Resident Medical nclude any direction for documentation of care	F	842			
	made aware of the information was pro	findings. No further					

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		AND HUMAN SERVICES	FORM APPROVE OMB NO. 0938-039						
	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIP	PLE CONSTRUCTION	T	SURVEY		
	F CORRECTION	IDENTIFICATION NUMBER:	· · /		G		PLETED		
		495401	B. WING	i		05/0)4/2018		
NAME OF F	PROVIDER OR SUPPLIER								
	RETREAT AT IRON B	RIDGE	12001 IRON BRIDGE RD						
TILERS				(CHESTER, VA 23831				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE		
F 842	Continued From pa	ge 95	F٤	842	2				
	4. The facility staff clinical record, the prescribed a treatm	failed to document in the reason Resident #46 was rent.							
	10/10/12 with the d high blood pressure stroke, aphasia, an The most recent M an annual assessm Reference Date) of cognitively impaired decisions. The res for bathing, hygiend	admitted to the facility on iagnoses of but not limited to e, dementia, osteoarthritis, d hemiplegia/hemiparesis. DS (Minimum Data Set) was nent with an ARD (Assessment 3/16/18. The resident was d in ability to make daily life ident required extensive care e, toileting, and transfers; ssing and eating; and was el and bladder.							
	physician's telepho "Permethrin cream leave on 8-14 hour	ical record revealed a ne order dated 3/19/18 for [1] 5% - Apply to entire body, s, then shower off." The order he reason for the Permethrin							
	reveal any evidence reason for the Perr evidence any indic	ne clinical record failed to e of a note documenting a methrin cream and failed to ation the resident had any a requiring the use of the							
	#1 (Registered Nu stated that there w scabies on the uni treated prophylacti	p.m., in an interview with RN rse, the unit manager), she ras one identified case of t and everyone else was cally. When asked about clinical record why a treatment							

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		AND HUMAN SERVICES			FORM	APPROVED		
[& MEDICAID SERVICES				1	MB NO. 0938-0391 (X3) DATE SURVEY	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		PLETED	
		495401	B. WING			05/0	4/2018	
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
TYLER'S	RETREAT AT IRON E	BRIDGE		1	12001 IRON BRIDGE RD CHESTER, VA 23831			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE	(X5) COMPLETION DATE	
F 842	reflect everything g reason why. A review of the facil Records" failed to it ensuring complete provided to a reside On 5/4/18 at 10:12 made aware of the information was pro- 5. The facility staff April 2018 pain flow record. Resident #30 was a 8/24/17 and readm diagnoses that incl type two diabetes, unspecified demen disturbance. Resid (minimum data set assessment with a date) of 3/1/18. Re being cognitively in decisions scoring 1	 ⁴¹ stated the record should oing on with a patient and the lity policy, "Resident Medical nclude any direction for documentation of care ent. a.m., the Administrator was findings. No further ovided. failed to ensure Resident #30's v sheet was in the clinical admitted to the facility on litted on 11/28/17 with uded but were not limited to neuropathy, gout, and thia without behavioral dent #30's most recent MDS assessment) was a quarterly n ARD (assessment reference esident #30 was coded as thact in the ability to make daily 12 out of possible 15 on the 	F	842				
	Review of Residen (physician order su documented the fo 1) "Hydrocodone-	ew for Mental Status) exam. It #30's most recent POS Jmmary) dated 4/30/18, Illowing pain medication orders: Acetaminophen (Norco) ram) Tablet 1 tab by mouth						
	every 6 hours for p	ain." This order was initiated						

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DEPAR	MENT OF HEALTH	AND HUMAN SERVICES			PI		: 05/10/2018
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			O		APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		495401	B. WING			05/	04/2018
NAME OF I	PROVIDER OR SUPPLIER		·	S	TREET ADDRESS, CITY, STATE, ZIP CODE		0
TYLER'S	RETREAT AT IRON E	BRIDGE			2001 IRON BRIDGE RD		
			I	C	HESTER, VA 23831		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 842	Continued From pa on 2/21/18.	-	F8	342			
	(650 mg) by mouth mild pain/temperatu	I) 325MG tablet Take two tabs every 4 hours as needed for ire. MAX Acetaminophen 3-4 ily total." This order was 7.					
	revealed that she re dates and times: 4/4	#30's April 2018 MAR eceived Norco on the following 4/18 at 12:15 a.m., and 6:00 9 a.m., and 4/9/18 at 12 a.m.					
	revealed that she re following dates and 4/19/18 at 1:00 a.m	esident #30's April 2018 MAR eceived Tylenol 650 mg on the times: 4/6/18 at 6:00 p.m., ., 4/22/18 at 12:00 a.m., n., and 4/30/18 at 2:00 a.m.					
	evidencing that a pa completed prior to the and Tylenol in April documentation in the follow up pain assess Tylenol was administed evidence that non-painterventions were a administration of PF	e clinical record documentation ain assessment was he administration of Norco of 2018. There was no e clinical record evidencing a ssment after the Norco and stered in April. There was no harmacological pain attempted prior to the RN pain medications. The pain was missing from the clinical					
	conducted with ASM member) #2, the DC regarding the proce administering a prn	a.m., an interview was (administrative staff DN (Director of Nursing), ss staff follows prior to pain medication. ASM #2 uld be conducted a pain					

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 495401 B. WING 05/04/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 12001 IRON BRIDGE RD **TYLER'S RETREAT AT IRON BRIDGE** CHESTER, VA 23831 SUMMARY STATEMENT OF DEFICIENCIES **PROVIDER'S PLAN OF CORRECTION** ID (X4) ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRFFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 842 Continued From page 98 F 842 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/PMH T0010590/?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/PMH T0008785/?report=details. 6. The facility staff failed to ensure Resident #19's April 2018 restorative log for toileting was on the

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		AND HUMAN SERVICES	v			FORM	: 05/10/2018 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		495401	B. WING	÷		05/	04/2018
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	001	04/2010
TYLER'S	RETREAT AT IRON E	BRIDGE			12001 IRON BRIDGE RD CHESTER, VA 23831		,
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 842	Continued From pa clinical record.	ge 99	F	842	2		
	4/20/16 and readmi diagnoses that inclu muscle weakness, f anxiety disorder, an Resident #19's mos set) assessment wa an ARD (assessme Resident #19 was c impaired of cognitive on the BIMS (Brief I exam. Resident #11 frequently incontine	admitted to the facility on tted on 8/15/17 with uded but were not limited to type two diabetes mellitus, d status post stroke. at recent MDS (minimum data as a quarterly assessment with nt reference date) of 2/20/18. oded as being moderately e function scoring 08 out of 15 nterview for Mental Status) 9 was coded as being nt of bowel and bladder and sistance from one staff J.					
	sheet) dated 4/30/18 order: "Toileting prog	#19's POS (physician order 8, documented the following gram every 3 hours from 9 order was initiated on					
	ambulation program	#19's March 2018 restorative , showed evidence that staff the toileting program.					
		2018 restorative ambulation g from Resident #19's clinical					
	conducted with ASM member) #1, the DC ASM #1 stated that evidence the April 20 log. ASM #1 stated	m., an interview was I (administrative staff DN (Director of Nursing). the unit manager could not 018 restorative ambulation that she would expect to find ecord because this document					

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		ND HUMAN SERVICES			PRINTED: 05/11/20 FORM APPROVI OMB NO: 0938-03		
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED		
		495401	B. WING		05/04/2018		
NAME OF P			s	TREET ADDRESS, CITY, STATE, ZIP CODE			
TYLER'S I	RETREAT AT IRON BRID	GE		2001 IRON BRIDGE RD HESTER, VA 23831			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRC DEFICIENCY)	LD BE COMPLETIO		
F 842	Continued From page was a part of the clini		F 842				
F 880 SS=F		ented prior to exit. & Control	F 880				
	infection prevention a designed to provide a comfortable environm	blish and maintain an and control program a safe, sanitary and aent and to help prevent the asmission of communicable		 No correction to be made for res or 24. All residents are at risk for this d practice. Facility will develop a policy for and prevention of Legionella Disea b. Administrator or designee will it 	eficient or detection se.		
	program. The facility must esta and control program (a minimum, the follow	-		departments on checking of equipm needed and reporting them to the M Director.c. The Director of Nursing or desig inservice the licensed nursing staff	nent for repairs laintenance nee will on hand		
	reporting, investigatin and communicable di staff, volunteers, visit providing services un arrangement based u	pon the facility assessment to §483.70(e) and following		 washing protocols related to obtain Sugar. d. Director of Nursing or designee CNAs on infection control and han when assisting residents with meals e. Maintenance Director will adjus reach required temp while washing 	will inservice d washing s. t washers to		
	procedures for the probut are not limited to:						

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		ID HUMAN SERVICES MEDICAID SERVICES			FORM	APPROVED . 0938-0391		
STATEMENT O	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE			
		495401	B. WING _		05/	04/2018		
NAME OF PI			· [STREET ADDRESS, CITY, STATE, ZIP CODE	<u></u>			
TYLER'S F	RETREAT AT IRON BRID	GE	12001 IRON BRIDGE RD CHESTER, VA 23831					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE		
F 880	communicable diseas reported; (iii) Standard and tran to be followed to prev (iv)When and how iso resident; including but (A) The type and dura depending upon the in involved, and (B) A requirement tha least restrictive possific circumstances. (v) The circumstances must prohibit employed disease or infected sk contact with residents contact will transmit the	in possible incidents of se or infections should be asmission-based precautions ent spread of infections; alation should be used for a t not limited to: ation of the isolation, infectious agent or organism t the isolation should be the ble for the resident under the s under which the facility ees with a communicable kin lesions from direct s or their food, if direct he disease; and procedures to be followed	 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 ensur proper hand washing technique is used. c. Unit Manager or designee will audit Restorative Dining room 3x weekly x 2 months ensure staff is following hand washing protocols d. Maintenance Director will audit water temps in the laundry M-F x 2 months to ensure require 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. 					
	identified under the fa corrective actions take §483.80(e) Linens. Personnel must hand transport linens so as infection. §483.80(f) Annual rev The facility will condu IPCP and update thei This REQUIREMENT by: Based on observation document review and	en by the facility. le, store, process, and to prevent the spread of		Preparation and submission of this required by state and federal law. does not constitute an admission fo purposes of general liability, profes malpractice or any other court proc	rhis POC ssional	6/4/ <u>18</u>		

Facility ID: VA0402

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DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES			PI		: 05/10/2018
		& MEDICAID SERVICES			O		APPROVED . 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		495401	B. WING			05/	04/2018
NAME OF	PROVIDER OR SUPPLIER		-	S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
TYLER'S	RETREAT AT IRON E	BRIDGE			2001 IRON BRIDGE RD		
				C	CHESTER, VA 23831		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	Continued From an	~~ 100					
		ge 102 plete infection control	F8	380			
1. N.		to maintain infection control					
	practices for one of	one shower stretchers and					
	two of two washing	machines.	-				
	1. The facility staff f	ailed to have a policy and					
	procedure for the de	etection and prevention of					
	Legionella Disease.						
		ailed to maintain a shower er to prevent infections.					
	giving medications t	ailed to wash their hands after o Resident #70 and taking a from Resident #62.					
		failed to maintain the asher's water temperature at ommended by the					
	control practices wh	ailed to maintain infection ile assisting Resident #24 e restorative dining room.					
	The findings include						
		ailed to have a policy and etection and prevention of					
	approximately 8:00 a the documentation of management policy risk of growth and s	e facility on 5/1/18 at a.m. A request was made for of the facility's water and procedures to reduce the pread of Legionella and other gens in the building water					

DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES			F	RINTED): 05/10/2018	
		& MEDICAID SERVICES			C		APPROVED	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	(X3) DA	ATE SURVEY DMPLETED	
		495401	B. WING			05/04/2018		
NAME OF	PROVIDER OR SUPPLIER		1	S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 03	104/2018	
TYLER'S	RETREAT AT IRON E	BRIDGE			12001 IRON BRIDGE RD CHESTER, VA 23831			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 880	Continued From page	ge 103	F8	80)			
	member (ASM) #1, document titled, "Le Assessment Form." failed to reveal a co Questions that shouleft blank. The form number of rooms th (e.g., patient rooms) The form further doo of stay for occupant blank. "10. Are there or hydrotherapy spa was left blank. The f in two spa rooms. T of a date when the f An interview was co (administrative staff administrator, on 5/2 above was reviewed why the form was in questions not answe former director of m form. When asked f program, ASM #1 st management progra had been tested, AS tested to her recolle provide documentat completed. When a director is involved i program, ASM #1 st On 5/2/18 at 1:54 p.	member) #1, the 2/18 at 1:33 p.m. The form 4 with ASM #1. When asked complete with many ered, ASM #1 stated the aintenance completed the or the facility water treatment tated, "We don't have a water am." When asked if the water SM #1 stated the water was ction. ASM #1 was asked to ion of the water testing usked if the new maintenance in the water management tated, "Not at this time." m., ASM #1 presented a ne water testing and stated,						

Facility ID: VA0402

If continuation sheet Page 104 of 112

					FORM	: 05/10/2018 APPROVED
T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	X3) DATE SURVEY COMPLETED	
	495401	B. WING	;		05	/04/2018
PROVIDER OR SUPPLIER		4	[1 00/	04/2010
RETREAT AT IRON E	BRIDGE					
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	1		(EACH CORRECTIVE ACTION SHOUL	D BE	(X5) COMPLETION DATE
ASM #1, the admini of nursing, and ASM clinical services wer concern on 5/3/18 a No further information	strator, ASM #2, the director 4 #3, the regional director of re made aware of the above at 6:50 p.m. on was provided prior to exit.	F٤	380	ן		
stretcher in a manne Observation was ma a resident in the sho unit. The resident w being assisted by a On 5/4/18 at 10:20 a 100/200 unit was ob member (OSM) #4. observed with 13 dr top of the mess stre three of the holes di plastic coating. The cracks and tears in the approximately 1/2 in inches. The white n pad was visible in for that is safe and san wouldn't want to take An interview was co nurse) #4 on 5/4/18 shown the shower s on the 100/200 hall. concern that the stre tears in it, RN #4 sta	er to prevent infections. ade on 5/4/18 at 10:10 a.m. of ower room on the 100/200 vas on the shower stretcher staff member. a.m. the shower room on the oserved with other staff The shower stretcher was ain holes in the cushion on tcher. Of the 13 holes, only d not have any tears in the other 10 drain holes had the plastic ranging from the to approximately eight naterial inside of the stretcher our of the tears. When asked if tary, OSM #4 stated, "I e a shower on it." nducted with RN (registered at 10:32 a.m. RN #4 was tretcher in the shower room When asked why it was a etcher cushion had rips and ated, "Germs in there."					
	RS FOR MEDICARE TOF DEFICIENCIES OF CORRECTION PROVIDER OR SUPPLIER S RETREAT AT IRON E SUMMARY STA (EACH DEFICIENCY REGULATORY OR LS Continued From par ASM #1, the admini of nursing, and ASM clinical services wer concern on 5/3/18 a No further information 2. The facility staff fa stretcher in a manner Observation was ma a resident in the sho unit. The resident w being assisted by a On 5/4/18 at 10:20 a 100/200 unit was ob member (OSM) #4. observed with 13 dr top of the mess stret three of the holes di plastic coating. The cracks and tears in the approximately 1/2 in inches. The white m pad was visible in fo that is safe and sami wouldn't want to take An interview was co nurse) #4 on 5/4/18 shown the shower s on the 100/200 hall. concern that the streat tears in it, RN #4 sta	DEPENDENTIFICATION NUMBER: 495401 PROVIDER OR SUPPLIER 5 RETREAT AT IRON BRIDGE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	RS FOR MEDICARE & MEDICAID SERVICES TOF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MU A BUILT A95401 B. WING PROVIDER OR SUPPLIER SETREAT AT IRON BRIDGE ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID 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. Fat No further information was provided prior to exit. 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 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 t	RS FOR MEDICARE & MEDICAID SERVICES COF DEFICIENCIES CALL DEF CORRECTION (X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER. A BUILDING 495401 B. WING PROVIDER OR SUPPLIER SRETREAT AT IRON BRIDGE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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." A	ABS FOR MEDICARE & MEDICAID SERVICES (22) MULTIPLE CONSTRUCTION OF DEFICIENCIES (11) PROVIDERSUPPLIERCIAL (22) MULTIPLE CONSTRUCTION A BULDING 495401 B. WING PROVIDER OR SUPPLIER SRETREAT AT IRON BRIDGE SRETREAT AT IRON BRIDGE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PROCEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 stretcher being assisted by a staff member. On 5/4/18 at 10:20 a.m. the shower stretcher being assisted by a staff member. On 5/4/18 at 10:20 a.m. the shower stretcher being assisted by a staff member. On 5/4/18 at 10:20 a.m. the shower stretcher being assisted by a staff member. On 5/4/18 at 0:10 d.m. to a proximately 1/2 inch to approximately eight inches. The while material inside of the stretcher pad was visible in four of the tears. When asked if that is aside and sanitary, OSM #4 stated, " wouldn't want to take a shower on it." An interview was conducted with RN (registered nurse) #4 on 5/4/18 at 3 member.	FIGHT OF TIGENTIAND TIGURAD SERVICES FORM TOF DEFICIENCIES (X1) PROVIDERSUPPLERCIA IDENTIFICATION NUMBER (X2) MULTIPLE CONSTRUCTION A BUILDING (X2) DATA CON 495401 INING 05. PROVIDER OR SUPPLIER 495401 INING 05. SRETREAT AT IRON BRIDGE STREET ADDRESS, CITY, STATE, ZIP CODE 12001 IRON BRIDGE RD CHESTER, VA 23831 05. SUMMARY STATEMENT OF DEFICIENCIES (RCH) DEPRICIENCY MUST BE PRECEDED BY FULL REGULATORY ON USC DENTIFYING INFORMATION) IPREFX FORWDER'S PLANOF CORRECTION (EACH CORRECTIVE ADDRESS, CITY, STATE, ZIP CODE 12001 IRON BRIDGE RD CHESTER, VA 23831 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. F 880 No further information was provided prior to exit. F 880 2. The facility staff failed to maintain a shower stretcher in a manner to prevent infections. F 880 Observation was made on 5/4/18 at 10:10 a.m. of a resident was on the shower stretcher being assisted by a staff member. F OR HA TO CO HA 13 holes, only three of the holes in the cushion on top of the mess stretcher. On 5/4/18 at 10:20 a.m. the shower stretcher palstic 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, "1 wouldn't want to take a shower not it."

DEPAR	MENT OF HEALTH	AND HUMAN SERVICES					05/10/2018 APPROVED
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES). 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		495401	B. WING	€		05	/04/2018
NAME OF	PROVIDER OR SUPPLIER		L	Γ	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00	10412010
TYLER'S	RETREAT AT IRON E	BRIDGE		1	12001 IRON BRIDGE RD		
					CHESTER, VA 23831		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 880	 (administrative staff administrator, on 5/ asked who maintain #1 stated, "Maintena needed and the nur nursing assistants) them." When asked rips and tears in the stretcher, ASM #1 s it would be a concer infection control con A request was made maintaining the shor On 5/4/18 at 11:11 a director of clinical set the facility staff did r maintaining the shor informed this survey removed. No further information 3. The facility staff fa practices to wash th medications to Residual blood sugar reading Resident #70 was a 12/2/17 with diagnos limited to: irregular h blood pressure and The most recent MD quarterly assessment reference date) of 4/ having scored a set 	 member) #1, the 4/18 at 10:40 a.m. When as the shower stretchers, ASM ance repairs anything that is ses and CNAs (certified observe them when they use d if it was acceptable to have e cushion of the shower stated, "No." When asked why rn, ASM #1 stated, "It's an acern and it's a safety hazard. e for the facility policy on wer stretchers. a.m. ASM #4, the regional ervices informed this surveyor not have a policy on wer stretchers. "ASM #4 yor that the cushion has been on was provided prior to exit. 	F٤	880			

Facility ID: VA0402

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		AND HUMAN SERVICES				FORM	05/10/2018 APPROVED 0938-0391		
STATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DA	(X3) DATE SURVEY COMPLETED		
		495401	B. WING	;		05	/04/2018		
NAME OF	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE				
TYLER'S	RETREAT AT IRON E	BRIDGE			12001 IRON BRIDGE RD CHESTER, VA 23831				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE		
F 880	resident was severed resident was coded staff for all activities eating which the resident was set up. The having a feeding tulk Resident #62 was a 9/13/17 with diagno- limited to: repeated pressure and deme The most recent MI significant change a (assessment refere resident as having s BIMS (brief interviet the resident was set The resident was set The resident was set The resident was set an observation was of LPN (licensed pri- medications to Resident). LPI of water after giving then threw away the #1 did not sanitize for the medications. LF medication cart action room. LPN #1 put of blood glucose moni- and wiped it off. LPI resident's room to the termine the set of the set of the set of the set of the resident's room to the set of the set of the set of the set of the resident's room to the set of the set of the set of the set of the set of the set of the set of the set of the set of the set of th	aly impaired cognitively. The as requiring assistance from s of daily living except for sident could perform after the e resident was coded as be. admitted to the facility on ses that included but were not falls, diabetes, high blood entia. DS (minimum data set), a assessment, with an ARD ence date) of 4/9/18 coded the scored a four out of 15 on the w for mental status) indicating verely impaired cognitively. oded as requiring assistance ivities of daily living with the which the resident could	F	380					

Facility ID: VA0402

If continuation sheet Page 107 of 112

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	05/10/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		495401	B. WING	;		05/	04/2018
	PROVIDER OR SUPPLIER	BRIDGE	1		STREET ADDRESS, CITY, STATE, ZIP CODE 12001 IRON BRIDGE RD CHESTER, VA 23831		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	LPN #1 returned to gloved hands into h out and obtained an LPN #1 then obtain returned to the resider returned to the resider returned to the cart, off the monitor and An interview was co p.m. with LPN #1, ret their hands. LPN # and I didn't do it bet and #62)." When as their gloved hands i stated, "I should hav issue. It's contamina On 5/3/18 at 6:45 p. member) #1, the ad director of nursing w findings. An interview was co a.m. with ASM #2. W their hands, ASM #2 in-between activities should do after they their gloves off even Review of the facility Washing" document is the most important the spread of infecti replace the need for rubbing or hand was Perform hand-hygie	the medication cart, put her er pockets to get the cart keys nother lancet from the cart. ed another lancet and dent's room. LPN #1 then nt's blood sugar. LPN #1 removed her gloves, wiped put it back into the cart. anducted on 5/3/18, at 5:30 egarding when staff washed 1 stated, "Between patients ween (names of Resident #70 sked what staff did if they put nto their pockets, LPN #1 ve re-gloved. It's a safety ation." m. ASM (administrative staff ministrator and ASM #2, the vere made aware of the anducted on 5/4/18 at 8:30 When asked when staff wash 2 stated, "Before, after and s." When asked what staff put their gloved hands in #2 stated, "They should take	F	880			

Facility ID: VA0402

If continuation sheet Page 108 of 112

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		DATE SURVEY
				IG		
		495401	B. WING _			05/04/2018
NAME OF I	PROVIDER OR SUPPLIEF	र		STREET ADDRESS, CITY, STAT	E, ZIP CODE	
TYLER'S	RETREAT AT IRON	BRIDGE		12001 IRON BRIDGE RD CHESTER, VA 23831		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		PROVIDER'S PLAN	OF CORRECTION	(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE) CROSS-REFERENCED DEFICI	TO THE APPROPRIATE	COMPLET DATE
F 880	Continued From p	age 108	F 88	30		
		andling an invasive device				
		ether or not gloves are used) for				
	No further informa	ation was provided prior to exit.				
	temperature in the	f failed to maintain the water e residents' clothes washer at ecommended by the				
	laundry with OHM director of laundry washing machines control reading on what the water ter OSM #6 stated, "H conversation the of When asked if, ar temperature in the stated, "No. (Nam maintenance) con temperature in the water temperature OSM #6 stated, "I not hot. Especially	bservation was on 5/4/18 at 9:10 a.m. of the dry with OHM (other staff member) #6, the tor of laundry services. There were two ning machines. There was no temperature rol reading on the machines. When asked the water temperature in the machines was, I #6 stated, "Hmmm, we just had that ersation the other day. It was in the 90's." n asked if, and how the staff checked the berature in the washing machines, OSM #6 d, "No. (Name of OSM #4, the director of tenance) comes in and he checks the berature in the faucet." When asked why the r temperature needed to be at a certain level I #6 stated, "It's not going to get clean if it's not. Especially the soiled linens."				
		conducted on 5/4/18 at 9:55 , the director of maintenance.				-

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			PI		: 05/10/2018 APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			O		0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		LE CONSTRUCTION		E SURVEY IPLETED
		495401	B. WING			05/	04/2018
NAME OF F	PROVIDER OR SUPPLIER		·		TREET ADDRESS, CITY, STATE, ZIP CODE		
TYLER'S	RETREAT AT IRON B	BRIDGE			2001 IRON BRIDGE RD CHESTER, VA 23831		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	Continued From page	-	F 8	80			
	On 5/4/18 at 10:10 at the April and May 20 the sink in the laund was documented as degrees Fahrenheit machine alarmed if below 160 degrees, not." When asked h washing resident's I temperature, OSM at the manufacturer." On 5/4/18 at 10:41 at the stated, "So the manufacturer says if When asked what the OSM #4 stated, "14 heaters in the back On 5/4/18 at 11:05 at administrator was not fahrenheit]." Per immanufacturer said of temperature should Fahrenheit. No further informatif	#4 stated, "I'll call the a.m., OSM #4 returned and nufacturer says whatever that what you're going to get. The it has to run at 160 degrees." he temperature was set at, 0 degrees. All the water are set at 140." a.m. ASM #1, the notified of the findings. ufacturer's information for the documented, "Hot water 90 rade) [194 degrees terview with OSM #4, the on the telephone that the water be at least 160 degrees on was provided prior to exit.					
	control practices wh	nile assisting Resident #24 e restorative dining room.					

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		AND HUMAN SERVICES				FORM): 05/10/2018 APPROVED). 0938-0391		
	AND PLAN OF CORRECTION IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495401	B. WING	i		05	/04/2018		
	NAME OF PROVIDER OR SUPPLIER TYLER'S RETREAT AT IRON BRIDGE				REET ADDRESS, CITY, STATE, ZIP CODE 2001 IRON BRIDGE RD HESTER, VA 23831				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATICN)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE		
F 880	Resident #24 was a 6/2/17 with diagnost imited to high chole stroke, and muscle most recent MDS (assessment was a ARD (assessment was a ARD (assessment was a ARD (assessment #24 was a ability to make daily possible 15 on the Mental Status) exaits being totally dep with meals. On 5/02/18 at 8:05 restorative dining restorative ding and feed Resident and feed Resident a.m., RN#2 got up over to speak to an bare hand (right) or while she was talkin back down and pro the rest of her brea sanitize her hands. On 5/03/18 at 4:17 conducted with RN maintain infection or resident with their mould wash her har touch the residents	admitted to the facility on ses that included but were not esterol, high blood pressure, weakness. Resident #24's	F	880					

Facility ID: VA0402

If continuation sheet Page 111 of 112

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 05/10 FORM APPR							
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			0		. 0938-0391
AND DIAN OF CODDECTION IDENTIFICATION MUNDED.		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495401	B. WING			05/	/04/2018
NAME OF	PROVIDER OR SUPPLIER		·	S	STREET ADDRESS, CITY, STATE, ZIP CODE		0.12010
TYLER'S	RETREAT AT IRON E	BRIDGE		1	12001 IRON BRIDGE RD		
					CHESTER, VA 23831		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
E 000							
F 880		-	F8	880			
	1	2 stated that had washed her ng Resident #24. When RN					
		the above observations, RN					
		I should probably wash my					
		ed why she should wash her buching another resident and					
		after touching a resident's hair,					
		naintain infect on control."					
	$O_{22} = E/4/19$ at 10:20	a m ASM (administrativo					
		a.m., ASM (administrative ne administrator was made					
	aware of the above						
	documents in part, t is the most important the spread of infect	led, "Hand Washing," the following: "Hand washing nt component for preventing ionPerform hand hygiene: having direct contact with					
	No further informati	on was presented prior to exit.					
							¥.
		х.					

Facility ID: VA0402

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDIO

STATEME	NT OF DEFICIENCIES	KEDICAID SERVICES KEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(¥2) 141	11 710		OMB	RM AP 10. 09	38-0	
SALE AND CONNECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVE COMPLETED		
NAME OF	P 000	495401	B. WING	3					
NAME OF	F PROVIDER OR SUPPLIER			1 5	STREET ADDRESS, CITY, STATE, ZIP CODE		5/04/2	2018	
TYLER	'S RETREAT AT IRON E	RIDGE		1	2001 IRON BRIDGE RD				
(X4) ID					CHESTER, VA 23831				
PRÉFIX		TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID		PROVIDER'S PLAN OF CORRECT				
TAG	REGULATORY OR LS	C IDENTIFYING INFORMATION)	PREFI) TAG		(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DOC		(X5) MPLETIC DATE	
E 000	Initial Comments		E 00	00					
	The facility was in su CFR Part 483.73, Re Care Facilities.	nergency Preparedness ed 5/2/18 through 5/4/18. bstantial compliance with 42 equirement for Long-Term			,	·			
F 000	INITIAL COMMENTS	;	F 00	00					
	survey was conducted	e Safety Code							
550 F	consisted of 33 curren (Residents #1, #36, #1 #56, #47, #7, #35, #19 #50, #28, #45, #12, #2 #44, #42, #68, #26, #4	3, #323, #30, #24, #58, , #326, #2, #62, #60, #16, 9, #70, #4, #25, #273, #49, 6, and #21) and 3 closed nts #74, #73, and #75).	F 550		F 550				
ac ac ou th	ccess to persons and subside the facility, inclu is section.	to a dignified existence, communication with and services inside and ding those specified in		di de 3.	. No corrections to be made for esident #28 or #12. All residents in the restorative ining program are at risk for the eficient practice. a. Social Worker will inservice	State of Lot			
re: pro he	sident in a manner and omotes maintenance o r quality of life, recogn	in an environment that		Re b. res	ursing Department Staff on esident Rights and Dignity. Facility will reassess set up in storative dining room and staffin alleviate wait times.	6	2018		

Any deficiency statement enging with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that 6/4 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 14 118 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

	STATEMENT OF DEFICIENCIES (X [*]) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		VA0402	B. WING		05/	04/2018
NAME OF	PROVIDER CR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE		
TYLER'S	S RETREAT AT IRON E	SRIDGE	ON BRIDGE R R, VA 23831	RD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
F 001	Continued From pa	ge 1	F 001			
	12VAC5-250.F cros	ss references to F656				
	12VAC5-250.F cros	s references to F657				
		references to F685				
	F12VAC5-371-140. E		· · · · · ·			
	review, it was detern obtain complete bac 25 employees prior (registered nurse) #	view and facility document mined facility staff failed to ckground checks on three of to employment, RN ⁶ 6, CNA (certified nursing SM (other staff member) #12.				
		d to obtain the license registered nurse) #6 prior to				
		t to obtain the license (œrtified nursing assistant)				
		d to obtain the background er staff member) #12, the				
	The findings include	r:				
		s employee record failed to a of the nursing license.				
		a.m., a request was made to ss office manager for a copy ation for RN #6.				
		a.m., OSM #8 returned and t." OSM #8 was asked about				

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If continuation sheet 2 of 5

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		VA0402	B. WING		05/	04/2018	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE			
YLER'S	RETREAT AT IRON E	RIDGE	ON BRIDGE R R, VA 23831	D			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE	
F 001	stated, "When I heat they want to hire so check and license w they checked the st "To ensure they are right to be giving ca On 5/4/18 at 11:05 a member) #1, the ac of the findings. Review of the facilit Resident Abuse Po This facility will not mistreatment, explo misappropriation of PROCEDURE: 1. S the Facility to under employees and to r of current employee The facility will do th new employee: ii. C licensing and certifit that employees hold certification status to and have no discipit abuse or neglect." 2. Review of CNA # evidence verification On 5/4/18 at 10:05	ge 2 d for hiring staff, OSM #8 ar from a department head meone we do the background verification." When asked why aff's license, OSM #8 stated, a certified and have a legal are to the residents." a.m. ASM (administrative staff dministrator was made aware by's policy titled, "Virginia licy" documented, "POLICY: tolerate abuse, neglect, bitation of residents, and resident property by anyone. Greening - 1) It is the policy of rtake background checks of all etain on file applicable records as regarding such checks. a. he following prior to hiring a Check with all applicable cation authorities to ensure d the requisite license and/or to perform their nob functions linary action as a result of #6's employee record failed to an of the CNA certification. a.m., a request was made to ess office manager for a copy					
	On 5/4/18 at 10:55 stated, "I didn't find	f the certification for CNA #6. a.m., OSM #8 returned and it." OSM #8 was asked about ed for hiring staff, OSM #8					

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If continuation sheet 3 of 5

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State of Virgi	inia				FURIN	APPROVED
STATEMENT OF AND PLAN OF C		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		VA0402	B. WING		05/0	4/2018
NAME OF PROVI	IDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
TYLER'S RET	REAT AT IRON E	SRIUGE	ON BRIDGE F R, VA 23831	RD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CRCSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
F 001 Cor	ntinued From pa	ge 3	F 001			
stat they che they "To righ On 3. R evid was On State the state the state they chee #8) and Whe OSM any worl On f	eed, "When I hea y want to hire so ock and license v y checked the st ensure they are it to be giving ca 5/4/18 at 11:05 a mber) #1, the ad he findings. Review of OSM # dence document a done. 5/4/18 at 10:05 a ed, "I didn't find process followed ed, "When I hea y wart to hire so ck and license v she was a trans we got a lot of t en asked if they kground check, en asked why th M #8 stated, "To criminal history king."	ar from a department head meone we do the background verification." When asked why aff's license, OSM #8 stated, certified and have a legal re to the residents." a.m. ASM (administrative staff ministrator was made aware 412's employee file failed to ation that a background check a.m., a request was made to ess office manager for a copy check for OSM #12. a.m., OSM #8 returned and it." OSM #8 returned and it." OSM #8 was asked about d for hiring staff, OSM #8 r from a department head meone we do the background erification. For (name of OSM fer from a sister community he information from them." would still require a OSM #8 stated they would. ey get a background check, make sure they don't have that would prohibit them from				
No f	further information	on was obtained prior to exit.]

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State of Virginia STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _____ B. WING VA0402 05/04/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 12001 IRON BRIDGE RD **TYLER'S RETREAT AT IRON BRIDGE** CHESTER, VA 23831 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY)

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