PRINTED: 09/13/2021 FORM APPROVED OMB NO. 0938-0391

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		495401	B. WING		C 08/05/2021
	ROVIDER OR SUPPLIER RETREAT AT IRON BRID	GE		STREET ADDRESS, CITY, STATE, ZIP CODE 12001 IRON BRIDGE RD CHESTER, VA 23831	1 00/00/2021
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
E 000	Initial Comments		E 00	0	
F 000	survey was conducted facility was in substar	nergency Preparedness d 8/3/21 through 8/5/21. The ntial compliance with 42 CFR ment for Long-Term Care	F 00	0	
	survey was conducted complaints were investigated (VA00052538 - substant VA00047112 - under required for comp	dicare/Medicaid standard d 8/3/21 through 8/5/21. Two stigated during the survey antiated without deficiency nsubstantiated). Corrections bliance with 42 CFR Part 483 are Requirements. The Life eport will follow.			
F 558 SS=D	time of the survey. The of 33 current resident record reviews.	bed facility was 68 at the ne survey sample consisted reviews and four closed odations Needs/Preferences	F 55	8	9/10/21
	services in the facility accommodation of represent we endanger the health cother residents.	sident needs and			
	Based on observation document review, and was determined that the ensure the accommod 37 residents in the sure	n, staff interview, facility d clinical record review, it the facility staff failed to dation of needs for one of rvey sample, Resident #29. I to place Resident #29's call		Corrective Action(s). Resident #29's of bell was placed in resident's reach an remains in reach while in room. Identification of Deficient Practice(s) & Corrective Action(s):	d
ABORATORY I	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE

Electronically Signed

08/25/2021

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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495401	B. WING			C 08/05/2021
	ROVIDER OR SUPPLIER	DGE		STREET ADDRESS, CITY, STATE, ZIP CODE 12001 IRON BRIDGE RD CHESTER, VA 23831	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 558	6/21/21 with diagnos and bipolar disorder (minimum data set), with an ARD (assess 6/22/21, Resident #2 severely cognitively decisions, having so BIMS (brief interview coded as having had admission, and as hadmission to the facility observations conduction and time: 8/3/21 at 18/4/21 at 9:53 a.m., observed lying in between the sident #29's call behind the head of his revealed there were beside the resident's A review of Resident plan, dated 6/22/21, revealed, in part: "Mifalls/minimize injurieright side of bedIm	dmitted to the facility on ses including dementia (1) (2). On the most recent MDS an admission assessment sment reference date) of 29 was coded as being impaired for making daily ored five out of 15 on the of for mental status). She was a fall in the month prior to aving had no falls since lity. Setted on the following dates 2:47 p.m. and 4:00 p.m.; revealed Resident #29 was d. During each observation, well was lying on the floor er bed. Further observation no fall mats on the floor bed. Setting the following dates 2:47 p.m. and 4:00 p.m.; revealed Resident #29 was d. During each observation, well was lying on the floor er bed. Further observation no fall mats on the floor bed. Setting the following dates 2:47 p.m. and 4:00 p.m.; revealed Resident #29 was d. During each observation, well was lying on the floor er bed. Further observation no fall mats on the floor bed. Setting the first provided the following dates are updated on 7/22/21, mimize risks for a related to falls: "Fall mat to plement preventative fall isMaintain call light within	F 55	<u> </u>	all were gative of d agency DN and/or oning and vith in ill be Il within on. ger will ly x 12 e. Any ed at time bN. o QAPI	
	nurse) # 2 was intervall bells should be particularly stated the call bells s	.m., LPN (licensed practical viewed. When asked where placed in resident rooms, she should always be within a en asked who is responsible				

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		495401	B. WING _			C 08/05/2021
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F 558	for making sure the of #2 stated, "It is every Everyone who enters On 8/4/21 at 3:44 p.r was interviewed. She always be placed wit asked if Resident #2 bell, RN #3 stated, "time." On 8/4/21 at 4:54 p.r member) #1, the adr (director of nursing), vice-president of operegional nurse consuconcerns. On 8/5/21 at 8:43 a.r When asked where a be located, she state a resident's reach. When asked where a be located it is "everyone sure a resident's call asked why it is import to be within reach, Characteristic A review of the facilit Communication Systems and the state of the facilit Communication Systems are sided, in part: "W	call bells are in reach, LPN /body's responsibility. s the room." m., RN (registered nurse) #3 e stated call bells should thin a resident's reach. When 9 is capable of using her call Yes. She uses it from time to m., ASM (administrative staff ministrator, ASM #2, the DON ASM #3, the regional erations, and ASM #4, the ultant, were informed of these m., CNA #5 was interviewed. a resident's call bell should ed it should be located within /hen asked if Resident #29 is call bell, she stated yes. She e's responsibility" to make bell is within reach. When rtant for a resident's call bell ENA #5 stated, "Safety."	F	1		
	REFERENCES (1) "Dementia is a gr	radual and permanent loss of occurs with certain diseases.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING				(X3) DATE COMP	SURVEY		
			71. 5012511			,	c
		495401	B. WING			08/	/05/2021
	ROVIDER OR SUPPLIER RETREAT AT IRON BRID	GE		12001	T ADDRESS, CITY, STATE, ZIP CODE IRON BRIDGE RD ITER, VA 23831		
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
F 558	and behavior." This in website https://medlineplus.go (2) "Bipolar disorder (manic-depressive illna a mental disorder tha mood, energy, activity the ability to carry out information is taken front https://www.nimh.nih.order/index.shtml.	nking, language, judgment, information is taken from the ov/ency/article/000746.htm. (formerly called less or manic depression) is t causes unusual shifts in y levels, concentration, and t day-to-day tasks." This		558			9/10/21
SS=D	CFR(s): 483.12(b)(1)- §483.12(b) The facilit implement written pol §483.12(b)(1) Prohibi neglect, and exploitat misappropriation of reference with the facility staff failed abuse policy to imme of abuse to the facility staff failed abuse to the admir	y must develop and licies and procedures that: and prevent abuse, licion of residents and lesident property,		Co In- sta rec ab Ad	corrective Action(s): -service education was provided to al aff by Facility Administrator on the tim quirement to report all allegations of buse immediately to Facility dministrator or Director of Nursing. entification of Deficient Practice(s) &		5/10/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED		
			7 t. BOILD	_		l ,	С
		495401	B. WING			1	/05/2021
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	700/2021
				1:	2001 IRON BRIDGE RD		
TYLER'S I	RETREAT AT IRON BRID	OGE		c	CHESTER, VA 23831		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 607	Continued From page	e 4	F	607			
		d an allegation of abuse to			Corrective Action(s):		
		21. The facility staff failed to			Current residents residing in the facility	,	
		is allegation to the facility			may have been potentially affected. A		
		1. ASM #1 stated he did not			100% audit of facility concern forms for	•	
	· ·	s allegation of abuse to the			the previous 30 days will be completed		
	T	d other officials until 1/19/21,			Any negative findings of reportable		
	because he was not	made aware of the allegation			occurrences will result in an internal		
	until that date.				investigation with appropriate notification	on	
					of outcomes to state agencies, attendir	ıg	
	The findings include:				physician and responsible parties.		
	The facility abuse pol	licy documented, "Facility			Systemic Change(s):		
	staff must immediate	ly report all such allegations			The facility Policy and Procedure for		
	to the Administrator/A	Abuse Coordinator. The			reporting resident abuse & neglect has		
		Coordinator will immediately			been reviewed and no changes are		
		n and notify the applicable			warranted at this time. Facility staff, to	_	
	_	cies in accordance with the			include new hires and agency staff will	be	
		licy. 6) Initial Reports a.			in-serviced by the administrator on the		
	Timing. All allegations				abuse prevention, investigation, and		
	-	n, Injuries of Unknown			reporting policy. These in-services reviewed prevention, identifying, timely		
	must be reported imn	opriation of resident property			reporting and investigating of incidents		
	-	or of Nursing (DON) and to			and allegations of abuse, neglect or		
	the applicable State				mistreatment of residents, resident to		
	are approaule state.				resident altercations and misappropriate	tion	
	Resident #31 was ad	mitted to the facility on			of property that are reported.		
		I's diagnoses included but					
	were not limited to str	roke, chronic kidney disease			Monitoring:		
	and anxiety disorder.	Resident #31's quarterly			The Administrator will be responsible for	or	
	minimum data set as	sessment with an			maintaining compliance. Facility conce		
		e date of 6/23/21, coded the			forms will be reviewed 5 times weekly		
	resident's cognition a	is severely impaired.			12 weeks by the Administrator/designe		
					ensure any potential reportable events	are	
		1/16/21 documented,			investigated and reported as required.		
		dication stated this evening			Confidential files of reported incidents	and	
		around that she was beat up			follow-up documentation will be		
		ne named HR sec heard not			maintained in the Administrator's office		
		ut also said that she was and all shift she was saving			Documentation will be reviewed month 3 months by QAPI committee for further	•	
	- mana non ner nasoa	anu an sini she was savini	1		L S HOURIS DY WAET COMMINER TO MININE	<i>2</i> 1	1

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strange things like s tv." A FRI (facility report SA on 1/19/21 docu 1/19/21. Incident Do Involved: (Resident of abuse/mistreatme Administrator regard (Resident #31) to he that she had been be her husband. A full completed and the rinjury" The final report was abuse was found. The nurse who docu note was no longer of the conducted with RN or regarding a resident stated she is going to safe, conduct a full be resident's skin, obtain allegation of abuse of administrator immed RN #2 stated she we abuse within 20 to 3 one hour. On 8/4/21 at 5:01 p. conducted with ASM member) #1 (the administrator)	ed incident) submitted to the mented, "Report Date: ate: 1/16/21. Residents #31). Injuries: No. Allegation ent. Incident was reported to ding statement from resident er nurse. The resident stated eaten up and was hiding from body assessment was esident showed no signs of completed on 1/25/21 and no amented the 1/16/21 nurse's employed at the facility. Image: The resident stated eaten up and was hiding from body assessment was esident showed no signs of completed on 1/25/21 and no amented the 1/16/21 nurse's employed at the facility. Image: The resident is employed at the resident is produced to the director of abuse. RN #2 to make sure the resident is produced to the director of nursing or diately after her assessment. The product of the director of nursing or diately after her assessment. The product of the director of nursing or diately after her assessment. The product of the director of nursing or diately after her assessment. The product of the director of nursing or diately after her assessment. The product of the director of nursing or diately after her assessment. The product of the director of nursing or diately after her assessment. The product of the director of nursing or diately after her assessment. The product of the director of nursing or diately after her assessment. The product of the	F 60	review or recommendations.			
	ROVIDER OR SUPPLIER RETREAT AT IRON BRI SUMMARY S (EACH DEFICIEN REGULATORY OF REGULATORY OF REGULATORY OF REGULATORY OF REGULATORY OF REGULATORY OF STRAINS IN THE REGULATORY OF STRAINS IN THE REGULATORY OF REGULATORY OF STRAINS IN THE REGULATORY OF RE	ROVIDER OR SUPPLIER RETREAT AT IRON BRIDGE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 5 strange things like saying calling her name on the tv." A FRI (facility reported incident) submitted to the SA on 1/19/21 documented, "Report Date: 1/19/21. Incident Date: 1/16/21. Residents Involved: (Resident #31). Injuries: No. Allegation of abuse/mistreatment. Incident was reported to Administrator regarding statement from resident (Resident #31) to her nurse. The resident stated that she had been beaten up and was hiding from her husband. A full body assessment was completed and the resident showed no signs of injury" The final report was completed on 1/25/21 and no abuse was found. The nurse who documented the 1/16/21 nurse's note was no longer employed at the facility. On 8/4/21 at 3:24 p.m., an interview was conducted with RN (registered nurse) #2 regarding a resident's allegation of abuse. RN #2 stated she is going to make sure the resident is safe, conduct a full body assessment, check the resident's skin, obtain vital signs then report an allegation of abuse to the director of nursing or administrator immediately after her assessment. RN #2 stated she would report an allegation of abuse within 20 to 30 minutes and no later than	ROVIDER OR SUPPLIER RETREAT AT IRON BRIDGE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 5 strange things like saying calling her name on the tv." A FRI (facility reported incident) submitted to the SA on 1/19/21 documented, "Report Date: 1/16/21. Residents Involved: (Resident #31). Injuries: No. Allegation of abuse/mistreatment. Incident was reported to Administrator regarding statement from resident (Resident #31) to her nurse. The resident stated that she had been beaten up and was hiding from her husband. A full body assessment was completed and the resident showed no signs of injury" The final report was completed on 1/25/21 and no abuse was found. The nurse who documented the 1/16/21 nurse's note was no longer employed at the facility. On 8/4/21 at 3:24 p.m., an interview was conducted with RN (registered nurse) #2 regarding a resident's allegation of abuse. RN #2 stated she is going to make sure the resident is safe, conduct a full body assessment, check the resident's skin, obtain vital signs then report an allegation of abuse to the director of nursing or administrator immediately after her assessment. RN #2 stated she would report an allegation of abuse within 20 to 30 minutes and no later than one hour. On 8/4/21 at 5:01 p.m., an interview was conducted with ASM (administrative staff member) #1 (the administrative staff member) #1 (the administrator). ASM #1 stated an allegation of abuse must be reported to the SA within two hours. ASM #1 and ASM #2 (the	RETREAT AT IRON BRIDGE SUMMARY STATEMENT OF DEFICIENCIES (REACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 5 strange things like saying calling her name on the tv." A FRI (facility reported incident) submitted to the SA on 1/19/21 documented, "Report Date: 1/19/21. Incident Date: 1/16/21. Residents Involved: (Resident #31). Injuries: No. Allegation of abuse/mistreatment. Incident was reported to Administrator regarding statement from resident (Resident #31) to her nurse. The resident stated that she had been beaten up and was hiding from her husband. A full body assessment was completed and the resident showed no signs of injury" The final report was completed on 1/25/21 and no abuse was found. The nurse who documented the 1/16/21 nurse's note was no longer employed at the facility. On 8/4/21 at 3:24 p.m., an interview was conducted with RN (registered nurse) #2 regarding a resident's allegation of abuse. RN #2 stated she is going to make sure the resident is safe, conduct a full body assessment, check the resident's skin, obtain vital signs then report an allegation of abuse to the director of nursing or administrator immediately after her assessment. RN #2 stated she would report an allegation of abuse within 20 to 30 minutes and no later than one hour. On 8/4/21 at 5:01 p.m., an interview was conducted with ASM (administrative staff member) #1 (the administrator). ASM #1 stated an allegation of abuse must be reported to the SA within two hours. ASM #1 and ASM #2 (the		

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(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 CORR ((EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETION
F 607	stated he did not repo of abuse until 1/19/21	nately 9:00 a.m., ASM #1 ort Resident #31's allegation because he was not made	F6	507	
F 609 SS=D		√iolations	F 6	609	9/10/21
	involving abuse, negli- mistreatment, includir source and misappro- are reported immedia hours after the allegat that cause the allegat serious bodily injury, the events that cause abuse and do not res the administrator of the officials (including to the adult protective service for jurisdiction in long accordance with State procedures. §483.12(c)(4) Report investigations to the a designated represent accordance with State Survey Agency, within incident, and if the all appropriate corrective	ng injuries of unknown priation of resident property, tely, but not later than 2 tion is made, if the events ion involve abuse or result in or not later than 24 hours if the allegation do not involve ult in serious bodily injury, to be facility and to other the State Survey Agency and the state Survey Agency and the state is state in provides the state facilities in the law through established			

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		495401	B. WING			C	
NAME OF D	ROVIDER OR SUPPLIER	433401	1 3:	STREET ADDRESS, CITY, STATE, ZIP CODE		08/05/2021	
NAME OF P	ROVIDER OR SUPPLIER			, , ,			
TYLER'S F	RETREAT AT IRON BRID	GE		12001 IRON BRIDGE RD			
		<u>-</u>		CHESTER, VA 23831			
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F 609	Continued From page	e 7	F 60	9			
	•	iew, facility document review		Corrective Action(s)			
		view, it was determined that		In-service education provided t	o all staff		
		to report an allegation of		by Facility Administrator on time			
		mmediately but no later than		reporting allegations of abuse.	EIII IESS OI		
	•	37 residents in the survey		reporting allegations of abuse.			
	sample, Resident #3			Identification of Deficient Practi	ica(s) &		
	Sample, Resident #5	1.		Corrective Action(s):	(3) Q		
	Resident #31 reporte	d an allegation of abuse on		Current residents residing in th	e facility		
	•	staff failed to report this		may have been potentially affe	•		
	_	state agency) until 1/19/21.		100% audit of facility concern f			
	anogation to the of the	otate agency) and 1/10/21.		the previous 30 days will be co			
	The findings include:			Any negative findings of reports			
	The infamge melade.			occurrences will result in an int			
	Resident #31 was ad	mitted to the facility on		investigation with appropriate r			
		's diagnoses included but		of outcomes to state agencies,			
		roke, chronic kidney disease		physician and responsible parti			
		Resident #31's quarterly					
	minimum data set as	• •		Systemic Change(s):			
	assessment reference	e date of 6/23/21, coded the		The facility Policy and Procedu	re for		
	resident's cognition a	s severely impaired.		reporting resident abuse & neg			
		• •		been reviewed and no changes			
	A nurse's note dated	1/16/21 documented,		warranted at this time. Facility	staff, to		
	"resident refused med	dication stated this evening		include new hires and agency	staff will be		
	while other staff was	around that she was beat up		in-serviced by the administrato	r on abuse		
	by this person that sh	ne named HR sec heard not		prevention, investigation and re	∍porting		
	close i to her name b	ut also said that she was		policy. These in-services will fo	cus on		
	hiding from her husba	and all shift she was saying		prevention, identifying, timely re	eporting		
	strange things like sa	ying calling her name on the		and investigating of incidents a	nd		
	tv."			allegations of abuse, neglect of	r		
				mistreatment of residents, residents			
	` .	d incident) submitted to the		resident altercations and misar			
	SA on 1/19/21 docum	•		of property. The Administrator i			
		te: 1/16/21. Residents		responsible for completing inte			
	· ·	31). Injuries: No. Allegation		investigations for all reported in			
		nt. Incident was reported to		including injuries of unknown o			
		ng statement from resident		abuse, neglect, unusual occurr			
		nurse. The resident stated		misappropriation of resident pro			
	that she had been be	aten up and was hiding from		resident to resident altercations	3.		

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F 609	completed and the reinjury"	e 8 pody assessment was esident showed no signs of completed on 1/25/21 and no	F 60	Monitoring: The Administrator will be respo maintaining compliance. Facilit forms will be reviewed 5 times 12 weeks by the Administrator/	y concern weekly x	
	The nurse who docur note was no longer e On 8/4/21 at 3:24 p.m. conducted with RN (r regarding a resident's stated she is going to safe, conduct a full be resident's skin, obtain allegation of abuse to administrator immedi RN #2 stated she wo			ensure any potential reportable investigated and reported as re Confidential files of reported in follow-up documentation will be maintained in the Administrator Documentation will be reviewed 3 months by QAPI committee for review or recommendations.	e events are equired. cidents and e 's office. d monthly x	
	an allegation of abus within two hours. AS director of nursing) w above concern. On 8/5/21 at approximated he did not report the stated he did not report to	(administrative staff ninistrator). ASM #1 stated e must be reported to the SA M #1 and ASM #2 (the ere made aware of the mately 9:00 a.m., ASM #1 port Resident #31's allegation				
	aware of the allegation. The facility abuse points that immediate to the Administrator/A	I because he was not made on until that date. licy documented, "Facility ly report all such allegations Abuse Coordinator. The Coordinator will immediately				

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	ROVIDER OR SUPPLIER RETREAT AT IRON BRID	GE		1:	TREET ADDRESS, CITY, STATE, ZIP CODE 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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 609	local and state agence procedures in this pol Timing. All allegations Involuntary Seclusion Source, and Misappromust be reported immediantstrator, Director the applicable State All No further information Transfer and Discharge CFR(s): 483.15(c)(1) (1) §483.15(c) (1) Facility (i) The facility must peremain in the facility, discharge the resident (A) The transfer or discresident's welfare and cannot be met in the second to the resident's sufficiently so the resident's sufficiently	and notify the applicable ies in accordance with the icy. 6) Initial Reports a. s of Abuse, Neglect, Injuries of Unknown opriation of resident property nediately to the or of Nursing (DON) and to agency" In was presented prior to exit. ge Requirements in (ii) (ii) (2) (i) - (iii) and discharge-requirements-ermit each resident to and not transfer or at from the facility unless-scharge is necessary for the discharge is necessary for the discharge is appropriate shealth has improved ident no longer needs the		609	DEFICIENCY)		9/10/21
	endangered due to the status of the resident; (D) The health of indicatherwise be endanged (E) The resident has appropriate notice, to under Medicare or Medicare or Medicare applies submit the necessary payment or after the temperature of the status of t	viduals in the facility is e clinical or behavioral viduals in the facility would ered; failed, after reasonable and pay for (or to have paid edicaid) a stay at the facility. if the resident does not paperwork for third party					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTI AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495401	B. WING		08/05/2021
	ROVIDER OR SUPPLIER RETREAT AT IRON BRID	OGE		STREET ADDRESS, CITY, STATE, ZIP CODE 12001 IRON BRIDGE RD CHESTER, VA 23831	1 00/03/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION
F 622	resident who become admission to a facility resident only allowable or (F) The facility cease (ii) The facility may not resident while the ap § 431.230 of this charge notice from 431.220(a)(3) of this discharge notice from 431.220(a)(3) of this discharge or transfer or safety of the reside facility. The facility may that failure to transfer or safety of the reside facility. The facility may that failure to transfer or safety of the resident under any or in paragraphs (c)(1)(section, the facility may or discharge is documedical record and a communicated to the institution or provider (i) Documentation in must include: (A) The basis for the (i) of this section. (B) In the case of parasection, the specific of the met, facility attern needs, and the service facility to meet the needs in The documentation (2)(i) of this section in the section of the section in the section of the section in the section of the se	ay for his or her stay. For a se eligible for Medicaid after y, the facility may charge a ble charges under Medicaid; sto operate. To transfer or discharge the peal is pending, pursuant to pter, when a resident ight to appeal a transfer or in the facility pursuant to § chapter, unless the failure to would endanger the health ent or other individuals in the must document the danger or or discharge would pose. The circumstances specified (a)(A) through (F) of this ust ensure that the transfer mented in the resident's appropriate information is receiving health care the resident's medical record transfer per paragraph (c)(1) argraph (c)(1)(i)(A) of this resident need(s) that cannot put to meet the resident can available at the receiving seed(s). To required by paragraph (c)	F 62		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		495401	B. WING _		C 08/05/2021
	ROVIDER OR SUPPLIER	OGE		STREET ADDRESS, CITY, STATE, ZIP CODE 12001 IRON BRIDGE RD CHESTER, VA 23831	1 00/03/2021
(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 CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION
F 622	(A) or (B) of this sect (B) A physician when necessary under part this section. (iii) Information provious tinclude a minim (A) Contact information responsible for the car (B) Resident represe contact information (C) Advance Directiv (D) All special instruction ongoing care, as app (E) Comprehensive of (F) All other necessary of the resident's consistent with §483 any other document a safe and effective to the training of the	ry under paragraph (c) (1) ion; and transfer or discharge is agraph (c)(1)(i)(C) or (D) of ded to the receiving provider rum of the following: on of the practitioner are of the resident. Intative information including e information stions or precautions for ropriate. Fare plan goals; ary information, including a stick discharge summary, 21(c)(2) as applicable, and stion, as applicable, to ensure ransition of care. This not met as evidenced riew, facility document accility staff failed to provide ts to the receiving facility of 37 residents in the survey for and #25. filed to evidence Resident accare plan goals and other accord review, it was accility staff failed to provide and #25. filed to evidence Resident accare plan goals and other accord for the resident were active the Resident #64 was accord the resident #64 was accord to provide evidence accord to provide evidence according to pro	F 6	Corrective Action(s): Resident #64 and resident #25 had discharged from the facility. Identification of Deficient Practice(Corrective Action(s): A 100% audit of residents discharge transferred to hospital in the past of the form of the facility of the past of the facility. Any negative findings will be correctime of discovery. Systemic Change(s): The DON and/or ADON will inservation of the facility of the fa	s) & ged or 30 days cion. cted at
		eiving hospital staff when the red to the hospital on		staff and new hires on the discharge/transfer procedure and	the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495401	B. WING _			C 08/05/2021		
	ROVIDER OR SUPPLIER	GE		STREET ADDRESS, CITY, STATE, ZIP CODE 12001 IRON BRIDGE RD CHESTER, VA 23831			703/2021	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 622	6/26/21. The findings include: 1. Resident #64 was a 7/21/21 with diagnose (1) and generalized we recent MDS (minimur assessment with an Adate) of 7/22/21, Resideing moderately impledecisions, having sco BIMS (brief interview) A review of Resident revealed the following 7/23/21: "Called the conference of Resident #64] stating stated to send out to department)Reside medical services) at 3 ED Nurse and she stated admittedPatient is belood clot." Further review of Resident reveal any experiments and been sent 7/23/21. On 8/4/21 at 3:24 p.m. was interviewed. Whe she provides to the hois sent to the hospital resident's face sheet, of condition report, a face was recompressed to the hois sent to the hospital resident's face sheet, of condition report, a face was recompressed to the face sheet, of condition report, a face was recompressed to the face sheet, of condition report, a face was recompressed to the face sheet, of condition report, a face was recompressed to the face sheet, of condition report, a face was recompressed to the face w	admitted to the facility on es including atrial fibrillation reakness. On the most of data set), an admission area (area for making daily red nine out of 15 on the for mental status). #64's clinical record progress note, dated in-call dr (doctor) due to phis chest was hurtingshe are the ED (emergency in left with EMS (emergency in l	F	322	required documentation that is to be submitted to the receiving hospital or facility for the discharged resident. Monitoring: The DON and Social Services Director are responsible for compliance. The DO ADON and/or Social services director audit all residents discharged or transferred from the facility weekly to monitor for required documentation was ubmitted to the receiving facility for 12 weeks. Any negative finding will be corrected at time of discovery. Results the audits will be will be reported to QA committee monthly X 3 months for reviand recommendations.	ON, will ss 2 of API		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	3	(X3) DATE SURVEY COMPLETED		
	495401	B. WING		C 08/05/2021		
NAME OF PROVIDER OR SUPPLIER TYLER'S RETREAT AT IRON BE	RIDGE		STREET ADDRESS, CITY, STATE, ZIP CODE 12001 IRON BRIDGE RD CHESTER, VA 23831	·		
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFICIENCY)	D BE COMPLETION		
this is documented stated, "It should be On 8/4/21 at 4:54 pmember) #1, the according vice-president of or regional nurse conconcerns. On 8/5/21, ASM #2 whether or not Rescontained evidence documentation had 7/23/21, she stated locate it. When ask be included in the concount of the should. On 8/5/21 at 8:35 and nurse) #5 was interested to the should resident is transfer thospital should recomposed many many many many many many many many	in the clinical record, RN #2 e." o.m., ASM (administrative staff dministrator, ASM #2, the DON), ASM #3, the regional perations, and ASM #4, the sultant, were informed of these was interviewed. When asked sident #64's clinical record e that the required definition been able to seed if this information should clinical record, ASM #2 stated it a.m., LPN (licensed practical reviewed. When asked what be sent to the hospital when a red there, she stated the eive all physicians' orders, the als, and the transfer form. LPN should be documented in a slitty policy, "Discharge/Transfer aled no information related to the should be sent to the hospital	F 62				

		(X1) PROVIDER/SUPPLIER/CLIA (X2) MUL IDENTIFICATION NUMBER: A. BUILD		PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
		495401	B. WING _			C 08/05/2021		
	ROVIDER OR SUPPLIER RETREAT AT IRON BRII	DGE		STREET ADDRESS, CITY, STATE, ZIP CODE 12001 IRON BRIDGE RD CHESTER, VA 23831	'	30,30,202		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
F 622	beat much faster that upper and lower char as they should. When chambers do not fill blood to your lungs a feel tired or dizzy, or palpitations or chest your heart, which indictots and can leads to complications. Atrial without any signs or fibrillation can lead to life-threatening compataken from the webs https://www.nhlbi.nihation 2. Resident #25 was 6/14/21. Resident # were not limited to make the were not limited to make the western with an of 6/20/21, coded the severely impaired. Review of Resident at the resident was transfered into and staff had difficult further review of Reincluding nurses' not 6/26/21 failed to evice the resident to evice the resident of the control of the co	ation causes your heart to n normal. Also, your heart's mbers do not work together n this happens, the lower completely or pump enough and body. This can make you you may notice heart pain. Blood also pools in creases your risk of forming to strokes or other fibrillation can also occur symptoms. Untreated to serious and even olications." This information is ite admitted to the facility on 25's diagnoses included but auscle weakness, chronic oneumonia. Sesion minimum data set assessment reference date are resident's cognition as the bladder that drains urine] by inserting a new catheter. Sident #25's clinical record es and a transfer form dated dence that the facility staff t's comprehensive care plan if.	F 6	22				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
			7 50.25	_		,	С
		495401	B. WING			08/	05/2021
	ROVIDER OR SUPPLIER RETREAT AT IRON BRID	GE		1:	TREET ADDRESS, CITY, STATE, ZIP CODE 2001 IRON BRIDGE RD HESTER, VA 23831		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 623 SS=D	stated nurses are suptransfer sheet, change form, a copy of the phemodication administrathe physician's order is transferred to the hourses should docum was sent in a nurse's On 8/4/21 at 5:01 p.m member) #1 (the admidirector of nursing) was above concern. No further information Notice Requirements CFR(s): 483.15(c)(3)-\$483.15(c)(3) Notice Before a facility transfersident, the facility most resident, the facility most representative(s) of the reasons for the manguage and manner facility must send a corepresentative of the Long-Term Care Ombodischarge in the residence with para and	egistered nurse) #2. RN #2 sposed to send a face sheet, e of condition eInteract sysician order sheet, ation record and a copy of for transfer when a resident ospital. RN #2 stated ent that all this information note. a., ASM (administrative staff sinistrator) and ASM #2 (the ere made aware of the a was presented prior to exit. Before Transfer/Discharge (6)(8) before transfer. fers or discharges a nust- and the resident's ne transfer or discharge and ove in writing and in a r they understand. The opy of the notice to a Office of the State oudsman. ss for the transfer or ent's medical record in graph (c)(2) of this section; ce the items described in		622			9/10/21
	§483.15(c)(4) Timing (i) Except as specified	of the notice. d in paragraphs (c)(4)(ii) and					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495401		B. WING		C 08/05/2021		
	ROVIDER OR SUPPLIER	L		1	STREET ADDRESS, CITY, STATE, ZIP CODE 2001 IRON BRIDGE RD CHESTER, VA 23831	1 00/1	05/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 623	discharge required un made by the facility a resident is transferred (ii) Notice must be made before transfer or disc (A) The safety of individual be endangered under this section; (B) The health of individual be endangered, under this section; (C) The resident's health of individual be endangered, under this section; (C) The resident's health of individual be endangered, under this section; (D) An immediate transferred by the reside under paragraph (c)(10) (E) A resident has not days. §483.15(c)(5) Contennotice specified in paramust include the follo (i) The reason for tra (ii) The effective date (iii) The location to what transferred or dischar (iv) A statement of the including the name, a and telephone number receives such request to obtain an appeal for completing the form a hearing request; (v) The name, address	the notice of transfer or nder this section must be to least 30 days before the door discharged. Index as soon as practicable charge when- viduals in the facility would to paragraph (c)(1)(i)(C) of viduals in the facility would to paragraph (c)(1)(i)(D) of viduals in the facility would to paragraph (c)(1)(i)(D) of viduals in the facility would to paragraph (c)(1)(i)(D) of viduals in the facility would to paragraph (c)(1)(i)(D) of viduals in the facility would to paragraph (c)(i)(B) of this section; after or discharge is ent's urgent medical needs, and to in the facility for 30 to the section wing: In the notice. The written the transfer or discharge; of transfer or discharge; of transfer or discharge; of transfer or discharge; of the resident is the resident is god; or resident's appeal rights, and dress (mailing and email), are of the entity which the synthesis and information on how the office of the State with the office of the State	F	623				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		495401	B. WING		08/05/2021		
	ROVIDER OR SUPPLIER	l		STREET ADDRESS, CITY, STATE, ZIP CODE 12001 IRON BRIDGE RD CHESTER, VA 23831	1 00/05/2021		
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F 623	and developmental disabilities, the mailing telephone number of the protection and addevelopmental disabilities. C of the Developmental disabilities of the address and the agency responsible for advocacy of individual established under the for Mentally III Individual Sets of Mentally III Individual Sets of the information in the effecting the transfer must update the recipal practicable once to become available. Sets of facility the administrator of the written notification protection of the State Survey A State Long-Term Carthe facility, and the rewell as the plan for the relocation of the residual disability. This REQUIREMENT by: Based on staff intervental disabilities.	y residents with intellectual isabilities or related g and email address and the agency responsible for lyocacy of individuals with dilities established under Part stal Disabilities Assistance of 2000 (Pub. L. 106-402, 15001 et seq.); and ty residents with a mental sabilities, the mailing and lephone number of the or the protection and als with a mental disorder en Protection and Advocacy uals Act. The state of facility closure closure, the individual who is the facility must provide for to the impending closure agency, the Office of the en Ombudsman, residents of esident representatives, as the transfer and adequate dents, as required at § This is not met as evidenced friew, facility document	F 62	Corrective Action:			
	review, and clinical red determined that the fa	acility staff failed to notify the		Resident #69, #64 and #25 have been discharged from the facility.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION IG	(2	(X3) DATE SURVEY COMPLETED	
		495401	B. WING _			C 08/05/2021	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	<u>-</u> <u>-</u> E	00/00/2021	\neg
				12001 IRON BRIDGE RD			
TYLER'S I	RETREAT AT IRON BRID	GE		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 COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	1
F 623	Continued From page	e 18	F 6	23			
		esident representative), and					
		g of the resident's discharge		Identification of Deficient of De	eficient		
		ee of 37 residents in the		Practices & Corrective action(
		lents #69, #64, and #25.		A 100% audit of residents disc			
		, ,		transferred from the facility in	•		
	The findings include:			days will be completed to revie	ew for		
				written notification of discharg	e to the		
		led to notify the resident and		resident and/or resident repre			
		hen Resident #69 was		and the Ombudsman. Any/all			
		arged to the hospital on		finding will be corrected at tim	e of		
	7/16/21.			discovery.			
	Resident #69 was ad	mitted to the facility on		Systemic Changes:			
		es including endocarditis (1),		The DON and/or ADON will in	service		
	COPD (chronic obstru	uctive pulmonary disease)		licensed nursing staff, to inclu-	de agency		
		On the most recent MDS		staff and new hires on the			
		an admission assessment		Discharge/Transfer policy and	-) .	
	,	ment reference date) of		The in-service training will cov			
	7/26/21, Resident #69	•		required documents to be sub		1	
		y impaired for making daily		a resident when they are disch	-		
	decisions.			transferred from the facility an		~	
	A review of Resident	#60's slipical record		requirement that written notific		9	
	revealed the following			given to the resident and/or Rerepresentative and the Ombud			
		name of local hospital] to f/u		indicating the reason for disch			
		was admitted for aspiration		the facility.	argo nom		
		urther review of Resident		and ratemay.			
		reveal any evidence that the		Monitoring:			
	resident and or the R	R (resident representative)		The DON is responsible for co	ompliance.		
	was notified in writing	of the transfer.		The DON, ADON and/or Unit	Manager v	/ill	
				audit all residents being transf	ferred or		
		n., RN (registered nurse) #2		discharged from the facility we	ekly x 12		
		en asked how she notifies a		weeks to monitor that written			
		a discharge from the facility		documentation was submitted		t	
		stated, "You are supposed		and/or resident representative			
		sked if she ever provides		ombudsman indicating reason			
		N #2 stated, "I have never		discharge. Any negative finding	•	_	
	heard of that."			corrected at time of discovery.			
	l		1	the audits will be forwarded to	ine DON (JI	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	COMPLETED			
		495401	B. WING		08/05/2021		
	ROVIDER OR SUPPLIER	DGE		STREET ADDRESS, CITY, STATE, ZIP CODE 12001 IRON BRIDGE RD CHESTER, VA 23831	00/03/2021		
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F 623	member) #1, the ad (director of nursing) vice-president of op regional nurse consconcerns. On 8/5/21, ASM #2 if she had been able Resident #69 or the writing of the dischashe stated she had A review of the facili Letter Policy," reveacomplete discharge according to all federegulations." REFERENCES (1) "Infectious endothe endocardium, the well as the valves the chambers within the disease caused by lof manifestations are is taken from the we https://www.ncbi.nlm. (2) COPD is "a generon or support of employments." Barron's support of the processible lung of combination of emploronchitis." Barron's support of the processible lung of combination of emploronchitis."	m., ASM (administrative staff ministrator, ASM #2, the DON , ASM #3, the regional erations, and ASM #4, the ultant, were informed of these was interviewed. When asked to locate evidence that RR had been notified in large to the hospital on 7/16/21, not. Ity policy, "Discharge/Transfer alled, in part: "The Facility will letters appropriately and eral, state, and local carditis is the inflammation of the inner lining of the heart, as not separate each of the four the heart. It is primarily a cacteria and has a wide array and sequelae." This information elbsite in.nih.gov/books/NBK557641/. The primarity a cacteria and has a wide array and sequelae." This information elbsite in.nih.gov/books/NBK557641/. The primarity a cacteria and has a wide array and sequelae. This information elbsite in.nih.gov/books/NBK557641/. The primarity a cacteria and has a wide array and sequelae. This information elbsite in.nih.gov/books/NBK557641/. The primarity a cacteria and has a wide array and sequelae. This information elbsite in.nih.gov/books/NBK557641/. The primarity and the primarity and sequelae. This information elbsite in.nih.gov/books/NBK557641/. The primarity and the primarity and sequelae. This information elbsite in.nih.gov/books/NBK557641/.	F 623	designee for review. The audit find be reported to the QAPI committee review and recommendations mon months.	e for		
	brain function. This	radual and permanent loss of occurs with certain diseases. ninking, language, judgment,					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA (X2) MUL [*] IDENTIFICATION NUMBER: A. BUILDI		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		495401	B. WING _			C 08/05/2021		
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F 623	website https://medlineplus.g 2. The facility staff fain writing when Resident hospital on 7/23/ Resident #64 was ac 7/21/21 with diagnos (1) and generalized was according to the state of the state o	ov/ency/article/000746.htm. iled to notify the resident/RR dent #64 was discharged to	F6	523				
	assessment with an date) of 7/22/21, Resbeing moderately im decisions, having so BIMS (brief interview A review of Resident revealed the followin 7/23/21: "Called the [Resident #64] statin stated to send out to department)Reside medical services) at ED Nurse and she stadmittedPatient is blood clot."	ARD (assessment reference sident #64 was coded as paired for making daily ored nine out of 15 on the for mental status). #64's clinical record g progress note, dated on-call dr (doctor) due to g his chest was hurtingshe						
	RR had been notified to the hospital on 7/2 On 8/4/21 at 3:24 p.r was interviewed. Wheresident or the RR of	d in writing of the discharge						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		495401	B. WING _		C 08/05/2021		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 12001 IRON BRIDGE RD CHESTER, VA 23831	1 00/03/2021		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION		
F 623	written notification, heard of that." On 8/4/21 at 4:54 p member) #1, the add (director of nursing) vice-president of opregional nurse consconcerns. On 8/5/21, ASM #2 if she had been able Resident #64 and owriting of the dischashe stated she had No further information in the dischashe stated she had No further information in the dischashe stated she had the stated she	sked if she ever provides she stated: "I have never "I.m., ASM (administrative staff Iministrator, ASM #2, the DON I.ASM #3, the regional perations, and ASM #4, the sultant, were informed of these was interviewed. When asked to locate evidence that for the RR had been notified in large to the hospital on 7/16/21, not. Is one of the most common so, which are irregular heart lation causes your heart to an normal. Also, your heart's lation causes your heart to an normal. Also, your heart's lation causes your heart to an normal happens, the lower of completely or pump enough and body. This can make you way notice heart to pain. Blood also pools in coreases your risk of forming to strokes or other all fibrillation can also occur resymptoms. Untreated	F 6	23			
	life-threatening com taken from the web	plications." This information is					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495401	B. WING				C / 05/2021	
	ROVIDER OR SUPPLIER	GE		STREET ADDRE 12001 IRON BR CHESTER, VA		1 00/	03/2021	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	(EA	PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD E SS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE	
F 623	Continued From page	e 22	F	523				
	6/26/21. The facility	transferred to the hospital on staff failed to provide written asfer to the ombudsman and sentative.						
	6/14/21. Resident #2 were not limited to me kidney disease and p admission minimum of	mitted to the facility on 25's diagnoses included but uscle weakness, chronic neumonia. Resident #25's data set assessment with an e date of 6/20/21, coded the s severely impaired.						
	Review of Resident #25's clinical record revealed the resident was transferred to the hospital on 6/26/21 because he removed his Foley catheter (a tube inserted into the bladder that drains urine) and staff had difficulty inserting a new catheter.							
	(including nurses' not 6/26/21) revealed the was notified of the tra that written notificatio provided to Resident the clinical record fail	sident #25's clinical record les and a transfer form dated resident's representative lansfer but failed to reveal n of the transfer was #25's representative. Also, led to contain evidence that the transfer was provided to						
	stated nurses do not a resident is transferr further stated that nu	egistered nurse) #2. RN #2 notify the ombudsman when red to the hospital. RN #2 rses call the representative ard of providing written						
	On 8/4/21 at 5:01 p.m	n., ASM (administrative staff						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		495401		B. WING			C
	ROVIDER OR SUPPLIER			12	TREET ADDRESS, CITY, STATE, ZIP CODE 2001 IRON BRIDGE RD HESTER, VA 23831	<u> </u>	05/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 623	director of nursing) we above concern. On 8/4/21 at 5:24 p.m conducted with OSM social services director for notifying the ombut transfers). OSM #1 social services of Resident #2 6/26/21 to the ombud know the resident had hospital. No further information Accuracy of Assessm CFR(s): 483.20(g) §483.20(g) Accuracy The assessment must resident's status. This REQUIREMENT by: Based on staff interview, it was determined to maintain a confinement of the survey are sidents in the survey. The facility staff failed	aninistrator) and ASM #2 (the ere made aware of the ere and person responsible ere ere ere ere ere ere ere ere ere e		641	Corrective Action(s): Resident #21 has had their most recent MDS modified to accurately code section B & C. Resident #21's comprehensive care plan has been reviewed to ensure Cognition and Communication interventions are in place and accurate	on	9/10/21
	for sections B0700, B0800 and section C of Resident #21's quarterly MDS with an ARD (assessment reference date) of 6/12/21. The findings include: Resident #21 was admitted to the facility on 5/27/20. Resident #21's diagnoses included but				Identification of Deficient Practice(s) and Corrective Action(s): A 100% audit of all residents current MI assessments will be completed by the MDS coordinators and/or designee to ensure that sections B & C of the MDS are coded correctly. All negative finding	DS	

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
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NAME OF PE	ROVIDER OR SUPPLIER	100.0.	1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	05/2021
IVAIVIL OI II	TO VIDER OR GOL LEEK				2001 IRON BRIDGE RD		
TYLER'S F	RETREAT AT IRON BRID	GE			CHESTER, VA 23831		
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	Х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 641	respiratory failure and #21's quarterly MDS revealed sections B0 (assessments of whe self-understood and vunderstand others) w section C (a cognition completed with the recompleted with the recompleted with RN (rMDS coordinator and completing section B trained to code section Resident #21's cognisection C on the 6/12 assess the resident for conducted with OSM social services direction cognitive assessment	gh blood pressure, chronic d pain. Review of Resident with an ARD of 6/12/21 700 and B0800 ther the resident can make whether the resident can ere not completed. Also, assessment) was not esident or with staff. In., an interview was egistered nurse) #4 (the person responsible for person responsible for person RN #4 stated she was an B based on section C and the person to a section C and the person to a section C and the person of the person to a section C and the person to a section	F	641	will be reported to the MDS department for immediate correction. A Modification will be completed for each discrepancy identified on the most current MDS and the residents comprehensive care plan will be revised as needed. Systemic Change(s): The Resident Interdisciplinary Care Teathas been inserviced by the Regional Clinical Nurse and/or DON on the propassessment and coding of sections B 8 of the MDS. Monitoring: The DON and MDS coordinator are responsible for monitoring compliance. MDS assessment audits will be compleweekly for 12 weeks coinciding with the MDS calendar to monitor for compliance. All negative finds from the audits will be reported to the DON and RCC at the tir of discovery for immediate correction. Aggregate findings will be reported to the QAPI committee monthly x 3 months for review, analysis and recommendations	eted eece. ee	
	member) #1 (the adm	n., ASM (administrative staff ninistrator) and ASM #2 (the ere made aware of the			change in facility policy, procedure and practice.	or	
	Resident Assessmen documented the follor "B0700: Makes Self U Health-related Quality Problems making se frustrating for the resi	wing, Jnderstood					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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		495401	B. WING			08/	05/2021
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IILEKSI	RETREAT AT INON BRID	GE			CHESTER, VA 23831		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
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F 641	Continued From page	. 25	_	C 4 4			
F 0 4 1	Continued From page		-	641			
		nunication problems can be					
	inappropriately mistal						
	cognitive impairment.						
	Steps for Assessmen						
	_	esident's preferred language					
	or method of commun						
		sident. Be sure he or she					
	can hear you or have	communication. If the					
	-	le to communicate, offer					
	alternatives such as v						
	language, or using cu						
		interactions with others in					
	different settings and						
	•	imary nurse assistants (over					
	all shifts) and the resi						
	speech-language pat	•					
	B0800: Ability to Und	-					
	Health-related Quality						
		nd direct person-to-person					
	communication						
	- Can severely limit as	ssociation with others.					
	- Can inhibit the indivi	idual's ability to follow					
		affect health and safety.					
	Planning						
	Steps for Assessmen						
		lent's preferred language or					
	preferred method of o						
		s a hearing aid, hearing					
		nunications enhancement					
	· ·	hould use that device during					
		resident's understanding of					
	person-to-person con						
		sident and observe his or					
	_	other's communication.					
		care staff over all shifts, if					
	possible, the resident						
		hologist (if involved in care). Il record for indications of					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		CONSTRUCTION	(X3) DATE	SURVEY
			7. 50.25				c
		495401	B. WING			08/	05/2021
	ROVIDER OR SUPPLIER RETREAT AT IRON BRID	GE		120	REET ADDRESS, CITY, STATE, ZIP CODE 101 IRON BRIDGE RD IESTER, 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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 641	SECTION C: COGNI' Intent: The items in the determine the resider ability to register and These items are cruc care-planning decision	understands others TIVE PATTERNS his section are intended to ht's attention, orientation and recall new information. hial factors in many hs"	F	641			
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1) §483.21 Comprehens Planning §483.21(a) Baseline §483.21(a) Baseline that includes the instreffective and personthat meet professiona The baseline care platicity and personthat meet professiona. (ii) Include the minimulation (iii) Include the minimulation (iii) Include the minimulation (b) Initial goals based (c) Dietary orders. (c) Dietary orders. (d) Therapy services (e) Social services. (f) PASARR recommulations (f) PASARR recommulations (f) The faccomprehensive care care plan if the comprehensity	Care Plans cility must develop and care plan for each resident ructions needed to provide centered care of the resident al standards of quality care. In must- in 48 hours of a resident's rum healthcare information or care for a resident ted to- d on admission orders. cility may develop a plan in place of the baseline	F	655			9/10/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER	455401	1 3	STREET ADDRESS, CITY, STATE, ZIP COL		8/05/2021
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TYLER'S	RETREAT AT IRON BI	RIDGE		CHESTER, VA 23831		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 655	(b) of this section (this section). §483.21(a)(3) The resident and their of the baseline car limited to: (i) The initial goals (ii) A summary of dietary instructions (iii) Any services a administered by thon behalf of the factive) Any updated ir of the comprehens This REQUIREME by: Based on observed document review, was determined the develop a baseline residents in the surand #69). For Residents in the surand #69). For Reside rails. For Reside rails. For Reside rails. For Reside rails. For Reside rails are provided to the findings included t	rements set forth in paragraph excepting paragraph (b)(2)(i) of a facility must provide the representative with a summary e plan that includes but is not as of the resident. The resident's medications and a facility and personnel acting cility. In the facility and personnel acting cility. The formation based on the details give care plan, as necessary. The is not met as evidenced atton, staff interview, facility and clinical record review, it at the facility staff failed to be care plan for two of 37 rivey sample, (Residents #59 ident #59, the facility staff failed line care plan for the use of ident #69, the facility staff failed to be care for the use of side rails.	Fé	Corrective Action(s): Resident #59's comprehensing has been updated to include quarter rails for assistance were positioning while in bed. Resident #69 is no longer at Identification of Deficient Praction Corrective Action(s): A 100% review of all new and the last 30 days will be conducted	the use of with the facility. Inctice(s) & missions in sucted by the esignee to thave an completed to hails. All their viewed and quarter rails	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495401	B. WING			C 08/05/2021	
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	10115211 011 001 1 21211				2001 IRON BRIDGE RD		
TYLER'S I	RETREAT AT IRON BRID	GE			CHESTER, VA 23831		
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F 655	Continued From page	÷ 28	F 6	355			
	coded as requiring the assistance of two staff members for bed mobility.				The MDS coordinators, IDT and Licens Nurses will be inserviced by the region clinical nurse and/or the DON on the	al	
		s and times: 8/3/21 at 12:22			development and implementation of the	Э	
		/4/21 at 9:48 a.m. and 4:05			baseline care plan as well as ensuring		
		ealed Resident #59 was with her eyes closed. At			that the baseline care plan is accurate prior to providing care plan summary to	,	
	, ,	ations, bilateral side rails			the residents and/or Resident	,	
	were up at the head o				Representative.		
	A review of Resident				Monitoring:		
	revealed a Side Rail E				The MDS coordinators are responsible	for	
	assessment for the us	cumented the resident's			maintaining compliance. The MDS coordinators and or DON/ADON will		
		nd benefits, and the date of			perform weekly chart audits of all new		
		the use of the side rails.			admissions for 12 weeks to ensure		
					baseline care plans are being complete	∍d	
	A review of Resident	#59's baseline care plan			accurately, timey and that a written		
	dated 7/14/21 revealed	ed no evidence of any			summary has been completed and		
	information related to	her use of side rails.			reviewed with the resident and/or		
					Resident Representative. Any negative	;	
		m., LPN (licensed practical			findings will be reported to the MDS		
	,	ewed. When asked if side			coordinator for correction. Detailed		
		ed on a resident's care plan, if it is necessary for resident			findings of the care plan audit will be reported to the QAPI committee for rev	vio.w	
	safety, it should be ca				monthly x 3 months for review, analysis		
	Saicty, it should be de	ne planned.			and recommendations for change in	,	
		n., RN (registered nurse) #1, nterviewed. When asked if			facility policy, procedure and or practice	e.	
	side rails should be in	cluded on a resident's					
		N #1 stated the facility used					
		ery resident's bed, and it					
		al resident whether or not					
	they wanted to use th						
		as only been attaching them					
		who are assessed for them					
		hen asked if side rails					
		n a resident's baseline care n my mind, they came on					

495401 B. WING 08/05/20		
	495401 B. WING	
NAME OF PROVIDER OR SUPPLIER TYLER'S RETREAT AT IRON BRIDGE STREET ADDRESS, CITY, STATE, ZIP CODE 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 COM CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL	
F 655 Continued From page 29 the beds when we opened this building. If they didn't need them, they didn't use them." She added if it does not impede the resident's functioning, it is not a restraint. "They are not something I would think needed to be on the care plan." When asked who develops the baseline care plan, RN #1 stated that on admission, the MDS nurse or the floor nurse initiates the care plan. On 8/4/21 at 4:54 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (director of nursing), ASM #3, the regional vice-president of operations, and ASM #4, the regional nurse consultant, were informed of these concerns. A review of the facility policy, "Comprehensive Care Planning," revealed, in part: "An "Interim" Baseline Care plan must be developed within 48 hours of admission to insure that the resident's needs are met appropriately until the Comprehensive Care Plan is completed." No further information was provided prior to exit. 2. Resident #69 was admitted to the facility on 7/14/21 with diagnoses including endocarditis (1), COPD (chronic obstructive pulmonary disease) (2), and dementia (3), On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 7/26/21, Resident #69 was coded as being moderately conjunitively impaired for making daily decisions. He was coded as requiring the assistance of two staff members for bed mobility and transfers. On the following dates and times: 8/3/21 at 12:36	the beds when we odidn't need them, the added if it does not in functioning, it is not something I would the plan." When asked we care plan, RN #1 state MDS nurse or the flooplan. On 8/4/21 at 4:54 p. member) #1, the addirector of nursingly vice-president of operegional nurse consconcerns. A review of the facilic Care Planning," reversided are met approximated and the process of admission in the plan in the p	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG		OATE SURVEY OMPLETED	
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	ROVIDER OR SUPPLIER RETREAT AT IRON BRID	OGE		STREET ADDRESS, CITY, STATE, ZIP CODE 12001 IRON BRIDGE RD CHESTER, VA 23831	<u>'</u>	30/30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 655	Continued From pag	e 30	F 6	55		
	head of the resident's	d, Resident #69 was d. At each of these al side rails were up at the s bed.				
	7/20/21. The form do assessment for the u explanation of risks a	Evaluation form dated cumented the resident's				
		#69's baseline care plan ed no evidence of any his use of side rails.				
	nurse) #2 was intervi rails should be include	.m., LPN (licensed practical ewed. When asked if side led on a resident's care plan, if it is necessary for resident are planned."				
	the MDS nurse, was side rails should be i baseline care plan, F to put side rails on ever was up to the individing they wanted to use the recently, the facility he to beds for residents and agree to them.	n., RN (registered nurse) #1, interviewed. When asked if included on a resident's RN #1 stated the facility used very resident's bed, and it ual resident whether or not nem. She stated most has only been attaching them who are assessed for them When asked if side rails				
	plan, RN #1 stated, " the beds when we op didn't need them, the added if it does not in	n a resident's baseline care In my mind, they came on pened this building. If they by didn't use them." She mpede the resident's a restraint. "They are not				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
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(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 655	plan." When asked w care plan, RN #1 state MDS nurse or the floor plan. On 8/4/21 at 4:54 p.m member) #1, the adm (director of nursing), vice-president of operegional nurse consultance. No further information. REFERENCES (1) "Infectious endocate endocardium, the well as the valves that chambers within the ledisease caused by be of manifestations and is taken from the web https://www.ncbi.nlm. (2) COPD is "a gener nonreversible lung discombination of emphybronchitis." Barron's If for the Non-Medical FRothenberg and Chambers memory, this of the state of th	nk needed to be on the care ho develops the baseline ed that on admission, the or nurse initiates the care a., ASM (administrative staff hinistrator, ASM #2, the DON ASM #3, the regional rations, and ASM #4, the stant, were informed of these in was provided prior to exit. arditis is the inflammation of inner lining of the heart, as it separate each of the four heart. It is primarily a facteria and has a wide array a sequelae." This information is ite nih.gov/books/NBK557641/. al term for chronic, sease that is usually a sysema and chronic Dictionary of Medical Terms Reader, 5th edition,	F 6	55		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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F 656 F 656 SS=E	CFR(s): 483.21(b)(1) §483.21(b) Compreh §483.21(b)(1) The faimplement a comprecare plan for each reresident rights set for §483.10(c)(3), that in objectives and timefinedical, nursing, an needs that are identifus assessment. The condescribe the following (i) The services that or maintain the reside physical, mental, and required under §483.24, §483 provided due to the funder §483.10, inclustreatment under §483.10, inclustreatment under §483.10 inclustr	Comprehensive Care Plan) nensive Care Plans acility must develop and thensive person-centered esident, consistent with the arth at §483.10(c)(2) and acludes measurable armes to meet a resident's ad mental and psychosocial affed in the comprehensive mprehensive care plan must ag - are to be furnished to attain are to be furnished are to be furnished to attain are to be furnished to attain are	F 65		9/10/21	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED			
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NAME OF PR	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/00//	2021	
				12001 IRON BRIDGE RD			
TYLER'S F	RETREAT AT IRON BRID	GE		CHESTER, VA 23831			
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F 656	Continued From page 33		F 6	56			
F 050	entities, for this purpo (C) Discharge plans in plan, as appropriate, requirements set forth section. This REQUIREMENT by: Based on observation interviews, clinical reduction of the comprehensive caresidents in the surver #6, #17, #48, #67, #2 The findings include: 1. The facility staff fare a #58's comprehensive of non-pharmacological administration of as in	n the comprehensive care in accordance with the in in paragraph (c) of this is not met as evidenced in, resident interviews, staff cord reviews and facility was determined that the evelop and/or implement are plan for eight of 37 y sample, (Residents #58,	F 6:	Corrective Action(s): Resident #17 has expired. Resident #67, #28, #6, and #48's care plans w updated to include the use of quarter Resident #29's care plans was updat include a fall mat at right side of bed in bed. Resident #58's PRN pain medication has been discontinued. Identification of Deficient Practice(s) Corrective Action(s): A 100% audit of current comprehensicare plans will be conducted by the M Coordinators, Unit Mangers, DON an ADON to identify residents with inaccor incomplete comprehensive care plans.	ere rails. ed to while we IDS d/or urate		
	•	ed but were not limited to nd cirrhosis of the liver (2).		Any negative findings will be correcte time of discovery.	d at		
	set), an admission as (assessment reference Resident #58 as scor assessment for mental of 0 - 15, 13- being or daily decisions. Sective receiving scheduled a medications. Section #58 not receiving non for pain and having particles.	al status (BIMS) of a score ognitively intact for making ion J coded Resident #58 and as needed pain J further coded Residentmedication interventions ain almost constantly.		Systemic Change(s): The comprehensive care plan policy been reviewed and no changes are warranted at this time. The IDT will be inserviced by regional clinical nurse and/or the DON on the development, implementation and revision of comprehensive care plans on admiss quarterly and as needed with signification change is status. Monitoring:	ion,		
	On 8/3/2021 at appro	ximately 4:15 p.m., an		The MDS coordinators will audit 4			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		495401	B. WING _			C 98/05/2021
	ROVIDER OR SUPPLIER RETREAT AT IRON BRID	OGE		STREET ADDRESS, CITY, STATE, ZIP CODE 12001 IRON BRIDGE RD CHESTER, VA 23831		0/00/2021
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F 656	their room. When as management, Reside medications had to be when needed. Reside nurses assessed his number his pain was medication. When a non-pharmacological administering the mestated that they just of the comprehensive dated 7/13/2021 door has reported episode further pain. Date In: Date: 07/27/2021" it documented in part pharmacological intelike Distraction techn breathing exercises, Date Initiated: 07/13/07/27/2021" The physician orders documented in part, - "oxyCODONE HCL MG, Give 2 (two) tab hours as needed for 07/13/2021. End Da - "Dilaudid Tablet 2 N (HYDROmorphone Femouth every 4 (four) Order Date: 07/16/2021. The eMAR (electroni record) dated 7/1/2021 the Oxycodone admi	cted with Resident #58 in ked about pain ent #58 stated that pain e requested to the nurses lent #58 stated that the pain by asking him what and provided the sked if staff attempt or offer interventions prior to dication, Resident #58 gave him the medication. Care plan for Resident #58 umented in part, "Resident es of pain with potential for itiated: 07/13/2021. Revision Under "Interventions/Tasks" t, "Implement non reventions to release the pain iques, relaxation and music therapy, re-position. 2021; Revision on: In for Resident #58 [Inydrochloride] Tablet 5 [Ithe by mouth every 4 (four) pain. Order Date: te: 07/16/2021." MG (milligram) HCL) Give 1 (one) tablet by hours as needed for pain.	F 6	resident's care plans weekly with the care plan calendar monitor for compliance. Any findings will be corrected at discovery and the results of be forwarded to the DON or Audit findings will be reporte communities monthly x 3 m further review and recomme	x 12 weeks to regative time of the audits will designee. The to QAPI conths for	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER RETREAT AT IRON BRII	DGE		STREET ADDRESS, CITY, STATE, ZIP CODE 12001 IRON BRIDGE RD CHESTER, VA 23831	, 00.00.202.	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
F 656	seven and on 7/16/2 level of seven. The eMAR dated 7/1 documented the Dila Resident #58 on 7/1 level of five and at 15 five. The eMAR furti #58 receiving the Dilp.m. for a pain level p.m. for a pain level p.m. for a pain level 9:52 a.m. for a pain level 9:52 a.m. for a pain level site evidence documenta interventions prior to needed pain medical listed above. The progress notes revidence documenta interventions prior to needed pain medical listed above. On 8/4/2021 at approinterview was condupractical nurse) #2. plan gives an idea of to take care of them. was responsible for was followed.	2 p.m. for a pain level of 021 at 1:39 a.m. for a pain //2021-7/31/2021 audid administered to 7/2021 at 6:20 a.m. for a pain 2:13 p.m. for a pain level of the documented Resident audid on 7/18/2021 at 12:10 of eight, on 7/20/21 at 8:38 of eight, on 7/22/21 at 1:23 of eight and on 7/26/21 at evel of five. //2021-7/31/2021 failed to ation of non-pharmacological the administration of the as ation on the dates and times for Resident #58 failed to ation of non-pharmacological the administration of the as ation on the dates and times for Resident #58 failed to ation of non-pharmacological the administration of the as ation on the dates and times for Resident #58 failed to ation of non-pharmacological the administration of the as ation on the dates and times for Resident #58 failed to ation of non-pharmacological the administration of the as ation on the dates and times Eximately 1:00 p.m., an acted with LPN (licensed LPN #2 stated that the care fa resident's needs and how LPN #2 stated that nursing ensuring that the care plan eximately 8:35 a.m., an	F 65	6		
	interview was condu manager. LPN #5 st	cted with LPN #5, unit tated that when a resident they assessed the resident to				

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		ATE SURVEY OMPLETED
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(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORR ((EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 656	Continued From pag determine the level of cause of the pain. L	of pain and the possible	F 6	556		
	pain. LPN #5 stated non-pharmacological successful in relievir administer the order stated that this was a medications administed. LPN #5 stated that they to relieve part non-pharmacological documented on the administration record LPN #5 reviewed they dated 7/1/2021-7/31 and stated that they that non-pharmacological attempted prior to the needed pain medical LPN #5 stated that several successions.	e if they could relieve the that if the I interventions were not ag the pain, then they would ed pain medication. LPN #5 to minimize the amount of tered to the resident unless sted that they utilized I interventions such as s, turning and repositioning to in. LPN #5 stated that I interventions were eMAR (electronic medication d) or in the nurses' notes. e eMAR for Resident #58 //2021 and progress notes did not see documentation ogical interventions were e administration of the as tions documented above. taff were not implementing plan if non-pharmacological				
	interview was condustaff member) #2, th #2 stated that staff with non-pharmacological and repositioning or administering as need #2 stated that staff with the non-pharmacologificativeness in the pasked to provide evi-	oximately 9:20 a.m., an cted with ASM (administrative e director of nursing. ASM vere expected to implement I interventions like turning offering a cold pack prior to eded pain medications. ASM vere expected to document gical interventions with their nurses' notes. ASM #2 was dence of staff g non-pharmacological				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
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	ROVIDER OR SUPPLIER RETREAT AT IRON BRID	OGE		STREET ADDRESS, CITY, STATE, ZIP CODE 12001 IRON BRIDGE RD CHESTER, VA 23831		
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F 656	Continued From pag		F 650	6		
		the administration of the as tions as listed above.				
	#2 stated that there	oximately 10:10 a.m., ASM were no non-pharmacological ented for Resident #58 on d above.				
	the administrator, pro Lippincott Manual of Edition via email as t	oximately 2:30 p.m., ASM #1, ovided a title page from the Nursing Practice, Eleventh their nursing standard of pon survey entrance.				
	Williams and Wilkins documented, "A writt communication tool a members that helps careThe nursing cainformation about the and goals. It contain achieving the goals and is used to direct revise and update the	ten care plan serves as a among health care team				
	with new orders" On 8/5/2021 at approrequest was made to	oximately 11:00 a.m., a o ASM #1 for the facility policy nplementing the care plan.				
	"An interdisciplinary established for every accordance with stat requirements and on	0/2019 documented in part,				

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			COMPLETED		
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 12001 IRON BRIDGE RD CHESTER, VA 23831	.	08/05/2021
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F 656	must always know, un Resident's Care Plan part of the plan, notify Coordinator, so that the Care Plan change On 8/5/2021 at appro#1, the administrator, nursing and ASM #3 to operations were made further information was References: 1. "Encephalopathy if a disease that affects your brain." This inforwebsite https://www.healthlinealopathy. 2. "Cirrhosis is scarriforms because of injuth Scartissue cannot do does - make protein, the blood, help digest This information was https://vsearch.nlm.nimeta?v%3Aproject=nmedlineplus-bundle&9383.513196122.162936034	inderstand and follow their. If unable to implement any your Charge Nurse or MDS his can be documented or ed if necessary" Eximately 11:30 a.m., ASM ASM #2, the director of the regional vice president of e aware of the concern. No as provided prior to exit. Is a general term describing the function or structure of mation is taken from the e.com/health/hepatic-enceph or long-term disease. If what healthy liver tissue help fight infections, clean food and store energy. If obtained from the website: h.gov/vivisimo/cgi-bin/query-nedlineplus&v%3Asources=query=cirrhosis&_ga=2.7315 6311381-1838772440.1562	F 6	56		
	Resident #6 was adm	itted to the facility with				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG		OMPLETED
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	ROVIDER OR SUPPLIER	OGE		STREET ADDRESS, CITY, STATE, ZIP CODE 12001 IRON BRIDGE RD CHESTER, VA 23831	•	00/00/2021
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F 656	•	led but were not limited to	F 6	56		
	(1) and dysphagia (2					
	set), a quarterly asse (assessment referen Resident #6 as scori assessment for ment of 0 - 15, 9- being making daily decision	ce date) of 7/28/2021, coded ing a 9 on the staff cal status (BIMS) of a score oderately impaired for ins. Section G coded				
	two staff members fo	g extensive assistance from r bed mobility and extensive aff member for transfers, al hygiene.				
	observation was made eating lunch. Reside bed with bilateral upp time, an interview wa #6. Resident #6 stat	eximately 1:10 p.m., an offer deep feet the feet that he used the feet that he used the side rails him to turn and move up in				
		ns on 8/3/2021 at 4:00 p.m. a.m. revealed the bilateral d Resident #6 in bed.				
	dated 4/8/2021 docu has self-care deficit.	care plan for Resident #6 mented in part, "Resident Date Initiated: 04/08/2021" to evidence a documentation ils.				
		s for Resident #6 failed to r the use of side rails.				
	The document, "Eval	uation for use of Side Rails"				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		495401	B. WING			C 8/05/2021
	ROVIDER OR SUPPLIER	DGE		STREET ADDRESS, CITY, STATE, ZIP CODE 12001 IRON BRIDGE RD CHESTER, VA 23831	1 0	0/03/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 656	part, "Side rail(s) a when resident is in bhave been discussed Family/Resident Repside rails have been Family, Resident reponder of the side rails have been Family, Resident reponder of the side rails have been Family, Resident reponder of the side rails have been Family, Resident reponder of the side rails and set of the side rails are not soon the kardex." On 8/4/21 at 3:57 put conducted with LPN the care plan. LPN side what the residents' res	d 7/20/2021 documented in the recommended at all times and. Side rail precautions divith Resident, presentative. Alternatives to discussed with Resident, presentative" oximately 1:00 p.m., an octed with LPN (licensed LPN #2 stated that the care of a resident's needs and how of LPN #2 stated that nursing ensuring that the care plan of the plan because they were not safety. m., an interview was registered nurse) #1, MDS coordinator, regarding the plan and if care plans should ised for the use of bed rails. Ose of care plan is to let staff or themMost recently we are them [bed rails/side rails], they hen we got them, so we orders. I'm not going to ails are on every care plan. plan when there is a change on the care plan, it should be on the care plan, it should be	F 63	56		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION G		ATE SURVEY DMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC 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	use of bed rails shouthe use is something re-assessing, for saft continued need for the con	g and repositioning and the alld be care planned because g nurses have to keep fety and to see if there is a he bed rails. oximately 11:30 a.m., ASM member) #1, the #2, the director of nursing and all vice president of operations findings. No further	F 65	,			
	information was obta https://www.nlm.nih.sorders.html 3. The facility staff fimplement a compre of side rails for Resident #17 was addiagnoses that includent chronic obstructive p(1) and atrial fibrillating Resident #17's most set), an admission a	chensive care plan for the use dent #17. dmitted to the facility with ded but were not limited to bulmonary disease (COPD)					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		X3) DATE SURVEY COMPLETED	
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F 656	assessment for mo of 0 - 15, 12- being making daily decis Resident #6 requir two staff members toilet use. On 8/3/2021 at ap observation was mith bilateral uppetime, an interview #17. Resident #17 when asked about Additional observation and 8/4/2021 at 8: side rails in place at the care plan faile addressing the use. The comprehensive dated 6/3/2021 do has self-care defice. The care plan faile addressing the use. The physician order the document, "Section and 6/2/2021 for part, "to assist in consent obtained for representative" On 8/4/2021 at ap interview was conceptant of the proper sentative and plan gives an idea.	coring a 12 on the staff ental status (BIMS) of a score of moderately impaired for sions. Section G coded ing extensive assistance from for bed mobility, transfers and proximately 1:20 p.m., an enade of Resident #17 in bed ar side rails in place. At this was attempted with Resident at did not answer appropriately the side rails. Itions on 8/3/2021 at 4:05 p.m. 30 a.m. revealed the bilateral and Resident #17 in bed. The care plan for Resident #17 cumented in part, "Resident it. Date Initiated: 06/03/2021"	F	556			

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 656	was followed. LPN # should be on the care necessary for resider On 8/4/21 at 3:15 p.n conducted with RN (r (minimum data set) of purpose of the care purpose of the care purpose of the care for the came on the beds with didn't always have or guarantee that bed raw we update the care purpose of the care purpose of the care purpose of the care on the beds with the bedrails are not of the care purpose of t	nsuring that the care plan 2 stated that side rails e plan because they were at safety. n., an interview was egistered nurse) #1, MDS coordinator, regarding the lan and if care plans should sed for the use of bed rails. se of care plan is to let staff themMost recently we are in [bed rails/side rails], they sen we got them, so we ders. I'm not going to alls are on every care plan. The plan when there is a change ow to add the bedrails. If in the care plan, it should be and, an interview was the tregarding the purpose of 1 stated, "To let you know seeds are, how you meet their in doed rails are used to assist and repositioning and the industry and to see if there is a see bed rails. In the care planned because nurses have to keep sty and to see if there is a see bed rails. In the care planned because nurses have to keep sty and to see if there is a see bed rails. In the care planned because nurses have to keep sty and to see if there is a see bed rails. In the care planned because nurses have to keep sty and to see if there is a see bed rails. In the care plan in the ca	F 65	6	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED			
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(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 APPRO DEFICIENCY)	LD BE COMPLETION
F 656	(COPD): Disease that that can lead to short information was obtated https://www.nlm.nih.g. 2. Atrial fibrillation: A rhythm of the heartbe obtained from the west of side rails for Resident #48 was addiagnoses that included dysphagia (1) and desired from the west obtained fr	re pulmonary disease at makes it difficult to breath mess of breath. This ined from the website: gov/medlineplus/copd.html. A problem with the speed or eat. This information was bsite: .gov/medlineplus/atrialfibrillat alied to develop and mensive care plan for the use ent #48. Imitted to the facility with led but were not limited to mentia (2). Trecent MDS (minimum data assment with an ARD ce date) of 7/13/2021, coded ring a 4 on the staff all status (BIMS) of a score verely impaired for making iton G coded Resident #48 ssistance from two staff bility and totally dependent for toileting and personal	F 65	56	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	LE CONSTRUCTION	COMPLETED	
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F 656	Continued From particular Additional observation and 2:00 p.m. reversible place and Resident The comprehensive dated 4/8/2021 door has self-care deficing The care plan failed addressing the user The physician order evidence an order of the document, "Sa dated 7/23/2021 for part, "mobilityIn resident/resident resident/re	ions on 8/4/2021 at 11:30 a.m. aled the bilateral side rails in a #48 in bed. e care plan for Resident #48 sumented in part, "Resident to evidence documentation of side rails. r's for Resident #48 failed to for the use of side rails. ber Bed Rail Assessment" r Resident #48 documented in formed consent obtained from expresentative" eroximately 1:00 p.m., an aucted with LPN (licensed LPN #2 stated that the care of a resident's needs and how in LPN #2 stated that nursing rensuring that the care plan #2 stated that side rails are plan because they were	F 65	,	
	On 8/4/21 at 3:15 p conducted with RN (minimum data set) purpose of the care be reviewed and re RN #1 stated, "Pur know how to care f having orders for th came on the beds didn't always have	e.m., an interview was (registered nurse) #1, MDS coordinator, regarding the e plan and if care plans should evised for the use of bed rails. pose of care plan is to let staff for themMost recently we are nem [bed rails/side rails], they when we got them, so we orders. I'm not going to rails are on every care plan.			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION G		LETED
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F 656	Continued From page	e 46	F 65	56		
	I don't necessarily kn	olan when there is a change. ow to add the bedrails. If n the care plan, it should be				
	the care plan. LPN # what the residents' no goals." LPN #1 state residents with turning use of bed rails shoul the use is something	#1 regarding the purpose of 1 stated, "To let you know eeds are, how you meet their d bed rails are used to assist and repositioning and the d be care planned because nurses have to keep ety and to see if there is a				
	(administrative staff n administrator, ASM #	2, the director of nursing and vice president of operations ndings. No further				
	information was obtai	llowing disorder. This ned from the website: ov/medlineplus/swallowingdi				
	with certain diseases. language, judgment, information was obtai https://medlineplus.go 5. The facility failed to	of brain function that occurs . It affects memory, thinking, and behavior. This ned from the website: by/ency/article/000739.htm. o develop a comprehensive the use of bed rails for				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		495401	B. WING			08/	05/2021
	ROVIDER OR SUPPLIER RETREAT AT IRON BRID	GE		1	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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	Resident #67 was add 12/29/20. Resident # were not limited to: A (progressive loss of noften accompanied by fracture of left femur (and degeneration of cinvolves tissue and control cushioning tissue between the resident #67's most set) assessment, a quassessment reference resident as scoring 98 (brief interview for methe resident was unal interview. MDS Sectic coded the resident, as bed mobility, transfers hygiene and bathing; not occur. A review of and Bladder: coded to incontinent for bowel Resident #67 was obside rails up on 8/3/208:05 AM. A review of Resident plan dated 12/21/20 adocuments in part, "F self-care deficit. INTE activities of daily living toileting, feeding and for adaptive equipments care plan failed to evi	mitted to the facility on 67s diagnoses included but discheimer's disease mental ability and function by personality changes) (1), (break in left thighbone) (2) discs (physical decline that cellular changes of the ween the vertebrae) (3). Trecent MDS (minimum data contact arterly assessment, with an cellular date of 7/25/21, coded the cout of 15 on the BIMS cental status) score, indicating cole to complete the con G- Functional Status: conserved sessistance with conserved and locomotion did coff MDS Section H- Bowel che resident as always and for bladder. Served in bed with bilateral contact at 11:30 AM and 8/4/21 at #67's comprehensive care and revised on 6/15/21, OCUS-The resident has ERVENTIONS-Assist with contact and care. Evaluate needs contact and care. Evaluate needs contact and comprehensive	F	656			

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495401	B. WING		C 08/05/2021
	ROVIDER OR SUPPLIER	OGE		STREET ADDRESS, CITY, STATE, ZIP CODE 12001 IRON BRIDGE RD CHESTER, VA 23831	1 00/00/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 656	A review of Resident plan on 8/5/21, docu revision to the care prails to bed." An interview was conwith LPN (Licensed the purpose of the care after significant charantes". When asked who is responsible, the care after significant charantes". When asked sure care plan is followed." When ask care planned, LPN # be. If it is necessary be care planned." An interview was conply with RN (register Coordinator regarding comprehensive care purpose of care planned care for them. Generalls are not consider an assist bar. The when we got them. that bedrails are one the care plan when th	#67's comprehensive care mented in part, the following plan on 8/4/21 "Two assist and ucted on 8/4/21 at 1:01 PM practical nurse) #2 regarding comprehensive care plan. LPN to the idea of a resident's ecare of them". When sible for implementing care "The MDS coordinator is eplan is updated/revised ge or based on progress who is responsible to make owed, LPN #2 stated, ple for the care plan is updated if the side rails should be 2 stated, "Yes, they should for resident safety, it should and ucted on 8/04/21 at 3:15 and nurse) #1, the MDS go the purpose of the plan. RN #1 stated, "The is to let staff know how to rally, I would say not the bed and a restraint because they ne bedrails came on the beds am not going to guarantee every care plan. We update there is a change. I don't add the bedrails." AM, ASM (administrative administrator, ASM #2, the and ASM, the regional VP of	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
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	ROVIDER OR SUPPLIER	OGE		STREET ADDRESS, CITY, STATE, ZIP CODE 12001 IRON BRIDGE RD CHESTER, VA 23831	1 00/03/2021	
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F 656	Continued From pag	e 49	F 6	56		
	Plan" policy dated 7/ "The MDS Coordinat Report daily for signi resident's ADL status Coordinator will add status to the existing No further informatio References: (1) Barron's Dictiona Non-Medical Reader Chapman, page 25. (2) Barron's Dictiona Non-Medical Reader Chapman, page 218. (3) Barron's Dictiona Non-Medical Reader Chapman, page 218. (3) Barron's Dictiona Non-Medical Reader Chapman, page 153 6. The facility failed t care plan to address Resident #28 was ac 9/16/20. Resident #2 were not limited to: (circulatory congestic water by the kidneys (narrowing or strictur	minor changes in resident's Care Plans on daily basis." In was provided prior to exit. In yof Medical Terms for the control of Med				
	set) assessment, a q	recent MDS (minimum data uarterly assessment, with an ee date of 6/21/21, coded the 9 out of 15 on the BIMS				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
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F 656	the resident was una interview. MDS Sect coded the resident as bed mobility, transfe hygiene and bathing and walking and loc review of MDS Secticoded the resident as bowel and for bladdor Resident #28 was coside rails up on 8/3/28:00 AM. A review of Resident plan dated 6/16/21, "FOCUS-The reside INTERVENTIONS-Aliving, dressing, groof oral care. Evaluate equipment. Educated devices. Promote in reinforcement for all comprehensive cared documentation addreviewed on 8/3/21 and A review of Resident plan on 8/5/21, documentation on 8/4/21 "The An interview was cowith LPN (Licensed the purpose of the comprehendation of the comprehendation of the comprehendation of the comprehendation on 8/4/21 "The An interview was cowith LPN (Licensed the purpose of the comprehendation of the	dental status) score, indicating able to complete the cion G- Functional Status: as extensive assistance with rs, dressing, personal; eating required supervision comotion did not occur. A con H- Bowel and Bladder: as frequently incontinent for er. Abserved in bed with bilateral 21 at 11:20 AM and 8/4/21 at the transfer documents in part, as self-care deficit. Assist with activities of daily coming, toileting, feeding and the eldirect the use of assistive activities attempted." The plan failed to evidence essing the use of bed rails	F 65	56	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X5) MULTIPLE CONSTRUCTION (X6) MULTIPLE (X6) MULTIPL		' '	(X3) DATE SURVEY COMPLETED			
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(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 656	responsible, the care after significant channotes". When asked sure care plan is followed." When ask care planned, LPN #be. If it is necessary be care planned." An interview was comply with RN (register Coordinator regarding comprehensive care purpose of care plan care for them. Gene rails are not consider are an assist bar. The when we got them. If that bedrails are one the care plan when	e plan is updated/revised ge or based on progress who is responsible to make owed, LPN #2 stated, ble for the care plan is sted if the side rails should be 2 stated, "Yes, they should for resident safety, it should aducted on 8/04/21 at 3:15 ged nurse) #1, the MDS gethe purpose of the plan. RN #1 stated, "The is to let staff know how to rally, I would say not the bed red a restraint because they he bedrails came on the beds am not going to guarantee every care plan. We update there is a change. I don't hadd the bedrails." AM, ASM (administrative end ASM, the regional VP of the concern. By's "Comprehensive Care 19/19, documents in part, or is to review the 24- Hour ficant changes or changes in	F 68	56		

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	RIPLE CONSTRUCTION NG	(×	(X3) DATE SURVEY COMPLETED		
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE		
F 656	(4) Barron's Dictionar Non-Medical Reader, Chapman, page 133. (5) Barron's Dictionar Non-Medical Reader, Chapman, page 43. (6) Barron's Dictionar Non-Medical Reader, Chapman, page 344. 7. The facility staff fair comprehensive care #53's use of side rails. Resident #53 was ad 7/9/21 with diagnoses infection and diabetes MDS (minimum data assessment with an Adate) of 7/15/21, Resbeing moderately impledecisions, having soo BIMS (brief interview coded as requiring the staff for bed mobility. On the following date p.m. and 4:02 p.m.; 8 #53 was observed lyilobservations, bilaterathe hood of the resident Rail Evaluation form adocumented the residuse of side rails, the benefits, and the date use of the side rails.	ry of Medical Terms for the 7th edition, Rothenberg and ry of Medical Terms for the 7th edition, Rothenberg and ry of Medical Terms for the 7th edition, Rothenberg and red to develop a plan to address Resident st. mitted to the facility on a plan to address Resident st. mitted to develop a plan to address Resident st. mitted to develop a plan to address Resident st. mitted to develop a plan to address Resident st. mitted to the facility on a plan to address Resident st. mitted to address R	F	656				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MI IDENTIFICATION NUMBER: A. BUIL			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 656	Continued From page	÷ 53	F	356			
	plan, dated 7/13/21 a revealed no evidence to the use of side rails	of any information related					
	nurse) #2 was intervieuralls should be include	m., LPN (licensed practical ewed. When asked if side ed on a resident's care plan, is necessary for resident are planned."					
	the MDS nurse, was side rails should be in plan, she stated the form on every resident's be individual resident who use them. RN #1 state has only been attaching residents who are asset to them. When asked included on a resident #1 stated, "In my min when we opened this them, they didn't use not impede the resider restraint. "They are more meeded to be on the control of the side of the s	sessed for them and agree if side rails should be t's baseline care plan, RN d, they came on the beds building. If they didn't need them." She added if it does ent's functioning, it is not a but something I would think care plan."					
	member) #1, the adm (director of nursing), a vice-president of open	n., ASM (administrative staff ninistrator, ASM #2, the DON ASM #3, the regional rations, and ASM #4, the tant, were informed of these					
	No further information	n was provided prior to exit.					
	REFERENCES (1) "Diabetes (mellitus	s) is a disease in which your					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X'		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTI IDENTIFICATION NUMBER: A. BUILDIN		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 656		ood sugar, levels are too on is taken from the website	F 6	56			
	#29's comprehensive	iled to implement Resident e care plan to place the hin reach and to place fall dent's bed.					
	6/21/21 with diagnoss and bipolar disorder (minimum data set), with an ARD (assess 6/22/21, Resident #2 severely cognitively decisions, having so BIMS (brief interview coded as having had	dmitted to the facility on es including dementia (1) (2). On the most recent MDS an admission assessment ement reference date) of 19 was coded as being impaired for making daily pred five out of 15 on the 17 for mental status). She was a fall in the month prior to eaving had no falls since lity.					
	p.m. and 4:00 p.m.; a #29 was observed by observation, the resi the floor behind the b	es and times: 8/3/21 at 12:47 8/4/21 at 9:53 a.m., Resident ing in bed. At each dent's call bell was lying on nead of her bed, and no fall on the floor beside her bed.					
	A review of Resident revealed she had su 7/1/21, 7/2/21, and 7	stained falls without injury on					
	plan, dated 6/22/21 a revealed, in part: "M	#29's comprehensive care and updated 7/22/21, nimize risks for s related to falls: "Fall mat to					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 656	Continued From page	÷ 55	F	556			
		olement preventative fall Maintain call light within ent to use call light."					
	On 8/4/21 at 12:53 p. nurse) # 2 was intervior of a care plan. LPN # of the resident's need the residents. She stapart in making sure the implemented. She also responsible for implemented the DON (direct managers tell nurses have been added to the total tota	m., LPN (licensed practical ewed regarding the purpose 2 stated it gives you an idea is and how to take care of ated the MDS nurse has a see care plan gets is o said nurses are menting the care plan. She cor of nursing) and the unit if any new interventions the care plan. In, RN (registered nurse) #1, interviewed. When asked re plan, RN #1 stated, "So care of the resident." In, RN (registered nurse) #3 is asked how makes certain intions are implemented, RN is responsibility. She stated res are usually listed on the any updates or changes to seed along in report, and she on along to CNAs and other or a resident. She stated fall help lessen the chance for injury. In, ASM (administrative staff					
	member) #1, the adm (director of nursing), / vice-president of oper	inistrator, ASM #2, the DON					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER			1:	TREET ADDRESS, CITY, STATE, ZIP CODE 2001 IRON BRIDGE RD CHESTER, VA 23831	1 00/	03/2021
(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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	When asked where a be located, she stated a resident's reach. When any fall prevention into #29's care plan, she is check with the nurse. responsible for making interventions are in play stated, "I am. And I go No further information REFERENCES (1) "Dementia is a grate brain function. This of It affects memory, this and behavior." This in website https://medlineplus.go	a., CNA #5 was interviewed. resident's call bell should dit should be located within hen asked if she is aware of erventions on Resident stated she would have to When asked who is g sure fall prevention ace for residents, CNA #5 uess all of us." a was provided prior to exit. adual and permanent loss of ccurs with certain diseases. hking, language, judgment, uformation is taken from the	F	656			
F 657 SS=E	a mental disorder tha mood, energy, activity the ability to carry out information is taken fr https://www.nimh.nih.order/index.shtml. Care Plan Timing and CFR(s): 483.21(b)(2)(2)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)	ess or manic depression) is t causes unusual shifts in la levels, concentration, and day-to-day tasks." This com the website gov/health/topics/bipolar-dis I Revision (i)-(iii) ensive Care Plans orehensive care plan must	F	657			9/10/21

PRINTED: 09/13/2021 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 657	includes but is not lim (A) The attending phy (B) A registered nurse resident. (C) A nurse aide with resident. (D) A member of food (E) To the extent practice the resident and their resident reproduced in the produced in the resident reproduced in the resident's care plan. (F) Other appropriate disciplines as determined as requested by the (iii) Reviewed and revite am after each assessments. This REQUIREMENT by: Based on observation document review and was determined that the review and revise the for four of 37 resident Residents #31, #25, # The findings include: 1. The facility staff fair Resident #31's compuse of bed rails. Resident #31 was additional resident.	terdisciplinary team, that lited to-visician. with responsibility for the resident's representative(s). The included in a resident's participation of the resident resentative is determined be development of the resident's needs resident. The including both the resident responsibility review responsibility review responsibility review responsibility record review, it the facility staff failed to comprehensive care plants in the survey sample,	F	657	Corrective Action(s): Resident #25 is no longer in facility. Residents #21, #31 and #37 have had their care plans reviewed and revised to include the use of quarter rails while in bed. Identification of Deficient Practice(s)& Corrective Action(s): A 100% review of all current comprehensive care plans will be conducted by the MDS coordinators and/or DON/ADON to identify residents inaccurate or incomplete care plans. At negative findings will be corrected at time	s it ny	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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TYLER'S	RETREAT AT IRON BRID	GE			2001 IRON BRIDGE RD CHESTER, VA 23831		
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F 657	Continued From page	÷ 58	F 6	357			
	and anxiety disorder.	oke, chronic kidney disease Resident #31's quarterly			of discovery.		
	minimum data set ass				Systemic Change(s):		
		e date of 6/23/21, coded the			The regional clinical nurse and/or the	•	
	resident's cognition a	s severely impaired.			DON will provide inservice training to the IDT team on the requirement to develo		
	Review of Resident #	31's clinical record revealed			and implement a comprehensive care	Р	
	a bed rail assessmen				plan and to review and revise each		
	documented the resid	lent had not shown any			residents care plan as indicated by any	/	
	clinical need for side	rails (bed rails) at that time.			resident change in condition or change to care requirements.	:S	
	On 8/3/21 at 11:22 a.	m. and 8/4/21 at 8:01 a.m.,					
	Resident #31 was obs U bar bed rails.	served in bed with bilateral			Monitoring: The IDT team will audit Comprehensive Care Plans weekly coinciding with the	е	
	Review of Resident #	31's comprehensive care			care plan calendar for 12 weeks to		
	plan initiated on 1/6/2				monitor for compliance. Any negative		
	-	ding the use of bed rails.			findings or significant change will be reported to the DON and/or MDS		
	On 8/4/21 at 3:15 p.m				Coordinator for care plan correction. A	udit	
		egistered nurse) #1 (the set] coordinator) regarding			findings will be reported to the QAPI committee monthly for review and		
		mprehensive care plan and			recommendations x 3 months.		
		e plans should be reviewed			Teconimendations x o months.		
	and revised for the us	•					
	stated, "Purpose of ca	are plan is to let staff know					
	how to care for them.	Most recently we are					
		n [bed rails], they came on					
		t them, so we didn't always					
		going to guarantee that bed					
		e plan. We update the care					
		change. I don't necessarily ails. If the bedrails are not					
		ould be on the kardex."					
	On 8/4/21 at 3:57 p.m						
		licensed practical nurse) #1					
		e of the care plan. LPN #1 ow what the residents' needs					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF 12001 IRON BRIDGE RD CHESTER, VA 23831		J6/03/2021	
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F 657	bed rails are used to and repositioning and be care planned becar nurses have to keep it to see if there is a corrails. On 8/4/21 at 5:01 p.m member) #1 (the admidirector of nursing) was above concern. The facility policy title Planning" documente of care will be establist updated in accordance regulatory requirement basis." 2. The facility staff fair Resident #25's complete of bed rails. Resident #25 was add 6/14/21. Resident #2 were not limited to make the facility disease and padmission minimum of assessment reference resident's cognition at Review of Resident #4 a bed rail assessment documented bed rails.	eir goals." LPN #1 stated assist residents with turning I the use of bed rails should ause the use is something re-assessing, for safety and natinued need for the bed a., ASM (administrative staff initiatrator) and ASM #2 (the ere made aware of the d, "Comprehensive Care d, "An interdisciplinary plan shed for every resident and ewith state and federal and and an as needed led to review and revise rehensive care plan for the mitted to the facility on 5's diagnoses included but uscle weakness, chronic neumonia. Resident #25's data set assessment with an expected and a severely impaired. 25's clinical record revealed to dated 6/14/21 that is were needed for	F	657			
	-	m. and 8/3/21 at 4:42 p.m., served in bed with bilateral					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495401	B. WING				C 05/2021	
	ROVIDER OR SUPPLIER		-	120	REET ADDRESS, CITY, STATE, ZIP CODE 101 IRON BRIDGE RD 1ESTER, VA 23831	1 06/	05/2021	
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F 657	U bar bed rails. Review of Resident # plan initiated on 6/17/ documentation regard. On 8/4/21 at 3:15 p.m conducted with RN (n MDS [minimum data the purpose of the cashould be reviewed a bed rails. RN #1 state to let staff know how recently we are havin they came on the bed didn't always have or guarantee that bed rails we update the care planted to on the kardex." On 8/4/21 at 3:57 p.m conducted with LPN (regarding the purpose stated, "To let you know are, how you meet the bed rails are used to and repositioning and be care planned becanurses have to keep in the staff of the side of	25's comprehensive care 21 failed to reveal 3 failed to reveal 3 failed to reveal 3 failed to reveal 4 failed to reveal 5 failed to reveal 5 failed to revise was registered nurse) #1 (the set] coordinator) regarding for e plan and if care plans and revised for the use of red, "Purpose of care plan is to care for themMost gorders for them [bed rails], als when we got them, so we ders. I'm not going to 3 failed are on every care plan. The solution of the set of the se	F	657				
	member) #1 (the adm	n., ASM (administrative staff ninistrator) and ASM #2 (the ere made aware of the						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C			
		495401	B. WING		08/05/2021		
	ROVIDER OR SUPPLIER	IDGE		STREET ADDRESS, CITY, STATE, ZIP CODE 12001 IRON BRIDGE RD CHESTER, VA 23831	1 00/03/2021		
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F 657	Continued From pa	ge 61	F 65	7			
		ailed to review and revise prehensive care plan for the					
	5/28/19. Resident # were not limited to disorder and high bit quarterly minimum dissessment referen	ddmitted to the facility on #37's diagnoses included but convulsions, major depressive lood pressure. Resident #37's data set assessment with an ice date of 7/2/21, coded the skills for daily decision impaired.					
	a bed rail assessme documented bed ra and repositioning. On 8/3/21 at 11:29 a	#37's clinical record revealed ent dated 6/2/21 that ils were needed for turning a.m. and 8/4/21 at 8:03 a.m., observed in bed with bilateral					
	plan initiated on 7/2 documentation rega On 8/4/21 at 3:15 p	#37's comprehensive care 2/20 failed to reveal arding the use of bed rails. .m., an interview was (registered nurse) #1 (the					
	MDS [minimum data the purpose of the construction of the construct	a set] coordinator) regarding care plan and if care plans and revised for the use of ated, "Purpose of care plan is v to care for themMost ing orders for them [bed rails], eds when we got them, so we orders. I'm not going to rails are on every care plan. I plan when there is a change. I mow to add the bedrails. If on the care plan, it should be					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	OGE		STREET ADDRESS, CITY, STATE, ZIP CODE 12001 IRON BRIDGE RD CHESTER, VA 23831	<u> </u>	00/00/2021
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 657	regarding the purposs stated, "To let you kn are, how you meet the bed rails are used to and repositioning and be care planned beconurses have to keep to see if there is a corails. On 8/4/21 at 5:01 p.r member) #1 (the addirector of nursing) was above concern. 4. The facility staff fare Resident #21's compuse of bed rails. Resident #21 was ac 5/27/20. Resident #2 were not limited to his respiratory failure and quarterly minimum diassessment reference code the resident's compused for the resident's compused for the resident's concept as a bed rail assessment documented bed rails mobility. On 8/3/21 at 11:27 a	n., an interview was (licensed practical nurse) #1 e of the care plan. LPN #1 low what the residents' needs heir goals." LPN #1 stated hassist residents with turning did the use of bed rails should hause the use is something hause the us	F 6	57		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING		COMPL	(X3) DATE SURVEY COMPLETED				
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	ROVIDER OR SUPPLIER RETREAT AT IRON BRID	OGE		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 LSC 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 657	plan initiated on 5/28, documentation regard documentation regard. On 8/4/21 at 3:15 p.m. conducted with RN (r MDS [minimum data the purpose of the cashould be reviewed a bed rails. RN #1 stat to let staff know how recently we are having they came on the bed didn't always have or guarantee that bed raw We update the care planted to enter the bedrails are not on the kardex." On 8/4/21 at 3:57 p.m. conducted with LPN or regarding the purpose stated, "To let you know are, how you meet the bed rails are used to and repositioning and be care planned becan urses have to keep to see if there is a contails. On 8/4/21 at 5:01 p.m. member) #1 (the adminimatical states) and the purpose to see if there is a contails.	#21's comprehensive care //20 failed to reveal ding the use of bed rails. m., an interview was registered nurse) #1 (the set] coordinator) regarding are plan and if care plans and revised for the use of red, "Purpose of care plan is to care for themMost reg orders for them [bed rails], ds when we got them, so we ders. I'm not going to ails are on every care plan. Tolan when there is a change. Town to add the bedrails. If on the care plan, it should be	F 65	57			
F 675 SS=D	Quality of Life CFR(s): 483.24		F 67	75	9	9/10/21	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
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F 675	Continued From page	e 64	F 6	75		
	applies to all care and residents. Each residents. Each residential facility must provide the necessary care and so the highest practicab psychosocial well-be resident's compreher of care. This REQUIREMENT by: Based on observation interview, facility door record review, it was staff failed to provide promote a resident's residents in the survey The facility staff failed bed into a chair from through 8/3/21. The findings include: Resident #59 was ad 7/13/21 with diagnosheart attack and hear MDS (minimum data assessment with an adate) of 7/19/21, Resident with an adate) of 7/19/21, Resident with an adate) of 7/19/21, Resident with an adate) of 7/19/21, Residential for the product of th	damental principle that d services provided to facility dent must receive and the the services to attain or maintain le physical, mental, and ing, consistent with the nsive assessment and plan is not met as evidenced on, family interview, staff ument review, and clinical determined that the facility care and services to quality of life for one of 37 by sample, Resident #59. It to get Resident #59 out of her admission on 7/13/21 mitted to the facility on the including history of a refailure. On the most recent		Corrective Action(s): Resident #59 has been assessed a cleared by their attending physicial up out of bed daily to a wheeled re as tolerated by resident. Resident been screened by therapy for the appropriate transfer method to be transfer her out of bed and into receach day. Resident #59's care plar been revised to update her transfer mobility status. Identification of Deficient Practice(state Corrective Action(s): All current residents coded as sperall or most of their time in bed on the recent MDS may have been potent affected. A 100% audit of all reside coded for spending all or most of the time in bed will be completed to ide residents at risk. Residents identifier isk will be reassessed by their atterphysician and therapy to determine level of mobility and their ability to of bed safely. Their comprehensive of care will be updated to reflect each	n to be recliner #59 has used to sliner n has r and s) & nding he most tially ents heir entify ed at ending ed their be out e plans	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN		CONSTRUCTION		PLETED
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F 675	devices during the loc On the following date p.m. and 3:48 p.m.; 8 p.m., observations re bed with her eyes clo On 8/3/21 at 12:22 p. was interviewed. She that Resident #59 has chair since her admis stated she and her si- each day from approx approximately 5:30 p nor her sister had see She stated she told a she wanted to wash it the staff member told weak to get out of be had told the nursing is should remain in bed daughter could not re member with which is she managed to wash mother was lying in b hard." She stated her ambulatory for brief ti heart attack. She stat and she would just lo to be in a chair of sor bed room window to it the facility's courtyard A review of Resident contained no physicia resident's ability to get A review of Resident	s and times: 8/3/21 at 12:22 /4/21 at 9:48 a.m. and 4:05 vealed Resident #59 lying in sed. m., Resident #59's daughter stated she is concerned is not been out of bed in a sion to the facility. She ster are with the resident kimately 9:00 a.m. until i.m. She stated neither she en their mother up in a chair. staff member last week that her mother's hair. She stated her that her mother is too d, and that the therapy staff staff that Resident #59 at all times. Resident #59 at all times. Resident #59's call which specific staff he had spoken. She stated in her mother's hair while her ed, but noted it was "really mother had been mes each day before her ed her mother loves flowers, we for her mother to be able ne kind and be rolled to the see the beautiful flowers in l. #59's clinical record an's orders regarding the	F 6	375	resident's specific needs. Systemic Change(s): The facility policy and procedure has be reviewed and no revisions are warranted at this time. The DON and/or ADON with in-service all nursing staff, to include agency staff and new hires on the expectation that all residents are to be of bed daily unless medically contradic or the resident chooses to stay in bed. Monitoring: The DON will be responsible for maintaining compliance. The DON, AD and/or Unit Managers will perform new admission chart audits weekly x 12 westo ensure the residents mobility level at activity level are addressed at time of admission to monitor for compliance. Any/all negative findings will be correct at time of discovery. Audit findings will reported to QAPI committee monthly for moths for review, analysis and recommendations for change in facility policy, procedure, and/or practice.	ed II out ted ON eks ed be or 3	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	IPLE CONSTRUCTION NG	(X3	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP COD 12001 IRON BRIDGE RD CHESTER, VA 23831	E	00/03/2021
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F 675	part: "D/C (discharge Level AchievedPro (current level of functionsistent staff follow Mobility = Max (maxi Transfers = Max A; L Dependence w/o (wit W/C (wheelchair) motry)Discharge Recocare." A review of Resident assistant) POC (poin no evidence that Resident dated 7/14/21, revea activities of daily livin toileting, feeding, ora enjoys spending times she enjoyed oil paint her vegetable garder participate in activitie daysAssist to and for the composition of the composition) reason: Highest Practical gnosis to Maintain CLOF ioning) = Good with v-throughFunctional Bed mum) A (assistance); evel Surfaces = Total thout) attempts to initiate; bility + DNT (did not immendations: 24 hour with the properties of the care charting) revealed sident #59 had been out of sion on 7/13/21. #59's baseline care plantled, in part: "Assist with g, dressing, grooming, I care [Resident #59] with her family. In the pasting, quilting, and working in a [Resident #59] will so finterest over the next 90 rom activities of interest."	F	575		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G	' '	(X3) DATE SURVEY COMPLETED		
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F 675	they ever even try to is true primarily for re replacement surgery. On 8/4/21 at 2:31 p.m member) #8, a physicinterviewed. When as determining a newly status, OSM #8 state evaluate the resident including history, hos pertinent information assess the resident. resident about their gresident #59's thera Resident #59's thera Resident #59 came is significant hear failur stated the resident is family wanted her to therapy. She stated to therapy. She stated to the transfers. She stated between 7/14/21 and Resident #59 was dismet her maximum that he resident's main in were weakness and ever got Resident #5 did not. She stated shout transferrir and into a chair, OSM members to use a members to use a members.	evaluate a resident before move them. She stated this esidents who have had joint on., OSM (other staff cal therapist, was sked therapy's role with admitted resident's transfer d she gets an order to , and reviews the chart, pital records, and any other. She stated she goes to She stated she talks with the toals. When asked about by course, OSM #8 stated in from the hospital with the after a heart attack. She 101 years old, and her have aggressive care and the resident required for bed mobility and when worked with therapy 17/28/21. OSM #8 stated she are yout of bed, she stated she he assisted the resident to sit d, but the resident did not	F 67	75			
		ded to be supervised at all out of bed. She stated she					

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
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F 675	had not worked with I and no staff members assistance with the results of the staff member to get F was interviewed. When asked if she had out of bed, or if she had out of bed, or if she had the staff member to get F was stated she has not I have ever seen her did not know any reast been out of bed. She is "very involved." She not been getting out of that is the family's changed out of bed especiatopped working with Resident #59's quality by getting out of bed few minutes each day outside, RN #3 stated On 8/4/21 at 4:54 p.m member) #1, the adm (director of nursing), vice-president of ope regional nurse consultance of the control of the staff of the control	Resident #59 since 7/28/21, is had asked for her esident since that date. In., RN (registered nurse) #3 en asked if she is familiar dent #59, she stated she is. as ever seen Resident #59 as ever assisted another desident #59 out of bed, RN it. RN #3 stated, "I don't think out of bed." She stated she son why the resident had not stated Resident #59's family estated if the resident has of bed, it must be because bice. RN #3 stated it is bety to make sure resident's ally once therapy has them. When asked if y of life could be improved into a rolling recliner for a y so she could see flowers in., ASM (administrative staff sinistrator, ASM #2, the DON ASM #3, the regional rations, and ASM #4, the litant, were informed of these hat Resident #59 had been admission on 7/13/21 was elicies related to quality of life out of bed were requested. cility does not have a policy	F 6	575			

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B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	08/05/2021
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of bed of the se of the se of this se of this se of this se of this se of the se of th	675	
	BER: A. BUILD B. WING S. ID PREF ATION) For bed the se to this riewed. checks out of ever C. CNA her out vas "a that, safety the hifts. e could lling could c	BEER: A BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 12001 IRON BRIDGE RD CHESTER, VA 23831 S ID PROVIDER'S PLAN OF CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY) F 675 of bed of the see to this diewed, checks fout of see ever could ling could state that the manical When SSM #8 to the sis not

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE COMP	PLETED
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F 675	OSM #8 stated, "She assistance." On 8/5/21 at 11:21 a. practitioner) was internursing staff asked he out of bed on the prev ASM #5 stated, "The They haven't even tricthe staff at this facility because they are verwrote an order last eversident out of bed. Stated and they are that they have not trice #59's quality of life coout of bed into a rolling assistance."	m., ASM #5, the NP (nurse viewed. She stated the er about getting the resident vious afternoon (8/4/21). staff is scared to get her up. ed to get her up." She stated ordinarily needs an order y "task oriented," so she vening for the staff to get the he stated the resident's multiple times that the staff the resident out of bed, and ed. When asked if Resident and be improved by getting ag recliner for a few minutes d see flowers outside, ASM	F 67	5		
F 689 SS=D	Enrichment Vendor/Eno information related improving a resident's out of bed. No further information Free of Accident Haza CFR(s): 483.25(d)(1)(1)(1)(1)(2)(1)(2)(2)(3)(1)(1)(2)(3)(2)(3)(3)(3)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)		F 68	9		9/10/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	PLE CONSTRUCTION IG		DATE SURVEY COMPLETED	
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(V4) ID	SLIMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COF	RECTION	(X5)	
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F 689	Continued From page	ne 71	F 6	80			
		90 7 1		63			
		IT is not met as evidenced					
	by:						
		ion, staff interview, facility		Corrective Action(s):	l b all released		
		nd clinical record review, it the facility staff failed to		Resident #29 now has her call within reach and a fall mat has			
		ions to prevent a resident's		placed beside her bed while sl			
		one of 37 residents in the		Her Care plan has been review			
		ent #29. The facility staff failed		revised to reflect her current care			
		29's call bell within reach and					
		eside the resident's bed on		Identification of Deficient Pract	tice(s) &		
	8/3/21 and 8/4/21.			Corrective Action(s):	, ,		
				Current residents with physicia			
	The findings include	9:		fall prevention interventions m	•		
				been potentially affected. The			
		idmitted to the facility on		ADON and/or Unit Manager w			
		ses including dementia (1)		100% review of current reside			
		r (2). On the most recent MDS , an admission assessment		physician ordered fall preventi interventions to identify reside			
		sment reference date) of		for inconsistent implementation			
	,	29 was coded as being		intervention/equipment. Any re			
		impaired for making daily		identified at risk will be correct			
		cored five out of 15 on the		of discovery and their compret			
		w for mental status). She was		care plans updated to reflect the	neir current		
	coded as having ha	d a fall in the month prior to		fall prevention interventions.			
		naving had no falls since					
	admission to the fac	cility.		Systemic Change(s):			
				The facility policy and procedu			
		ucted on the following dates		prevention and management h			
		12:47 p.m. and 4:00 p.m.;		reviewed and no revisions are at this time. The DON and/or A			
		revealed Resident #29 was ed. During each observation,		inservice all nursing staff, to in			
		bell was lying on the floor		agency staff and new hires on			
		her bed and there were no fall		use of and application of fall p			
		eside the resident's bed.		interventions/equipment to inc			
				mats, call bells, concave mattr			
	A review of Residen	nt #29's clinical record		prevent falls and/or reduce po			
	revealed she had su	ustained falls without injury on		injury.			
	7/1/21, 7/2/21, and						

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	ROVIDER OR SUPPLIER RETREAT AT IRON BRID	GE		STREET ADDRESS, CITY, STATE, ZIP COI 12001 IRON BRIDGE RD CHESTER, VA 23831	DE	00/00/2021
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F 689	plan, dated 6/22/21 a revealed, in part: "Mir falls/minimize injuries right side of bedImp interventions/devices reach. Educate reside." On 8/4/21 at 12:53 p. nurse) # 2 was intervicall bells should be pl stated the call bells si resident's reach. Whe for making sure the call bells si resident's reach. Whe for making sure the call bells si resident's reach. Whe for making sure the call bells si resident's reach. Whe for making sure the call bells si resident's reach. Whe fall, she stated the inflare passed on in repocare plan. LPN #2 stall (certified nursing assi know if any residents measures to be impleed to the care plan are plan. RN #3 stated it is all staff's reprevention measures care plan. RN #3 stated to the care plan are plan are planses this informother staff who are call stated fall prevention chance for a resident	#29's comprehensive care and updated 7/22/21, nimize risks for related to falls: "Fall mat to plement preventative fallMaintain call light within ent to use call light." m., LPN (licensed practical ewed. When asked where aced in resident rooms, she nould always be within a en asked who is responsible all bells are in reach, LPN poody's responsibility. The room." When asked now which interventions end to prevent injury from a cormation and interventions are always on the sted she makes sure CNAs stants) working on her shift have specific fall prevention mented. a., RN (registered nurse) #3 en asked how makes certain intions are implemented, she esponsibility. She stated fall are usually listed on the ed any updates or changes assed along in report, and nation along to CNAs and uring for a resident. She measures help lessen the	F 6	Monitoring: The DON is responsible for recompliance. The DON, ADO Manager will perform 3 audit 12 weeks of all residents with order fall interventions/equip monitor for compliance. Any findings will be corrected at the discovery. Audits findings will QAPI monthly for 3 months for recommendations for 3 months.	N and/or Unit is weekly for th physician ment to negative time of Il reported to for review and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` ′	LE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		495401	B. WING		C 08/05/2021		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 12001 IRON BRIDGE RD CHESTER, VA 23831	00/03/2021		
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F 689	(director of nursing vice-president of or regional nurse consconcerns. On 8/5/21 at 8:43 at When asked where be located, she state a resident's reach, any fall prevention Resident #29, she check with the nurse responsible for mal interventions are in stated, "I am. And I was a review of the faci Management Policiple reviewed by an new interventions is and the care plantare review should incluse assessment, discussifications with the environ occurred, and discussifications which falls." No further informat REFERENCES (1) "Dementia is a gent of the president of	dministrator, ASM #2, the DON), ASM #3, the regional perations, and ASM #4, the sultant, were informed of these a.m., CNA #5 was interviewed. The a resident's call bell should ted it should be located within When asked if she is aware of interventions in place for stated she would have to se. When asked who is king sure fall prevention place for residents, CNA #5	F 68	9			
	and behavior." This website	s information is taken from the					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
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F 689	Continued From page	. 74	F (689		
F 695 SS=D	a mental disorder that mood, energy, activity the ability to carry out information is taken from https://www.nimh.nih.order/index.shtml. Respiratory/Tracheos CFR(s): 483.25(i) § 483.25(i) Respiratory tracheostomy care and tracheostomy care and tracheostomy care and tracheal succare, consistent with practice, the comprehencare plan, the resident and 483.65 of this suffithis REQUIREMENT by: The facility staff failed consistent with profess practice, and the complan of care for one of sample, Resident #17	ess or manic depression) is a causes unusual shifts in a levels, concentration, and day-to-day tasks." This com the website gov/health/topics/bipolar-dis tomy Care and Suctioning by care, including day tracheal suctioning. The that a resident who expect that a resident who expect toping, is provided such professional standards of the ensive person-centered tasts' goals and preferences, topart. The facility staff failed to the survey of the facility staff failed to the nebulizer tubing (1) as	F	Corrective Action(s) Resident #17's nebulizer mask, tubing and storage bag were discarded and replaced with a new nebulizer, tubing storage bag. Identification of Deficient Practice & Corrective Action(s): All current residents receiving physici	and	9/10/21
	Resident #17 was addiagnoses that include	mitted to the facility with ed but were not limited to ilmonary disease (COPD) n (3).		ordered nebulizer treatments may ha potentially been affected. A 100% rev of current residents with physician or nebulizer treatments will be conducte identify any/all residents at risk. Any negative findings were corrected at till	/e iew lered d to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY
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F 695	Resident #17's most is set), an admission as (assessment reference Resident #17 as scor assessment for menta of 0 - 15, 12- being making daily decision Resident #6 as requir from two staff member and toilet use. On 8/3/2021 at approximation observation was madher room. A nebulizer Resident #17's nights mask nebulizer deliver observed plugged into delivery device was olabeled with Resident and dated 6/16/21. Teliver device contain 6/16/21 on it. At this	recent MDS (minimum data sessment with an ARD se date) of 6/8/2021, coded ing a 12 on the staff al status (BIMS) of a score oderately impaired for	F 6	995	of discovery. Systemic Change(s): The facility policy and procedure has be reviewed and no changes are warranted at this time. All Nursing staff, to include agency staff and new hires will be inserviced by the DON and/or ADON of the proper procedure for storing and changing nebulizer masks, tubing and storage bags weekly and PRN. Monitoring: The DON is responsible for maintaining compliance. The DON, ADON and/or to Manager will perform 3 audits weekly or residents with Nebulizer treatments for weeks to monitor for compliance. Any negative findings will be corrected at time of discovery. Audit findings will be reported to the QAPI Committee for review and recommendations monthly 3 months.	g Jnit on 12	
	nebulizer. Additional observation on 8/3/2021 at 4:05 p a.m. revealed the nebin the bag dated 6/16 delivery device dated The physician orders documented in part, - "Neb (nebulizer) tub Wednesday and prn (6/3/2021"	for Resident #17					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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F 695	needed for COPD. On a "Brovana Nebulizat" (micrograms)/2 ML, 22 nebulizer two times as with water after each 06/03/2021" The eMAR (electronic record) for Resident 6/1/2021-6/30/2021 receiving the Brovan 6/3/2021 through 6/8 6/13/202021, 6/15/20 5:00 p.m., and 6/19/20 The eMAR for Resid 7/1/2021-7/31/2021	revery 6 (six) hours as Order Date: 06/02/2021" ion Solution 15 MCG 2 ML inhale orally via a day for COPD rinse mouth use. Order Date: c medication administration #17 dated documented Resident #17 a Nebulization Solution on 1/2021, 6/12/2021 through 6/16/2021 at 2021 through 6/30/2021. ent #17 dated documented Resident #17 a Nebulization Solution each	F6	995		
	The eMAR for Resid 8/1/2021-8/31/2021 or receiving the Brovan 8/1/2021 and 8/2/202 The comprehensive dated 6/3/2021 docu has COPD-potential Initiated: 06/03/2021 On 8/4/2021 at approximate in the role of the received was condupractical nurse) #2. The the role of the rol	ent #17 dated documented Resident #17 a Nebulization Solution on 21. care plan for Resident #17 mented in part, "Resident for impaired airway. Date				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG	_	(X3) DATE COMP	SURVEY LETED
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F 695	Continued From page dated. LPN #2 stated changed to keep ther On 8/4/2021 at approinterview was conducted that nebulizer's as needed when soile nebulizer was stored with the resident's nadate on them. LPN # changing the nebulizer control purposes. On 8/4/2021 at approobserved the nebulizer Resident #17's room that they could not sa June because it should be a supproceed that they could not sa June because it should be a supproceed that they could not sa June because it should be a supproced from the Lipping Practice, Eleventh Eduration, Eleventh Eduration, Guidelines 10-11 documents.	that the nebulizers were in clean. ximately 1:30 p.m., an ested with LPN #3. LPN #3 is were changed weekly and ed. LPN #3 stated that the in a bag when not in use in a bag when not in use in a bag when not in use in a bag when read the in a stated that the purpose of ear weekly was for infection in a stated that the purpose of ear weekly was for infection in a stated that the purpose of ear weekly was for infection in a stated early why the date was back in lid have been changed on in a stated early why the date was back in lid have been changed on in a stated early why the date was back in lid have been changed on in a stated early why the date was back in lid have been changed on in a stated early why the date was back in lid have been changed on in a stated early why the date was back in lid have been changed on in a stated early why the date was back in lid have been changed on in a stated early why the date was back in lid have been changed on in a stated early why the date was back in lid have been changed on in a stated early why the date was back in lid have been changed on in a stated early why the date was back in lid have been changed on in a stated early why the date was back in lid have been changed on in a stated early why the date was back in lid have been changed on in a stated early why the date was back in lid have been changed on in a stated early why the date was back in lid have been changed on in a stated early why the date was back in lid have been changed on in a stated early why the date was back in lid have been changed on in a stated early why the date was back in lid have been changed early why the date was back in lid have been changed early why the date was back in lid have been changed early why the date was back in lid have been changed early why the date was back in lid have been changed early why the date was back in lid have been changed early why the date was back in lid have been changed early why the date was back in lid have been changed early why the date was back in lid	F	595	DEFICIENCY)		
	clean nebulizer after equipment in the paties is changed according patient has own breat tubing and mouthpied cleaning, sterilization.	ons. 2. Disassemble and each use. Keep this ent's room. The equipment to facility policy. Each thing circuit (nebulizer,					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
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	ROVIDER OR SUPPLIER	GE		STREET ADDRESS, CITY, STATE, ZIP CODE 12001 IRON BRIDGE RD CHESTER, VA 23831	1 00/	03/2021
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F 695	request was made to for the use of nebulization for the use of nebulization for the use of nebulization for the use of nebulization. The facility policy "Net Policy" dated 12/16/2 guidance on frequency mask delivery device. On 8/4/2021 at approach the administrator, AS ASM #3, the regional and ASM #4, the regional and ASM #4, the regionotified of the findings was provided prior to References: 1. Nebulizer: "A device medications for deliver Encyclopedia & Diction Allied Health -Sevent page 1182. 2. Chronic obstructive (COPD): Disease that that can lead to short information was obtain https://www.nlm.nih.guidance. A rhythm of the heartbe obtained from the weight of the series of	ximately 11:00 a.m., a ASM #1 for the facility policy ers. bulizer Administration 019 failed to evidence by of replacing the nebulizer ximately 4:55 p.m., ASM #1, M #2, the director of nursing, vice president of operations onal nurse consultant were by No further information exit. ce used to aerosolize ery to patients." Taken from onary of Medicine, Nursing & h Edition, Miller-Keane, e pulmonary disease t makes it difficult to breath ness of breath. This ned from the website: ov/medlineplus/copd.html. problem with the speed or at. This information was	F 69	5		
F 700 SS=D	Bedrails		F 70	0		9/10/21

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NAME OF PROVIDER OR SUPPLIER TYLER'S RETREAT AT IRON BRIDGE		STREET ADDRESS, CITY, STATE, ZIP CODE 12001 IRON BRIDGE RD CHESTER, VA 23831	1 33/33/221
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F 700 Continued From page 79 CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropalternatives prior to installing a side or a bed or side rail is used, the facility must attempt to the foliolelements. §483.25(n)(1) Assess the resident for rentrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and beto bed rails with the resident or resident representative and obtain informed corto installation. §483.25(n)(3) Ensure that the bed's dirtare appropriate for the resident's size at \$483.25(n)(4) Follow the manufacturer recommendations and specifications for and maintaining bed rails. This REQUIREMENT is not met as every by: Based on observation, staff interview, document review and clinical record rewas determined that the facility staff fair implement bed rail requirements for two residents in the survey sample, (Reside and #67). 1. The facility staff implemented bed ratesident #31 without a documented clinical railed to obtain informed consent for the distribution of t	riate bed rail. If ust ensure nce of bed owing isk of llation. nefits of nsent prior mensions and weight. s' or installing idenced facility view, it led to o of 37 ents #31 ails for nical need or the use	Corrective Action(s): Residents #31, & #67 have bee reassessed by nursing for the u quarter rails for mobility and rep. The resident's comprehensive have been revised to reflect the use of quarter rails while in bed mobility and repositioning. Identification of Deficient Practic Corrective Action(s): All current residents using quarturning and positioning while in	use of positioning. care plans eir current I for ce(s) & ter rails for

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED	
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F 700	#67 was assessed for review risks / benefits informed consent prior. The findings include:	or risk of entrapment, failed to s and failed to obtain or to the use of bed rails.	F	700	have potentially been affected. Nursin will conduct a 100% audit of all current residents who use quarter rails to ensuthey have been properly assessed for use of quarter rails, consent has been obtained and that they are being used appropriately to meet the resident's	ire		
	1/3/20. Resident #3 ⁴ were not limited to st and anxiety disorder. minimum data set as	I's diagnoses included but roke, chronic kidney disease Resident #31's quarterly sessment with an le date of 6/23/21, coded the			current safety and mobility needs. Any, negative finding will be corrected at the time of discovery and the residents comprehensive care plans will be revis as needed to reflect their current level care.	e ed		
	a bed rail assessment documented, "Medica (bed rail) being consistency any clinical near Informed consent observes entative: NA" Review of Resident # plan initiated on 1/6/2	al need(s) for the side rail idered: Resident hasn't seed for side rails at this time. tained from resident/resident			Systemic Change(s): Facility policy & procedure has been reviewed and no revisions are warrante at this time. The DON and/or ADON wi inservice all licensed nursing staff, to include agency staff and new hires on procedure for obtaining informed conseand completing the side rail screening/assessment tool prior to initiating side rail use for any residents.	II the ent		
	On 8/3/21 at 11:22 a. Resident #31 was ob U bar bed rails up. On 8/5/21 at 8:35 a.n conducted with LPN LPN #5 stated some turning and reposition must be done to determine if be stated consent for the be obtained. LPN #5	m. and 8/4/21 at 8:01 a.m., aserved in bed with bilateral m., an interview was (licensed practical nurse) #5. residents use bed rails for ning but an assessment ermine the need for bed rails ed rails are safe. LPN #5 e use of bed rails also has to			Monitoring: The DON is responsible for maintaining compliance. The DON, ADON and/or Manager will audit new admission Side rail assessments weekly times 12 week coinciding with to monitor for compliane Audit findings will be reported to the Quote committee for review and recommendations monthly x 3 months.	Unit ks ce. API		

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F 700	reviewed Resident # dated 5/17/21. LPN assessment docume and no consent. LP Resident #31 curren On 8/5/21 at 9:36 a.member) #1 (the addirector of nursing) vabove concern. The facility bed rail pfacility will attempt to prior to installing a si 2. If a bed or side rai a. Assess the potent use of bed rails incluprior to bed rail instab. Assess the risk verail and review them applicable, the residic. Obtain informed cuse of bed rails prior No further information. 2. The facility staff farefor was assessed for review risks / benefit informed consent priors as a session of the progressive loss of often accompanied for the session of the session	buld not have them. LPN #5 31's bed rail assessment #5 stated that the ented no need for bed rails N #5 stated she thought tly did need bed rails. m., ASM (administrative staff ministrator) and ASM #2 (the were made aware of the bolicy documented, "1. The ouse appropriate alternatives ide or bed rail. il is used, the facility will: ial risks associated with the ding the risk of entrapment, llation. ersus benefits of using a bed with the resident or if ent's representative. onsent for the installation and to the installation" an was presented prior to exit. illed to evidence Resident or risk of entrapment, failed to s and failed to obtain or to the use of bed rails. dmitted to the facility on #67's diagnoses included but	F 70				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
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F 700	cushioning tissue be Resident #67's most set) assessment, a cassessment reference resident as scoring 9 (brief interview for method the resident was unainterview. MDS Sect coded the resident, a bed mobility, transfer hygiene and bathing not occur. A review and Bladder: coded incontinent for bower Resident #67 was obside rails up on 8/3/28:05 AM. A review of the phys "Bilateral side bars for A review of Resident to evidence, assessing failed to review risks informed consent. A review of the bed of for 2021, with the bed of the review of Resident plan dated 12/21/20 documents in part, "I self-care deficit. INT activities of daily livir assessment assessment as a second plan dated 12/21/20 documents in part, "I self-care deficit. INT activities of daily livir	recent MDS (minimum data quarterly assessment, with an ce date of 7/25/21, coded the 19 out of 15 on the BIMS ental status) score, indicating able to complete the ion G- Functional Status: as extensive assistance with rs, dressing, eating, personal walking and locomotion did of MDS Section H- Bowel the resident as always and for bladder. Deserved in bed with bilateral ental 11:30 AM and 8/4/21 at ician orders documented for assist." ##67's medical record, failed ment for risk of entrapment, hencefits and failed to obtain real inspection was completed	F 70	00	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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F 700	8/3/21 and 8/4/21. A review of Resident plan on 8/5/21, docu revision to the care prails to bed." A review of Resident to evidence, an asse entrapment, failed to risks / benefits for the Resident #67 and or representative, and for consent was obtained. A request was made evidence of assessmisks / benefits and in bedrails for Resident. On 8/5/21 at 9:55 AMmember) #1, the admits the documentation your and interview was con AM with LPN (Licens When asked what do bedrails, LPN #1 states assessment, discussed a consent." An interview was con with RN (registered in documentation is new stated, "You need a list was a consent."	#67's comprehensive care mented in part, the following plan on 8/4/21 "Two assist #67's medical record, failed ssment for risk of evidence a review of the e use of bed rails with the resident s ailed to reveal informed d prior to the use of bed rails. on 8/5/21 at 9:20 AM for the ment for risk of entrapment, informed consent for the #67. M. ASM (administrative staff ministrator, returned and ave any of the equested for Resident #67." Inducted on 8/4/21 at 11:01 and practical nurse) #1. becumentation is needed for	F 700			

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F 700	• - · · · · · · · · · · · · · · · · · ·	ive to get consent, RN #2	F 7	00		
	On 8/05/21 at 11:30 A administrator, ASM #. ASM, the regional VF informed of the concern	2, the director of nursing and of operations were				
	4/2/18, documents in used, the facility will: associated with the urisk of entrapment, pr Assess the risk versu and review them with	y's "Bed Rails" policy dated part, "If a bed or side rail is assess the potential risks se of bed rails including the ior to bed rail installation. s benefits of using a bed rail the resident. Obtain the use of the bed rails prior				
	References: (1) Barron's Dictionar Non-Medical Reader, Chapman, page 25. (2) Barron's Dictionar Non-Medical Reader, Chapman, page 218/ (3) Barron's Dictionar Non-Medical Reader, Chapman, page 153.	y of Medical Terms for the 7th edition, Rothenberg and				
F 757 SS=D	CFR(s): 483.45(d)(1)- §483.45(d) Unnecess Each resident's drug		F 7	57		9/10/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495401	B. WING			08/0	05/2021
	ROVIDER OR SUPPLIER RETREAT AT IRON BRID	ogE	•	1:	TREET ADDRESS, CITY, STATE, ZIP CODE 2001 IRON BRIDGE RD :HESTER, VA 23831		
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F 757	duplicate drug therape §483.45(d)(2) For excessions \$483.45(d)(4) Without use; or §483.45(d)(5) In the procession of th	essive dose (including by); or cessive duration; or at adequate monitoring; or at adequate indications for its cresence of adverse indicate the dose should be ued; or combinations of the reasons (d)(1) through (5) of this T is not met as evidenced atterview, staff interviews, s and facility document hined that the facility staff of 37 residents in the survey nnecessary medications,	F	757	Corrective Action(s): Resident #58's attending physician has reviewed resident #58's medication regime and the PRN pain medication h been changed to scheduled delivery th times a day. Identification of Deficient Practice(s) & Corrective Action(s): All current residents receiving PRN pair medication may have potentially been affected. The DON, ADON, and/or Unit Manager will review the medication ord of current residents receiving PRN pair medication to ensure that non-pharmacological interventions are ordered and attempted prior to administering PRN pain medications. Any/all negative findings will be communicated to the attending physicia	as ree n lers	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 757	Continued From page	e 86	F 7	757				
	(assessment reference Resident #58 as scor	ce date) of 7/18/2021, coded ing a 13 on the staff			for corrective action.			
	assessment for mentor of 0 - 15, 13- being contained and a daily decisions. Section receiving scheduled a medications. Section #58 as not receiving for pain and having pointerview was conducted to the new section when asked a Resident #58 stated to be requested to the new section by asking him who provided the medication attempted non-pharm relieve his pain prior to the section of the section	al status (BIMS) of a score opnitively intact for making ion J coded Resident #58 as and as needed pain a J further coded Resident mon-medication interventions ain almost constantly. Eximately 4:15 p.m., an exted of Resident #58 in their about pain management, that pain medications had to curses when needed. That the nurses assessed his hat number his pain was and ion. When asked if staff nacological interventions to to administering the #58 stated that they just	Sys All r and and proc mor inclu inte PRI Mor The com with com neg atte		Systemic Changes: All nursing staff, to include agency staff and new hires will inserviced by the DC and/or ADON on the facility policy and procedure for administration and monitoring of all medications. This includes attempting non-pharmacologic interventions prior to administration of PRN pain medications. Monitoring: The DON, ADON and/or Unit Manager complete weekly MAR audits coincidin with the care plan calendar to monitor compliance weekly for 12 weeks. All negative findings will be reported to the attending physician for correction. Aud findings will be reported to the QAPI committee for review, analysis, and recommendations for change in facility	on cal will g		
	MG, Give 2 (two) table hours as needed for p 07/13/2021. End Dat - "Dilaudid Tablet 2 M (HYDROmorphone H mouth every 4 (four) Order Date: 07/16/20 The eMAR (electronic record) dated 7/1/202 the Oxycodone was a on: 7/13/2021 at 4:08	[hydrochloride] Tablet 5 let by mouth every 4 (four) pain. Order Date: le: 07/16/2021." MG (milligram) CL) Give 1 (one) tablet by hours as needed for pain.			policy, procedure and practice.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION IG	COMPL	(X3) DATE SURVEY COMPLETED		
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F 757	of seven and on 7/16 level of seven. The eMAR dated 7/16 documented the Dilar Resident #58 on 7/17 level of five and at 12 five. The eMAR furth #58 receiving the Dilar p.m. for a pain level of p.m. for a pain level of a.m. for a pain level of 9:52 a.m. for a pain level of 9:52 a.m. for a pain level of 9:58 prior to the admit pain medication on the above. The progress notes for evidence documentation interventions attempts above.	/2021 at 1:39 a.m. for a pain /2021-7/31/2021 udid was administered to //2021 at 6:20 a.m. for a pain :13 p.m. for a pain level of er documented Resident audid on 7/18/2021 at 12:10 of eight, on 7/20/21 at 8:38 of eight, on 7/22/21 at 1:23 of eight and on 7/26/21 at	F 7	<u> </u>			
	above. The comprehensive of dated 7/13/2021 door has reported episode further pain. Date Init Date: 07/27/2021" it documented in part pharmacological interlike Distraction technical	ventions to release the pain ques, relaxation and music therapy, re-position.					

` · ·		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		, ,	(X3) DATE SURVEY COMPLETED	
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F 757	interview was conduc	oximately 8:35 a.m., an cted with LPN (licensed	F 7	57			
	that when a resident assessed the resider pain and the possible stated that intervention were attempted first the pain. LPN #5 stated that if the non-interventions were not pain, then they would medication. LPN #5 minimize the amount to the resident unless that they utilized non interventions such as turning and reposition pain. LPN #5 stated interventions were do (electronic medication the nurse's notes. LI for Resident #58 date progress notes and sidocumentation that minterventions were at	of successful in relieving the dadminister the ordered pain stated that this was to of medications administered is needed. LPN #5 stated pharmacological is relaxation techniques, ning to attempt to relieve that non-pharmacological ocumented on the eMAR in administration record) or in PN #5 reviewed the eMAR and 7/1/2021-7/31/2021 and stated that they did not see ion-pharmacological					
	On 8/5/2021 at approinterview was conducted staff member) #2, the #2 stated that staff when the mon-pharmacological and repositioning or the staff was a staff when the staff when the staff when the staff was a	eximately 9:20 a.m., an exted with ASM (administrative expected to implement interventions like turning offering a cold pack prior to ded pain medications. ASM					

AND DIAN OF CORRECTION IDENTIFICATION NUMBER		1 ' '	PLE CONSTRUCTION G	COMPLETED			
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F 757	the non-pharmacolog effectiveness in the rasked to provide evic offering/implementing interventions prior to needed pain medical. On 8/5/2021 at approverse stated that there winterventions docume the dates/times listed. On 8/5/2021 at approverse was made to on pain management. The facility policy "Parotocol" dated 5/21/" Non-pharmacolog attempted prior to the needed) pain medical. On 8/5/2021 at approverse was made to on pain management. The facility policy "Parotocol" dated 5/21/" Non-pharmacolog attempted prior to the needed) pain medical. On 8/5/2021 at approverse was approved by the pain medical. The administrator nursing and ASM #3 operations were made further information with the provention of the proven	ere expected to document gical interventions with their nurse's notes. ASM #2 was dence of staff g non-pharmacological the administration of the ascions as listed above. Example 10:10 a.m., ASM were no non-pharmacological ented for Resident #58 on a labove. Example 11:00 a.m., a pass ASM #1 for the facility policy t. Example 11:00 a.m., a pass ASM #1 for the facility policy t. Example 11:00 a.m., a pass ASM #1 for the facility policy t.	F 75	57			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
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F 757	Scar tissue cannot do does - make protein, the blood, help digest This information was https://vsearch.nlm.ni meta?v%3Aproject=n medlineplus-bundle&9383.513196122.162936034	ry or long-term disease. what healthy liver tissue help fight infections, clean food and store energy." obtained from the website: h.gov/vivisimo/cgi-bin/query- nedlineplus&v%3Asources= query=cirrhosis&_ga=2.7315 6311381-1838772440.1562	F	757		
F 758 SS=D	S483.45(e) Psychotron §483.45(c)(3) A psychaffects brain activities processes and behave but are not limited to, categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehence resident, the facility manual sychotropic drugs are unless the medication specific condition as of in the clinical record; §483.45(e)(2) Reside drugs receive gradual behavioral intervention	pic Drugs. notropic drug is any drug that associated with mental ior. These drugs include, drugs in the following ensive assessment of a nust ensure that ints who have not used the not given these drugs a is necessary to treat a diagnosed and documented ints who use psychotropic I dose reductions, and	F	758		9/10/21

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 758	Continued From page	e 91	F 75	8	
	unless that medication	ursuant to a PRN order on is necessary to treat a ondition that is documented			
	are limited to 14 days §483.45(e)(5), if the a prescribing practition appropriate for the Pl beyond 14 days, he of	RN order to be extended or she should document their ent's medical record and			
	drugs are limited to 1 renewed unless the a prescribing practition the appropriateness of	rders for anti-psychotic 4 days and cannot be attending physician or er evaluates the resident for of that medication. T is not met as evidenced			
	Based on observation document review, and was determined the fresident did not recei	tion for one of 37 residents in		Corrective Action(s): Resident #59's Alprazolam order has been reviewed and updated to include attempting nonpharmacological interventions prior to administrator of F psychotropic medication.	
	indications for the use medication Alprazola non-pharmacological administration of the	m, failed to offer interventions prior to the medication to Resident #59 Resident #59 for side effects		Identification of Deficient Practice(s) & Corrective Action(s): All other residents receiving PRN psychotropic medications may have be potentially affected. The DON, ADON and/or pharmacy consultant will audit current residents with PRN psychotrop medication orders to identify residents without nonpharmacological intervention	een all sic

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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F 758	Resident #59 was add 7/13/21 with diagnose heart attack and heart MDS (minimum data assessment with an Adate) of 7/19/21, Resibeing moderately implecisions, having sco BIMS (brief interview coded as not having ranxiety during the loo On the following date: was observed lying in 8/3/21 at 12:22 p.m. a.m. and 4:05 p.m. A review of Resident revealed the following "Alprazolam Tablet 0. tablet by mouth at bee was signed by ASM (affective was of Resident and A review of R	mitted to the facility on es including history of a t failure. On the most recent set), an admission and (assessment reference dent #59 was coded as aired for making daily red nine out of 15 on the for mental status). She was eceived medications to treat k back period. Is and times, Resident #59 bed with her eyes closed: and 3:48 p.m.; 8/4/21 at 9:48 #59's clinical record order, dated 7/26/21: 25 MG (milligrams) Give 1 dtime for Anxiety." The order administrative staff member) ctitioner).		758		een ans Juit nan as ed ans	
	the resident began re Further review of Res failed to reveal evider	ident #59's clinical record nce in the progress notes or ecords that facility staff had					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	` '	ATE SURVEY DMPLETED
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F 758	ASM #5's progress note, dated 7/26/21 in room today - rem responding poorly ir (complains of) patie bedtime." The review to review evidence to review evidence than to resident any other intervention reported anxiety prick A review of Resident dated 7/14/21 did noted to Resident #59's All comprehensive care 8/3/21. On 8/4/21 at 12:53 purse) #2 was intervented was intervented anxiety, should do for a resident resident more comforts of anxiety, should do for a resident resident more comforts when asked if she will let the resident hear When asked if she will have a known diagran not just because the On 8/4/21 at 3:44 p. was interviewed and Alprazolam. RN #3 resident gets it for a resident is asleep malways arouses eas does try to crawl our asked what side effects.	an anxiolytic. A review of notes revealed the following: "Patient seen and examined ains weak looking and in therapyDaughter c/o not being more anxious at w of the progress notes failed that the staff had attempted ons to address Resident #59's for to initiating the Alprazolam. In the staff had attempted ons to address Resident #59's for to initiating the Alprazolam. In the staff had attempted ons to address Resident #59's for to initiating the Alprazolam. In the staff had attempted ons to address Resident #59's for to initiating the Alprazolam. In the staff had attempted on the staff had attempted by the	F 7	58		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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F 758	Resident #59's recombeing monitored for stall Alprazolam. After revicinical record, RN #3 see." On 8/4/21 at 4:54 p.m. member) #1, the admit (director of nursing), vice-president of operegional nurse consuconcerns. On 8/5/21 at 8:19 a.m. She stated ASM #5 conformation regarding for starting the resident stated she could not resident was being manitoring immediated a new anxiolytic. ASM monitor for side effect contraindicated in the On 8/5/21 at 11:21 a. interviewed. She stated the daughter hof anxiety at bedtime Alprazolam for the reprimary side effect is	RN #3 was asked to review d for evidence that she is ide effects of receiving iewing Resident #59's 8 stated, "No. Not that I can h., ASM (administrative staff hinistrator, ASM #2, the DON ASM #3, the regional rations, and ASM #4, the Itant, were informed of these h., ASM #2 was interviewed. Ould provide more the indications and reason and on Alprazolam. ASM #2 find evidence that the ionitored for side effects of the time of survey entrance. Itsually begins side effect ely when a resident starts on the indications and reason at the ionitored for side effect ely when a resident starts on the image. It is important to the important to the because "[Alprazolam] is elederly." m., ASM #5 was the Resident #59's daughters and taken Alprazolam at pital admission. ASM #5 and reported the symptoms, and that is why she started sident. She stated the sedation. If policy, "Psychoactive is a state is in the indication in the indication in the indication is a state of the indication."	F	758				
		evealed, in part: "Residents ve medication will have a						

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	COM	E SURVEY PLETED
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F 758	meds [medication] ar order process in the (other/behavior flow, effects) or paper flow a. Each psychoactive on BFR b. Resident specific be medication use will be c. Diagnosi[e]s support	n Flow Record (BFR) n or whenever psychoactive e ordered using the batch electronic record both interventions and side records: e medication will be entered pehaviors related to e entered on BFR	F 7	58		
	B. Nurses will docum shift: a. Number of behavior b. Specific non-medicenter code as indicated concentration on BFR in the second service on BFR in the second service on the supportive physical and activities of the supportive physical and service on the supportive physical and service of the supportive physical service	cation interventions used - ed on BFR entions - use code key listed ons - individualized approaches (including direct nat are provided as part of a nd psychological directed toward preventing, odating a resident's observed-use code key listed on was provided prior to exit. ed to treat anxiety disorders udden, unexpected attacks				
		vorry about these attacks). ass of medications called vorks by decreasing				

1 7		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 758	tml. Food Procurement, Sir CFR(s): 483.60(i)(1)(1)(1)(1)(1)(2)(2)(3)(3)(4)(3)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)	in the brain." This in from the website by/druginfo/meds/a684001.h core/Prepare/Serve-Sanitary (2) by requirements. The food from sources ed satisfactory by federal, les. bood items obtained directly subject to applicable State plations. It is not prohibit or prevent roduce grown in facility ompliance with applicable	F 75	В	9/10/21
	serve food in accorda standards for food se This REQUIREMENT by: Based on observation document review it w failed to store food are dietary equipment in a The facility failed to dwalk-in refrigerator w signs of spoilage and blade on the kitchens	n, staff interview, and facility as determined facility staff		Corrective Action(s): The spoiled tomatoes were removed f walk-in refrigerator and disposed of. T electric food slicer was cleaned and sanitized and rust-colored area was removed from blade. Identification of Deficient Practice(s) & Corrective Action(s): A 100% audit of produce was conduct	'he

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NAME OF PROVIDER OR SUPPLIER TYLER'S RETREAT AT IRON BRIDGE MAINT SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES PREFIX PROVIDER'S PLAN OF CORRECTION PREFIX PROVIDER'S PLAN OF CORRECTION CONSISTENCY PROVIDER'S PLAN OF CORRECTION CONSISTENCY PREFIX PROVIDER'S PLAN OF CORRECTION PREFIX PROVIDER'S PLAN OF CORRECTION CONSISTENCY PREFIX PROVIDER'S PLAN OF CORRECTION CONSISTENCY PREFIX PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		1 ' '	1 ' '			l` ′	
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TYLER'S RETREAT AT IRON BRIDGE SUMMARY STATEMENT OF DEPICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY FULL TAGE DEPICIENCY			495401	B. WING			08	3/05/2021
FREETIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 812 Continued From page 97 the blade approximately one-quarter inch in size. The findings include: 1. On 8/3/2021 at approximately 11:15 a.m., an observation was conducted in the kitchen of the facility with OSM (other staff member) #2, the dietary manager. Observation of the kitchen's walk in refrigerator revealed a 25 pound cardboard box of tomatoes with a date of 7/26/21 hand-written on the lid. Upon removal of the lid from the box, four tomatoes were observed with black colored substance at the stem area of the tomatos. On 8/3/2021 at approximately 11:30 a.m., an interview was conducted that they normally received much smaller boxes of tomatoes with OSM #2. OSM #2 observed the tomatos in the walk-in refrigerator and stated that then they pulled produce out to use it, they discarded any produce that had signs of spoilage on the complete a daily audit of produce for signs of spoilage. Any produce for signs of spoilage. Any produce was conducted to the lid from the box, four tomatoes were observed with black colored spots on the surface of the outer skin and two tomatoes were observed with a white colored substance at the stem area of the tomatos. On 8/3/2021 at approximately 11:30 a.m., an interview was conducted with OSM #2. OSM #2 observed the tomatoes in the walk-in refrigerator and stated that then they pulled produce out to use it, they discarded any produce that had signs of spoilage on it. OSM #2 stated that normally they checked the produce daily but due to staffing only two employees in the kitchen currently they were unable to check them like they used to OSM #2 stated that then like they used to OSM #2 stated that then like they used to OSM #2 stated that then like they used to OSM #2 stated that then like they used to OSM #2 stated that then like they used to OSM #2 stated that then like they used to OSM #2 stated that then like they used to OSM #2 stated that then like they used to OSM #2 stated that then like they used to OSM #2 stat			GE		12	2001 IRON BRIDGE RD		
the blade approximately one-quarter inch in size. The findings include: 1. On 8/3/2021 at approximately 11:15 a.m., an observation was conducted in the kitchen of the facility with OSM (other staff member) #2, the dietary manager. Observation of the kitchen's walk in refrigerator revealed a 25 pound cardboard box of tomatoes with a date of 7/26/21 hand-written on the lid. Upon removal of the lid from the box, four tomatoes were observed with visible signs of spoilage on them. Two tomatoes were observed with black colored spots on the surface of the outer skin and two tomatoes were observed with a white colored substance at the stem area of the tomato. On 8/3/2021 at approximately 11:30 a.m., an interview was conducted with OSM #2. OSM #2 observed the tomatoes in the walk-in refrigerator and stated that they normally received much smaller boxes of tomatoes and that normally they did not keep so many in the refrigerator. OSM #2 stated that when they pulled produce out to use it, they discarded any produce that had signs of spoilage on it. OSM #2 stated that they had modified their process to discard any spoiled items when they pulled things out to cook meals. OSM #2 stated that the date	PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR		COMPLETION
that it was received in the facility and that they thought they kept produce for 14 days but had to check their policy to confirm. On 8/4/2021 at approximately 8:10 a.m., a	F 812	the blade approximate. The findings include: 1. On 8/3/2021 at apobservation was confacility with OSM (oth dietary manager. Obwalk in refrigerator recardboard box of tom hand-written on the liftom the box, four ton visible signs of spoila were observed with burface of the outers observed with a white stem area of the tomaton observed the tomaton observed the tomaton and stated that they resmaller boxes of tomatic did not keep so many stated that when they they discarded any proposed to the conference of the unable to check them stated that they had rediscard any spoiled it out to cook meals. Or 7/26/21 written on the that it was received in thought they kept procheck their policy to conserve the conference of the conferen	proximately 11:15 a.m., an ducted in the kitchen of the per staff member) #2, the proximately 12:15 a.m., and ducted in the kitchen of the per staff member) #2, the proximately 12:15 pound partoes with a date of 7/26/21 d. Upon removal of the lid partoes were observed with the ge on them. Two tomatoes obtained to the per colored spots on the partoes and the partoes and the parton promally received much partoes and that normally they are in the refrigerator. OSM #2 to pulled produce out to use it, roduce that had signs of the produce that had signs of the produce that had signs of the pulled produce out to use it, roduce that had signs of the pulled produce out to use it, roduce that had signs of the pulled produce to SM #2 the pulled their process to the pulled their process to the pulled their process to the pulled that the pulled for 14 days but had to confirm.	F	812	Any produce with signs of spoilage was removed and disposed of. A 100% audit of kitchen appliances was conducted to identify appliances that required cleaning and repair. Any neg findings were corrected at the time of discovery. Systemic Changes: The Dietary Manager and Dietary staff have been inserviced by the Dietician the procedure for inspecting produce a perishable foods for signs of spoilage daily and proper storage of produce as perishable foods. Monitoring: The Dietary Manager/Designee will complete a daily audit of produce for sof spoilage for 12 weeks to monitor for compliance. The Maintenance Director/Designee will complete a week audit of kitchen appliances for any need cleaning, repairs or maintenance for 1 weeks to monitor for compliance. The audit results will be reported to the QA committee monthly for 3 months for	s ative on and and aigns kly eded 2	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		495401	B. WING _			C 08/05/2021		
	NAME OF PROVIDER OR SUPPLIER TYLER'S RETREAT AT IRON BRIDGE			STREET ADDRESS, CITY, STATE, ZIP CODE 12001 IRON BRIDGE RD CHESTER, VA 23831	 	00/00/2021		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 812	Continued From pag	e 98	F 8	12				
		OSM #2 for the facility produce in the walk-in						
	#2 provided the police Reference" and state for seven days. OSM were received on 7/2	oximately 10:05 a.m., OSM by "Use-by Guide-Quick ed that the produce was kept of #2 stated that the tomatoes 16/21. OSM #2 stated that eipt would be 8/2/2021.						
	The facility policy "Use-By Guide - Quick Reference" documented in part, "Note: Storage guidelines above are meant as a general guide-Be alert for food spoilage; anything that looks or smells suspicious should be discarded immediately."							
	the administrator, AS ASM #3, the regiona	oximately 4:55 p.m., ASM #1, SM #2, the director of nursing, I vice president of operations ional nurse consultant were s.						
	the administrator pro documented, "Spoile produce was checke refrigerator. Spoiled and no other issues	oximately 8:00 a.m., ASM #1, vided a typed memo which d Produce. 8/4/2021. All d in the walk in dietary tomatoes were disposed of were found with the [Signature of ASM #1]."						
	No further informatio	n was provided prior to exit.						
	observation was con facility with OSM (oth	oproximately 11:15 a.m., an ducted in the kitchen of the ner staff member) #2, the oservation revealed the						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
	495401 B. WING		_	C 08/05/2021			
NAME OF PROVIDER OR SUPPLIER TYLER'S RETREAT AT IRON BRIDGE				STREET ADDRESS, CITY, STA 12001 IRON BRIDGE RD CHESTER, VA 23831	ATE, ZIP CODE	00/03/2021	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE ICED TO THE APPROPRIA EFICIENCY)		
F 812	,		F	312			
	and care of the electr On 8/5/2021 at appro	ximately 12:06 p.m., ASM president of operations					

		(1) PROVIDER/SUPPLIER/CLIA (X2) MUL' IDENTIFICATION NUMBER: A. BUILDI		PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
		495401	B. WING _			C 08/05/2021		
NAME OF PROVIDER OR SUPPLIER TYLER'S RETREAT AT IRON BRIDGE				STREET ADDRESS, CITY, STATE, ZIP CODE 12001 IRON BRIDGE RD CHESTER, VA 23831	'	00/00/2021		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
F 812	and according to the scheduleMaintenan broken blade. Report Maintenance Departs. On 8/4/2021 at approache administrator, ASASM #3, the regiona and ASM #4, the regnotified of the finding. On 8/5/2021 at approache administrator proache documented, "Berke meat slicer in the kitowas taken by Maintenance office to the blade. The blade therefore does not rowith a cloth to clean which came out look 8/4/2021. Attached it the meat slicer for re #6, director of maintenance of maintenanc	esource- Cleaning rocessor/Blender" "It will be cleaned as needed cleaning nce: Replace notched or rt dull blade to the ment." Eximately 4:55 p.m., ASM #1, SM #2, the director of nursing, I vice president of operations ional nurse consultant were s. Eximately 8:00 a.m., ASM #1, vided a typed memo which 827A Meat Slicer. The chen at [Name of Facility] nance Director to the o clean for possible rust on e is stainless steel and st. The blade was cleaned debris off, and polish blade, ing new. Completed on s the info (information) on ference. [Signature of OSM	F 8	12				

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495401	B. WING			C 08/05/2021		
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP COD	<u> </u>	00/00	0/2021	
T) (= D) 0				12001 IRON BRIDGE RD				
ITLER'S	RETREAT AT IRON BRID	GE		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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE	
F 812		e 101 n was provided prior to exit.	F 8	312				